WellCare of Kentucky, Inc. Response to

Commonwealth of Kentucky

The Cabinet for Health and Family Services (CHFS)

Department for Medicaid Services (DMS)

MEDICAID MANAGED CARE ORGANIZATION (MCO) - ALL REGIONS

RFP 758 2000000202

February 7, 2020 at 3:30 PM ET

ORIGINAL HARD/PAPER COPY - TECHNICAL

VOLUME 1 OF 3

WellCare®

Beyond Healthcare. A Better You.

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A.

TRANSMITTAL LETTER

WellCare®
Beyond Healthcare. A Better You.

William Jones
Chief Executive Officer

February 5, 2020

Amy Monroe, CPPB
Commonwealth of Kentucky
Finance and Administration Cabinet
Office of Procurement Services
New Capitol Annex
702 Capitol Avenue, Room 096
Frankfort, KY 40601

Dear Ms. Monroe:

WellCare Health Insurance Co. of Kentucky, Inc. (WellCare of Kentucky) is pleased to submit the attached response to the Office of Procurement Services RFP 758 2000000202.

Thank you for the opportunity to respond to the RFP. WellCare of Kentucky has been serving Medicaid beneficiaries in the Commonwealth of Kentucky since 2015. WellCare of Kentucky values the relationship it has with the Commonwealth since 2011 and looks forward to continued collaboration with the Department to provide quality services to the most vulnerable populations in Kentucky.

As required by Section 60.6 Technical Proposal Content of the RFP, we would like to confirm the following:

- WellCare of Kentucky understands that deviations from the contract are not allowed;
- If awarded a contract as a result of this solicitation, WellCare of Kentucky shall comply in full with all requirements of the Kentucky Civil Rights Act, and shall submit all data required by KRS 45.560 to 45.640;
- WellCare of Kentucky swears that pursuant to KRS 11A.040, it has not knowingly violated any provisions of the Executive Branch Code of Ethics;
- WellCare of Kentucky swears that it is in compliance with Prohibitions of Certain Conflicts of Interest;
- WellCare of Kentucky certifies that in accordance with Federal Acquisition Regulation 52.209-5, Certification Regarding Debarment, Suspension, and Proposed Debarment and to the best of our knowledge and belief, it and/or its principals are not presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any State or Federal agency.

Office Address: 13551 Triton Park Boulevard | Suite 1800 | Louisville, KY 40223
Telephone: 1-502-253-5201 | Fax: 1-502-253-5255 **| E-mail:** wiliam.jones@wellcare.com

Included below is the information for William Jones, the contact person for this RFP:

William Jones, Chief Executive Officer
WellCare of Kentucky
13551 Triton Park Boulevard
Suite 1800
Louisville, KY 40223
502-253-5201 Phone
502-253-5255 Fax
william.jones@wellcare.com

Included below is the information for Benjamin Orris, COO of WellCare of Kentucky, the contact person for day-to-day operations:

Benjamin Orris, Chief Operations Officer
WellCare of Kentucky
13551 Triton Park Boulevard
Suite 1800
Louisville, KY 40223
502-253-5201 Phone
502-253-5255 Fax
Benjamin.orris@wellcare.com

WellCare of Kentucky certifies that the thumb/flash drives submitted with our hard copy/paper proposal have been properly scanned for infected viruses. Using Symantec Endpoint Protection, version 14.2.1023 virus software and version to scan the drives, our IT department supervised this process. To summarize, our systems are set up to automatically perform virus scanning on all network and other drives as files are moved to them.

Therefore, by placing our files on a shared network drive we are ensuring that these files will automatically be scanned for virus and other malware signatures.

WellCare of Kentucky provides its subcontractor information on the following pages in table format and includes the name of the subcontractor company, address, telephone number and contact name, if applicable.

WellCare of Kentucky has noticeably labelled proprietary information on each sheet and provided it in a separate sealed cover marked “Proprietary Data”. We have included one marked original hard/paper copy marked “Proprietary Data” and 10 marked “Proprietary Data” thumb/flash drives.

WellCare
Beyond Healthcare. A Better You.

WellCare has been a trusted partner of the Commonwealth since the inception of Managed Care in 2011. We have grown to become the largest MCO in Kentucky with the highest Member and Provider Satisfaction. Our #1 ranking in Quality in Kentucky is driven by our comprehensive and integrated Care Model that includes Social Determinants along with strong Provider partnership. This has all resulted in members choosing WellCare more than any other MCO in the Commonwealth. Our commitment and dedication to provide the best care and service will continue, and our focus on improving health outcomes and partnering with our Provider and Stakeholder communities to bring innovative solutions will continue to move us forward.

Sincerely,

William Jones
Chief Executive Officer
WellCare Health Insurance Company of Kentucky, Inc.

STEPHANIE A. SALERNO
MY COMMISSION # GG 361822
EXPIRES: August 1, 2023
Bonded Thru Notary Public Underwriters

Stephanie A. Salerno
2/5/20

ORIGINAL

Office Address: 13551 Triton Park Boulevard | Suite 1800 | Louisville, KY 40223
Telephone: 1-502-253-5100 | Fax: 1-502-253-5253 | **E-mail:** william.jones@wellcare.com

WellCare of Kentucky Subcontractors

Subcontractor	Contact Person	Location	Phone Number
Aarete, LLC	Duane Harrington	200 E. Randolph Street, Suite 3010 Chicago, IL 60601	312-912-2977
AdminisTEP, LLC	Kenny Lee	2600 Technology Drive, Suite 700, Plano, TX 75074	214-440-3139
Advanced Medical Reviews, LLC.	Ally Michailov	600 Corporate Pointe, Suite 300 Culver City, CA 90230	310-575-0900
All Asian Group	Sandra Rueda	18-44 College Point Blvd. College Point, NY 11356	212-686-1333
Avesis Third Party Administrators, Inc.	Mel Fuller-Taylor	10324 S. Dolfield Road Owings Mills, MD 21117	410-413-9366
BCS Investment Group, LLC, dba Kaleidoscope Services	Brian Sauer	121 Anclote Blvd Tarpon Springs, FL 34689	727-945-0548
Brand dba Study Hall Research	Rob Iles	4409 West El Prado Blvd., Tampa, FL 33629	813-849-4255
C3/CustomercontactChannels Inc.	Helen Franco	Huntington Square I 3400 Lakeside Drive, Suite 515 Miramar, FL 33027	954-577-7702
CareCentrix, Inc.	Judith Platkin	20 Church Street, Suite 1200 Hartford, CT 06103	201-725-3392
CareerArc	Yair Riemer	3400 W. Olive Ave., Ste. 220 Burbank, CA 91505	818-360-3134
CIOX Health	Lori Reel	925 North Point Parkway, Suite 350 Alpharetta, GA 30005-5214	800-367-1500
Cobalt Therapeutics, LLC	Jim Wieland	55 Nod Road, Avon, CT 06001	952-225-5710
Common Health Corporation, Inc. dba Center Care Health Benefit Programs	John Mark Fones	800 Park Street Bowling Green, KY 42101	270-745-1514
Comprehensive Health Management, Inc.	Chuck Beeman	8735 Henderson Road, Building #2 Tampa, FL 33634-1143	813-206-5440
Concentrix Corp. (f/k/a IBM Daksh Business Process Services PVT Ltd)	Ralph Hulett	2000 Wade Hampton Blvd. Greenville, SC 29615	513-723-6345
Conduent Credit Balance Solutions, LLC (Formerly CDR Associates, LLC)	Douglas Creveling	307 International Circle, Suite 300 Hunt Valley, MD 21030	410-830-0242

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Subcontractor	Contact Person	Location	Phone Number
Cotiviti, LLC	Tim Shorey	One Glenlake Parkway, Suite 1400 Atlanta, GA 30328	203-642-5187
Council for Affordable Quality Healthcare, Inc.	Nicole Rainer	2020 K Street, NW, Suite 900 Washington, DC 20006	202-759-1847
CSI Southeast, Inc., d/b/a Interpretek	Adam Ledo	75 Highpower Road Rochester, NY 14623	407-339-4835
CVS - CaremarkPCS Health, LLC	Christie Raymond	One CVS Drive Woonsocket, RI 02895	480-438-2757
Transaction Applications Group	Praveen Katiyar	7950 Legacy Drive, Suite 900 Plano, TX 75024	214-263-0286
Devlin Consulting, Inc.	Ted Devlin	5505 W. Chandler Blvd, Suite 20 Chandler, AZ 85226	480-694-5964
Direct Technologies, Inc.	Brett Coltman	600 Satellite Blvd Suwanee, GA 30024	678-288-1700
Drynachan, LLC dba Advance Health	Vijay Prabhakar	4055 Valley View Lane, Suite 400 Dallas, TX 75244	858-361-4801
Eliza Corporation	Laura Wertam	5615 High Point Drive Irving, Texas 75038	978-223-9116
Elahi Enterprises dba Akorbi	Edward Cavazos	6504 International Pkwy, Ste 1500 Plano TX 75093	214-256-9222
Episource, LLC	Andrew Perlstein	500 W. 190th Street #400 Gardena, CA 90248	714-452-1961
eviCore (f/k/a CareCore National, LLC)	Cayce Awe	400 Buckwalter Place Blvd. Bluffton, SC 29910	800-918-8924
Equian (fka First Recovery Group)	Stephanie Elliot	5975 Castle Creek Pkwy N Dr. Indianapolis, IN 46250	720-259-4367
FiServ Solutions Inc.	Kimberly Stephens	255 Fiserv Drive Brookfield, WI 53045	281-274-6369
Focus Health Inc.	Bobby Harper	10801 Starkey Road #104-101 Seminole, FL 33777	727-202-4650
GeBBs HealthCare Solutions, Inc.	Gabe Stein	600 Corporate Pointe, Suite 1250 Culver City, CA 90230	310-907-7102
Good Measures, LLC	Caroline Carney	30 Rowes Wharf, Suite 410, Boston, MA 02110	857-702-0339
Health Help, LLC	Lystra McCoy	16945, Northchase Drive, Suite 1300 Houston, TX 77060	281-582-1728
Health Management Systems, Inc.	Shannon Cohen	5615 High Point Drive Irving, TX 75038	215-910-1543

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Subcontractor	Contact Person	Location	Phone Number
Healthy Profits, LLC dba Heal Pros, LLC	Eric Scott	3500 Piedmont Rd NE Ste 325, Atlanta, GA 30305	404-630-3369
Human Arc Corporation	Linda Roman	16260 N 71st Street, Suite 350 Scottsdale, AZ 85254	216-431-5200 ext 1550
InfoMedia Group, Inc. d/b/a Carenet Healthcare Services	Scott Schawe	11845 IH 10 West, Suite 400 San Antonio, TX 78230	210-595-2049
Inovalon, Inc.	Richard Thomas	4321 Collington Road Bowie, MD 20716	214-926-2751
Krames/Staywell	Jim Crouch	800 Township Line Road Yardley, PA 19067	208-890-1397
Mobile Medical Examination Services, Inc.	Shawheen Moridi	1241 East Dyer Road Suite 145 Santa Ana, CA 92705	888-306-0615
Multilingual Group	Sandra Rueda	18-44 College Point Blvd. College Point, NY 11356	212-686-1333
Novu, LLC	Liz Taran	5401 Gamble Drive, Suite 300 St. Louis Park, MN 55416	855-612-6688
O'Neil Data Systems, Inc.	Laura Bellantine	12655 Beatrice Street Los Angeles, CA 90066	678-764-1571
OptumInsight fka Ingenix	Allen Rayburn	11000 Optum Circle Eden Prairie, MN 55344	615-503-1220
Payspan, Inc.	Robert Booth	7751 Belfort Parkway, Ste 200 Jacksonville, FL 32256	904-588-7006
Prest and Associates, Inc.	Judith Shaffer	401 Charmany Dr., Suite 305 Madison, WI 53719	800-358-5129
Progeny Health, Inc.	Ellen Stang	450 Plymouth Rd, Suite 200 Plymouth Meeting PA 19462	610-832-2001
Revel Health, LLC fka HealthTel	Kyle Gunderson	123 North 3rd Street, Suite 605 Minneapolis, MN 55401	612-235-2111
RJ Health International Systems, LLC	Julie O'brien	237 Main St., First Floor Middletown, CT 06457	860-257-5873
Rodael Direct, Inc. dba Genesis Direct	Anne Sullivan	8514 Sunstate Street Tampa, FL 33634	813-855-4274 x1221
R.R. Donnelley & Sons Company	Frank Mega	35 West Wacker Drive Chicago, IL 60601	813-218-5506
SPH Analytics (f/k/a Patient Satisfaction Plus, LLC, d/b/a The Myers Group)	Midge Coker	11605 Haynes Bridge Road, Suite 400 Alpharetta, GA 30009	678-689-0295
Syrtis Solutions Ltd.	Howard Green	1601 Rio Grande, Suite 330 Austin, TX 78701	866-960-9358

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Telephone: 1-502-253-5100 | Fax: 1-502-253-5253 **| E-mail:** william.jones@wellcare.com

Subcontractor	Contact Person	Location	Phone Number
The Results Companies, LLC	Olga Golovin	100 N.E. 3rd Ave, Suite 200. Fort Lauderdale, FL 33301	678-412-6520
TPUSA, Inc. d/b/a Teleperformance	Bonnie Wortham	5295 S. Commerce Drive, Suite 600 Murray UT 84107	318-364-0258
Translation Station	Lindsey Cambardella	3460 Chamblee Dunwoody Way Atlanta , GA 30341	770-234-9387
Transunion Corp.	Justin Arnold	555 West Adams Street Chicago, IL 60661	704-970-1435
TurningPoint Healthcare Solutions, LLC	Stacy Wolf	59 Skyline Drive, Ste 1100, Lake Mary, FL 32746	805-896-7648
Virtual Frameworks, Inc. d/b/a Virtual Health	Ty McDonald	115 Fifth Avenue, 2nd Floor New York, NY 10003	781-264-7861
Voiance Language Services	Steven Cook	2650 E. Elvira Road, Suite 132, Tucson, AZ 85756	866-742-9080 ext 1776
Wellsource	Claire Egli	8100 SW Nyberg Street, Suite 450 Tualatin, OR 97062	503-557-9554

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B.

DISCLOSURE OF VIOLATION OF STATUTES

B. DISCLOSURE OF VIOLATION OF STATUTES

Pursuant to KRS 45A.485, contractors are required to reveal final determinations of violation of certain statutes incurred within the last five (5) years and be in continuous compliance with those statutes during the contract. Where applicable, the vendor is required to complete and submit Report of Prior Violations of Tax and Employment Laws.

B. DISCLOSURE OF VIOLATIONS OF STATUTES

To the best of our knowledge and belief, WellCare of Kentucky has had no violations of the statutes mentioned in KRS 45A.485 during the lookback period, nor have there been any final determinations of violations thereof, and we have been in continuous compliance with those statutes therefore completion of the Report of Prior Violations of Tax and Employment Laws is not applicable.

C.

KENTUCKY TAX REGISTRATION APPLICATION

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C. KENTUCKY TAX REGISTRATION APPLICATION

Revenue Form 10A100, Kentucky Tax Registration Application effective July 2008, is a form to be completed by any person or entity wishing to contract with the Commonwealth to provide goods or services subject to sales and use tax pursuant to KRS 139.200. The form is located at this web-link as Attachment 5:
http://finance.ky.gov/services/eprocurement/Pages/VendorServices.aspx.

In accordance with administrative regulation 200 KAR 5:390, this form has to be completed and submitted, before a contract can be awarded. Section 2 of the regulation also notes: "Failure to submit the required documentation or to remain registered and in compliance with the sales and use tax filing and remittance requirements of KRS 139.540 and KRS 139.550 throughout the duration of the contract shall constitute a material breach of the contract and the contract may be terminated."

C. KENTUCKY TAX REGISTRATION APPLICATION

Please see the attached completed Revenue Form 10A100, Kentucky Tax Registration Application. It is named **Attachment 60.6.C Kentucky Tax Registration Application.**

10A100(P)(7-13)
Commonwealth of Kentucky
DEPARTMENT OF REVENUE

This is an amended form. We made a mistake before with state of incorporation. It is corrected below.

FOR OFFICE USE ONLY						
☐ WH	☐ SU	☐ TEL	☐ CU	☐ CP	☐ CT	
	☐ TR	☐ UTL		☐ LL	☐ CID	
	☐ TF					
CRIS #						
CTS CASE #				Coded		
CTS Person ID #				Date Coded		
RCS Flag				Data Entry		
NAICS		SIC		Date Data Entered		

KENTUCKY TAX REGISTRATION APPLICATION

NOTE: *For your convenience, application may be filed online at http://onestop.ky.gov.*

- **Incomplete or illegible applications will delay processing and will be returned.**
- **Print or type the application using blue or black ink only.**
- **Please see instructions for questions regarding completion of the application.**
- *Need Help?* Call (502) 564-3306 or visit *www.revenue.ky.gov*

SECTION A REASON FOR COMPLETING THIS APPLICATION (Must Be Completed)

1. Effective Date 07/01/2015

- ☐ Opened new business/Began activity in Kentucky
- ☐ Resumption of business
- ☐ Hired employees working outside KY who have a KY residence
- ☐ Applying for other accounts/Began a new taxable activity
- ☒ Bidding for State Government Contract (State Vendor or Affiliates)
- ☐ Purchased an existing business (*See Instructions*)
- ☐ Ownership/Entity type change or conversion (Specify previous type; *See Instructions*) _____
- ☐ Change in Federal Identification Number (FEIN) or Kentucky Secretary of State Organization Number
- ☐ Other *(Specify)* _____

2. Previous Account Numbers ***(If Applicable)***

- Kentucky Employer's Withholding Tax _____
- Kentucky Sales and Use Tax _____
- Kentucky Telecommunications Tax _____
- Kentucky Utilities Gross Receipts License Tax _____
- Kentucky Consumer's Use Tax _____
- Kentucky Corporation Income Tax and/or Limited Liability Entity Tax _____
- Kentucky Coal Severance & Processing Tax
- Federal ID Number (FEIN) **KRS 61.878(1)(a)**
- Kentucky Secretary of State Organization Number _____

To update information for your existing account(s) or report opening a new location of your current business, use Form 10A104, *Update or Cancellation of Kentucky Tax Account(s).*

SECTION B BUSINESS / RESPONSIBLE PARTY / CONTACT INFORMATION (Must Be Completed)

3. Legal Business Name WellCare Health Insurance Company of Kentucky, Inc.

4. Doing Business As ***(See Instructions)*** WellCare of Kentucky, Inc.

5. Federal Employer Identification Number (FEIN)
(Required, complete prior to submitting) **KRS 61.878(1)(a)**

6. Secretary of State Information ***(if applicable)***

Kentucky Secretary of State Organization Number **KRS 61.878(1)(a)**		
Date of Incorporation/Organization	State of Incorporation/Organization	If an Out-of-state Entity, Date of Qualification with the Kentucky Secretary of State's Office
03-27-1962	KY	

7. Primary Business Location

Street Address *(DO NOT List a PO Box)*		
8735 Henderson Road, Ren. #2		
Tax Department		
City	State	Zip Code
Tampa	FL	33634
Telephone Number	County (if in Kentucky)	

8. Accounting Period

- ☒ Calendar Year: — Year Ending December 31st
- ☐ Fiscal Year: — Year Ending _____ *(mm/dd)*
- ☐ 52/53 Week Calendar Year: — December _____ (Day of Week that year ends)
- ☐ 52/53 Week Fiscal Year: _____ (Month & Day of Week that year ends)

9. Accounting Method

☐ Cash ☒ Accrual

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7013 2630 0001 4591 3663

10A100(P)(7-13)

10. Ownership Type

- [ ] Limited Liability Company (LLC or PLLC)
- [ ] Series of a Limited Liability Company
- [X] Corporation
- [ ] Professional Service Corporation (PSC)
- [ ] Association
- [ ] Cooperative
- [ ] Limited Cooperative Assn.
- [ ] Statutory Trust
- [ ] Series of a Statutory Trust
- [ ] Trust (Non-statutory)
- [ ] Limited Partnership (LP or PLP)
- [ ] Limited Liability Partnership (LLP or PLLP)
- [ ] Limited Liability Limited Partnership (LLLP or PLLLP)
- [ ] Series of a Partnership
- [ ] General Partnership
- [ ] Joint Venture
- [ ] Estate
- [ ] Government
- [ ] Unincorporated Non-profit
- [ ] Sole Proprietorship
- [ ] Home Health Care Service Recipient (HHCSR)
- [ ] Protected Cell Company (PCC)
- [ ] Cell of a Protected Cell Company
- [ ] Other *(Specify)* _____

11. How Will You be Taxed for Federal Purposes? (Sole Proprietorships, HHCSRs, Estates, and Governments SKIP question 11)

- [ ] Partnership
- [X] Corporation
- [ ] S-Corporation
- [ ] Non-Profit
- [ ] Homeowner's Association
- [ ] Cooperative
- [ ] Real Estate Investment Trust (REIT)
- [ ] Regulated Investment Company (RIC)
- [ ] Real Estate Mortgage Investment Conduit (REMIC)
- [ ] Trust
- [ ] **Single Member Disregarded Entity**
  Check below how the Member will be taxed Federally
  - [ ] Individual Sole Proprietorship
  - [ ] General Partnership/Joint Venture
  - [ ] Estate
  - [ ] Trust (non-statutory)
  - [ ] Other *(Specify how the member is federally taxed)* _____

12–13. OWNERSHIP DISCLOSURE–RESPONSIBLE PARTIES *(REQUIRED FOR ALL OWNERSHIP TYPES)*

Full Legal Name (Last, First, Middle)			Full Legal Name (Last, First, Middle)		
See attached List					
Social Security Number *(REQUIRED)*	KY Driver's License Number (if applicable)		Social Security Number *(REQUIRED)*	KY Driver's License Number (if applicable)	
Business Title	Effective Date of Title		Business Title	Effective Date of Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code
Telephone Number	County (if in Kentucky)		Telephone Number	County (if in Kentucky)	

14. Person to contact about this application:

Name (Last, First, Middle)	Title	Daytime Telephone	Extension
Jessie Xu	Sr. Tax Analyst	813-206-1115	
E-mail (By supplying your e-mail address you grant the Department of Revenue permission to contact you via e-mail.)	jessie.xu@wellcare.com		

SECTION C — TELL US ABOUT YOUR BUSINESS OR ORGANIZATION (Must Be Completed)

15. A. Describe the nature of your business activity in Kentucky, including any services provided.
Health Insurance

B. If you make sales in Kentucky, list the products sold. _____

C. Describe the nature of your business activity outside Kentucky, including any services provided.
Health Insurance

D. Business operations are primarily: [ ] Home Based [ ] Web Based [X] Office/Store Based [ ] Transient

	YES	NO
16. Do you have or will you hire employees to work in Kentucky within the next 6 months? (An employee is anyone to whom you pay wages, including part-time help and family members.)	[ ]	[X]
17. Do you wish to voluntarily withhold on Kentucky residents who work outside Kentucky?	[ ]	[X]
18. Do you wish to voluntarily withhold on pension and retirement payments?	[ ]	[X]
19. If your business is choosing taxation as a corporation for Federal purposes, will the Kentucky officers receive compensation other than dividends?	[ ]	[X]

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If you answered "YES" to ANY of questions 16 through 19, you must complete SECTION D.

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	Yes	No
20. Will you make retail and/or wholesale sales of tangible personal property or digital property in Kentucky? (Examples: prepared food, internet sales, downloaded music and books, see instructions for more.)		X
21. Will you install replacement parts for the repair or recondition of tangible personal property? (Examples: automotive repairs, computer or electronics repair, furniture repair, see instructions for more.)		X
22. Will you produce, fabricate, process, print or imprint tangible personal property? (Examples: sign making, window tinting, embroidery, screen printing, engraving, see instructions for more.)		X
23. Will you rent or lease tangible personal property or digital property to others, including related companies?		X
24. Will you charge taxable admissions?		X
25. Will you rent temporary lodging to others?		X
26. Will you sell for or are you a manufacturer's agent soliciting orders for a nonresident seller not registered in Kentucky?		X
27. Will you receive receipts from the breeding of a stallion to a mare in Kentucky?		X
28. Will you make sales of motor vehicles to residents of AZ, CA, FL, IN, MA, MI, SC, or WA?		X
29. Will you make sales of aviation jet fuel?		X
30. Are you a manufacturing fee processor or a contract miner located in Kentucky?		X
31. Are you bidding on a contract with Kentucky state government to be a state vendor?	X	
32. Are you an affiliate of a company that has been awarded a Kentucky state government contract and is a state vendor?		X

33. Will you sell any of the following?

Yes	No		Yes	No	
	X	A. Coal or other minerals		X	E. Sewer services
	X	B. Water utilities		X	F. Communication services
	X	C. Natural, artificial, or mixed gas utilities		X	G. Multichannel video programming services
	X	D. Electricity			*(see instructions)

If you answered "YES" to ANY of questions 20 through 33 (except 33 G), you must complete SECTION E and you may SKIP questions 34-35.
If you answered "YES" to ANY of questions 33 B through 33 G, you must ALSO complete SECTION F.

	Yes	No
34. Are you a construction company/contractor that will bring into this state construction materials or supplies on which no Kentucky sales tax or equivalent has been paid?		X
35. Will you make purchases from out-of-state vendors and not pay Kentucky sales or use tax to the seller on those purchases? (If you are a PROFESSIONAL SERVICE business or if your business will make a one-time purchase only, please see instructions for important additional details.)		X

If you answered "YES" to EITHER of questions 34 or 35, you must complete SECTION G.

	Yes	No
36. Will you mine coal that you own or possess the mineral rights to, either by deed, lease, consent, etc.?		X
37. Does your company perform one or more of the following activities:		
A. Purchase coal for the purpose of processing and resale?		X
B. Process refuse coal? (Processing means cleaning, breaking, sizing, dust allaying, treating to prevent freezing, or loading or unloading for any purpose.)		X
C. Purchase and sell coal as a coal broker?		X

If you answered "YES" to ANY of questions 36 or 37, you must complete SECTION H and SECTION E.

	Yes	No
38. Is your business/organization a corporation, S corporation, professional service corporation (PSC), association, homeowner's association, cooperative, limited cooperative association, statutory trust, series of a statutory trust, limited partnership (LP or PLP), limited liability partnership (LLP or PLLP), limited liability limited partnership (LLLP or PLLLP), series of a partnership, limited liability company (LLC or PLLC), series of a limited liability company, real estate investment trust (REIT), regulated investment company (RIC), real estate mortgage investment conduit (REMIC), protected cell company (PCC), cell of a protected cell company, or similar entity created with limited liability for the partners, members or shareholders?	X	

If you answered "YES" to question 38, you MUST answer questions 39 through 49.
Sole Proprietorships, HHCSRs, and General Partnerships should SKIP questions 39 through 49.

	Yes	No
39. Is your corporation incorporated or your limited liability entity organized under the laws of Kentucky with the Kentucky Secretary of State's Office?	X	
40. Will your corporation/limited liability entity have its commercial domicile in Kentucky?		X
41. Will your corporation/limited liability entity own or lease any real or tangible personal property located in Kentucky?		X
42. Will your corporation/limited liability entity have one or more individuals performing services in Kentucky?		X
43. Will your corporation/limited liability entity maintain an interest in a pass-through entity doing business in Kentucky?		X

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44.	Will your corporation/limited liability entity derive income from, or attributable to, sources within Kentucky?	X	
45.	Will your corporation/limited liability entity derive income directly or indirectly from a trust doing business in Kentucky?		X
46.	Will your corporation/limited liability entity derive income directly or indirectly from a single-member limited liability company that is doing business in Kentucky and is disregarded as an entity separate from its single member for federal income tax purposes?		X
47.	Will your corporation/limited liability entity direct activities at Kentucky customers for the purpose of selling them goods?		X
48.	Will your corporation/limited liability entity direct activities at Kentucky customers for the purpose of selling them services?	X	
49.	Will your corporation/limited liability entity own/lease any intangible property or receive payments from a related member as defined in KRS 141.205(1)(g) or an unrelated party for the use of intangible property in Kentucky such as royalties, franchise agreements, patents, trademarks, etc.?		X

If you answered "YES" to ANY of questions 39 through 49, you must complete SECTION I.

SECTION D — EMPLOYER'S WITHHOLDING TAX ACCOUNT

Must be completed if you answered "YES" to ANY of the questions 16 through 19.

For Office Use Only WH #

50. A. Has a Kentucky Employer's Withholding Tax Account already been assigned to this business? ☐ Yes ☐ No
B. If yes, list the Employer's Withholding Tax Account Number ☐☐☐☐☐☐

51. Number of Kentucky employees _____

52. Date wages/pensions first paid or will be paid (REQUIRED)

_____

53. Estimated total annual tax withheld in Kentucky:

☐ $0.00-$399.99 ☐ $2,000.00-$49,999.99

☐ $400.00-$1,999.99 ☐ $50,000.00 or more

54. *Employer's Withholding Tax* returns should be mailed to:
☐ Use the same address as listed on Page 1, Section B, Question 7

c/o or Attn		
Address		
City	State	Zip Code
Mailing Telephone Number	County (if in Kentucky)	

SECTION E — SALES AND USE TAX ACCOUNT TRANSIENT ROOM TAX ACCOUNT AND MOTOR VEHICLE TIRE FEE ACCOUNT

Must be completed if you answered "YES" to ANY of the questions 20 through 33 (except 33 G) or question 36 or 37.

For Office Use Only: SU/TR/TF #

55. A. Has a Kentucky Sales and Use Tax Account already been assigned to this business? ☐ Yes [X] No
B. If yes, list the Sales and Use Tax Account Number ☐☐☐☐☐☐

56. Date sales began or will begin (REQUIRED)

07-01-2015

57. Do you rent temporary lodging to others? ☐ Yes [X] No

58. Do you sell new tires for motor vehicles? ☐ Yes [X] No

59. Estimated gross monthly sales tax collected in Kentucky:
[X] $0.00-$1,199.99 ☐ $1,200.00 or more

60. A. Does this business have additional locations in Kentucky other than the one listed on Page 1, Section B, Question 7?
☐ Yes [X] No

B. If yes, attach a listing of all additional Kentucky locations. For each location, the attachment should include: doing business as (DBA) name, physical location address, phone number, date location was opened, and a description of the location's business activity.

61. *Sales and Use Tax* returns should be mailed to:
[X] Use the same address as listed on Page 1, Section B, Question 7

c/o or Attn		
Address		
City	State	Zip Code
Mailing Telephone Number	County (if in Kentucky)	

1062

SECTION F TELECOMMUNICATIONS TAX ACCOUNT AND/OR UTILITY GROSS RECEIPTS LICENSE TAX ACCOUNT

Must be completed if you answered "YES" to ANY of the questions 33B through 33G.

For Office Use Only TEL #
UTL #

62. A. Has a Kentucky Telecommunications and/or Utility Gross Receipts License Tax Account already been assigned to this business? ☐ Yes ☐ No

B. If yes, list the Telecommunications Tax Account Number

If yes, list the Utility Gross Receipts License Tax Account Number

63. Date sales of communications or utilities began or will begin (REQUIRED)

64. Telephone Number

Once the account for *Telecommunications Tax* is assigned, use the following website to set up account for online filing of returns.
http://revenue.ky.gov/business/Telecom.htm

Once the account for *Utility Gross Receipts License Tax* is assigned, use the following website to set up account for online filing of returns.
http://revenue.ky.gov/business/utilschool.htm

SECTION G CONSUMER'S USE TAX ACCOUNT

Must be completed if you answered "YES" to EITHER question 34 or 35.

For Office Use Only CU #

65. A. Has a Consumer's Use Tax Account already been assigned to this business? ☐ Yes ☐ No

B. If yes, list the Consumer's Use Tax Account Number

66. Date purchases began or will begin (REQUIRED)

67. *Consumer's Use Tax* returns should be mailed to:

☐ Use the same address as listed on Page 1, Section B, Question 7

c/o or Attn.		
Address		
City	State	Zip Code
Mailing Telephone Number	County (if in Kentucky)	

SECTION H COAL SEVERANCE/PROCESSING TAX ACCOUNT and/or COAL SELLER/PURCHASER CERTIFICATE ID

Must be completed if you answered "YES" to EITHER question 36 or 37.

For Office Use Only CT #
CID #

68. A. Has a Coal Severance Tax Account and/or a Coal Seller/Purchaser Certificate ID # already been assigned to this business? ☐ Yes ☐ No

B. If yes, list the Coal Severance Tax Account Number

If yes, list the Coal Seller/Purchaser Certificate ID Number

69. Date mining/processing or coal brokering operations began or will begin (REQUIRED)

70. *Coal Severance & Processing Tax* returns should be mailed to

☐ Use the same address as listed on Page 1, Section B, Question 7

c/o or Attn		
Address		
City	State	Zip Code
Mailing Telephone Number	County (if in Kentucky)	

1062 4W201P 1 000

10A100(P)(7-13)

SECTION I — CORPORATE INCOME AND/OR LIMITED LIABILITY ENTITY TAX ACCOUNT

Must be completed if you answered "YES" to ANY of the questions 39 through 49.

For Official Use Only CP/LL #

71. A. Has a Corporation Income and/or Limited Liability Entity Tax Account already been assigned to this business? ☐ Yes ☒ No

B. If yes, list the Corporation Income or Limited Liability Entity Tax Account Number ☐☐☐☐☐☐

72. A. Is your entity exempt from Corporation Income Tax and/or Limited Liability Entity Tax under Kentucky law? ☐ Yes ☒ No

B. If yes, select the exemption type below:

- ☐ Financial institution, as defined in KRS 136.500, except banker's banks organized under KRS 287.135 or KRS 286.3-135
- ☐ Savings and loan association organized under the laws of this state and under the laws of the United States and making loans to members only
- ☐ Bank for cooperatives
- ☐ Production credit association
- ☐ Insurance company, including farmers or other mutual hail, cyclone, windstorm, or fire insurance companies, insurers, and reciprocal underwriters (does not include insurance agencies)
- ☐ Corporation or other entity exempt under Section 501 of the Internal Revenue Code
- ☐ Religious, educational, charitable, or like corporation not organized or conducted for pecuniary profit
- ☐ Corporation whose only owned or leased property located in this state is located at the premises of a printer with which it has contracted for printing provided that: 1. The property consists of the final printed product, or copy from which the printed product is produced; and 2. The corporation has no individuals receiving compensation in this state as provided in KRS 141.120(8)(b)
- ☐ Public service corporation subject to tax under KRS 136.120
- ☐ Open-end registered investment company organized under the laws of this state and registered under the Investment Company Act of 1940
- ☐ Any property or facility which has been certified as a fluidized bed energy production facility as defined in KRS 211.390
- ☐ An alcohol production facility as defined in KRS 247.910
- ☐ Real estate investment trust (REIT) as defined in Section 856 of the Internal Revenue Code
- ☐ Regulated investment company (RIC) as defined in Section 851 of the Internal Revenue Code
- ☐ Real estate mortgage investment conduit (REMIC) as defined in Section 860D of the Internal Revenue Code
- ☐ Personal service corporation as defined in Section 269A(b)(1) of the Internal Revenue Code
- ☐ Publicly traded partnership as defined by Section 7704(b) of the Internal Revenue Code that is treated as a partnership for federal tax purposes under Section 7704(c) of the Internal Revenue Code, or their publicly traded partnership affiliates. (Publicly traded partnership affiliates shall include any limited liability company or limited partnership for which at least eighty percent (80%) of the limited liability company member interests or limited partner interests are owned directly or indirectly by the publicly traded partnership.)
- ☐ Qualified investment partnership (QIP) as defined in KRS 141.206(15)(a) &(b)
- ☐ Statutory trust or series of a statutory trust
- ☐ Cooperative described in Sections 521 and 1381 of the Internal Revenue Code *(Select category below)*
  - ☐ Farmers' agricultural and other cooperatives organized or recognized under KRS Chapter 272
  - ☐ Advertising cooperatives
  - ☐ Purchasing cooperatives
  - ☐ Homeowner's associations including those described in Section 528 of the Internal Revenue Code
  - ☐ Political organizations as defined in Section 527 of the Internal Revenue Code
  - ☐ Rural electric and rural telephone cooperatives

C. If **Political Organization** selected above, are you required to file Federal Form 1120-POL? ☐ Yes ☐ No

73. A. Is this entity treated Federally as a division of a parent company and not separately taxed as its own entity? ☐ Yes ☒ No

B. If yes, select the division type below:

- ☐ Qualified Subchapter S-corporation Subsidiary (QSUB)
- ☐ Qualified Real Estate Investment Trust Subsidiary (QRS)

74. If an out-of-state entity, is your Kentucky activity limited to the mere solicitation of the sale of tangible personal property and exempt from Corporation Income tax due to Public Law 86-272? ☐ Yes ☒ No

75. If an out-of-state entity, date that activity or receipt of pass through income began or will begin in Kentucky

76. *Corporation Income and/or Limited Liability Entity Tax* correspondence should be mailed to:

☒ Use the same address as listed on Page 1, Section B, Question 7

c/o or Attn		
Address		
City	State	Zip Code
Mailing Telephone Number	County (if in Kentucky)	

1062 4W201Q 1 000

10A100(P)(7-13) Page 7

IMPORTANT: THIS APPLICATION MUST BE SIGNED BELOW:

The statements contained in this application and any accompanying schedules are hereby certified to be correct to the best knowledge and belief of the undersigned who is duly authorized to sign this application.

Signed: _____ Signed: _____

Phone Number: 813-206-1994 Phone Number: _____

Title: CAO Date: 05/07/2015 (mm/dd/yyyy) Title: _____ Date: _____ (mm/dd/yyyy)

For assistance in completing the application, please call the **Taxpayer Registration Section** at **(502) 564-3306,** Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m., Eastern Time, or you may contact one of the Kentucky Taxpayer Service Centers or use the Telecommunications Device for the Deaf. Each office is open Monday through Friday, 8:00 a.m. to 5:00 p.m., local time. For a list of Taxpayer Service Centers and phone numbers, see the Instructions.

MAIL completed application to: **KENTUCKY DEPARTMENT OF REVENUE**
P.O. BOX 299, STATION 20
FRANKFORT, KENTUCKY 40602-0299

or **FAX to:** **502-227-0772**

If you are applying for a withholding account and/or a sales and use tax account and would like to register for Electronic Funds Transfer (EFT), visit the Kentucky Department of Revenue website at *www.revenue.ky.gov.*

To register for cigarette tax, minerals or natural gas severance tax, motor fuels tax, or any other miscellaneous taxes or fees administered by the Department of Revenue, visit the Department's website at *www.revenue.ky.gov.*

This form does not include registration with the Secretary of State, Unemployment Insurance, or Workers' Compensation Insurance. For assistance, please contact those offices at the numbers below.

Secretary of State	(502) 564-3490	Unemployment Insurance	(502) 564-2272	Workers' Compensation	(502) 564-5550
IRS–FEIN	(800) 829-4933				

For assistance with other questions about starting a business in Kentucky, including special licensing and permitting requirements, business structure registration, employer responsibilities, and business development resources, call the Business Information Clearinghouse at 1–800–626–2250 or visit the Kentucky Business One Stop website at *http://onestop.ky.gov.*

Kentucky
UNBRIDLED SPIRIT
1062

The Kentucky Department of Revenue does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, sexual orientation, gender identity, veteran status, genetic information or ancestry in employment or the provision of services.

4W201R 1.000

Wellcare Health Insurance Company of Kentucky, Inc
Officer List

Name	Title	SSN	Role Start	Last Elected	Address	Phone Number
Burdick, Kenneth A.	President	[redacted]	11/14/2014	11/14/2014	8735 Henderson Road, Ren 2, Tampa, FL 33634	(813) 290-6200
Asher, Andrew L.	Chief Financial Officer and Treasurer		11/14/2014	11/14/2014	8735 Henderson Road, Ren 2, Tampa, FL 33634	(813) 290-6200
Hebert, Maurice S.	Chief Accounting Officer and Assistant Treasurer		1/28/2010	4/1/2014	8735 Henderson Road, Ren 2, Tampa, FL 33634	(813) 290-6200
Munson, Kelly A.	Region President		7/25/2014	7/25/2014	8735 Henderson Road, Ren 2, Tampa, FL 33634	(813) 290-6200
Todt, Blair W.	Senior Vice President and Secretary		12/15/2014	12/15/2014	8735 Henderson Road, Ren 2, Tampa, FL 33634	(813) 290-6200

Note: The Social Security Numbers of the above individuals are reported on the original Tax Application document filed with the Kentucky Department of Revenue.

CONFIDENTIAL

D.

REGISTRATION WITH THE SECRETARY OF STATE BY A FOREIGN ENTITY

D. REGISTRATION WITH THE SECRETARY OF STATE BY A FOREIGN ENTITY

Pursuant to KRS 45A.480(1)(b), an agency, department, office, or political subdivision of the Commonwealth of Kentucky shall not award a state contract to a person that is a foreign entity required by KRS 14A.9-010 to obtain a certificate of authority to transact business in the Commonwealth ("certificate") from the Secretary of State under KRS 14A.9-030, therefore, foreign entities should submit a copy of their certificate with their solicitation response. If the foreign entity is not required to obtain a certificate as provided in KRS 14A.9-010, the foreign entity should identify the applicable exception in its solicitation response. Foreign entity is defined within KRS 14A.1-070. Businesses can register with the Secretary of State at: https://secure.kentucky.gov/sos/ftbr/welcome.aspx.

D. REGISTRATION WITH THE SECRETARY OF STATE BY A FOREIGN ENTITY

WellCare of Kentucky is not a foreign entity. No registration with the Secretary of State is necessary nor is a submission of a certificate.

E.

REQUIRED ANNUAL AFFIDAVIT AND OTHER AFFIDAVIT(S)

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Beyond Healthcare. A Better You.

E. REQUIRED ANNUAL AFFIDAVIT AND OTHER AFFIDAVITS

Please see the attached completed and signed affidavits:

- **60.6.E Affidavit Attachment A-1**
- **60.6.E Affidavit Attachment A-2**

60.6.E Affidavit A-3 does not apply to WellCare of Kentucky.

ATTACHMENT A (1)

Affidavit Effective Date:	January 15, 2020
Affidavit Expiration Date:	January 15, 2021
Maximum Length One-Year	

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS **PAGE 1 OF 2**

FOR BIDS AND CONTRACTS IN GENERAL:

I. Each bidder or offeror swears and affirms under penalty of perjury, that to the best of their knowledge:

a. In accordance with KRS 45A.110 and KRS 45A.115, neither the bidder or offeror as defined in KRS 45A.070(6), nor the entity which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth of Kentucky; and the award of a contract to the bidder or offeror or the entity which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.

b. The bidder or offeror swears and affirms under penalty of perjury that, to the extent required by Kentucky law, the entity bidding, and all subcontractors therein, are aware of the requirements and penalties outlined in KRS 45A.485; have properly disclosed all information required by this statute; and will continue to comply with such requirements for the duration of any contract awarded.

c. The bidder or offeror swears and affirms under penalty of perjury that, to the extent required by Kentucky law, the entity bidding, and its affiliates, are duly registered with the Kentucky Department of Revenue to collect and remit the sales and use tax imposed by KRS Chapter 139, and will remain registered for the duration of any contract awarded.

d. The bidder or offeror swears and affirms under penalty of perjury that the entity bidding is not delinquent on any state taxes or fees owed to the Commonwealth of Kentucky and will remain in good standing for the duration of any contract awarded.

e. The bidder or offeror swears and affirms under penalty of perjury that the entity bidding, is not currently engaged in, and will not for the duration of the contract engage in, the boycott of a person or an entity based in or doing business with a jurisdiction with which Kentucky can enjoy open trade, as defined in Executive Order No. 2018-905.

f. The bidder or offeror swears and affirms that the entity bidding, and all subcontractors therein, have not violated any of the prohibitions set forth in KRS 11A.236 during the previous ten (10) years, and further pledge to abide by the restrictions set forth in such statute for the duration of the contract awarded.

FOR "NON-BID" CONTRACTS (I.E. SOLE-SOURCE; NOT-PRACTICAL OR FEASIBLE TO BID; OR EMERGENCY CONTRACTS, ETC):

II. Each contractor further swears and affirms under penalty of perjury, that to the best of their knowledge:

a. In accordance with KRS 121.056, and if this is a non-bid contract, neither the contractor, nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of any contract awarded, have contributed more than the amount specified in KRS 121.150 to the campaign of the gubernatorial slate elected in the election last preceding the date of contract award.

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS PAGE 2 OF 2

b. In accordance with KRS 121.330(1) and (2), and if this is a non-bid contract, neither the contractor, nor officers or employees of the contractor or any entity affiliated with the contractor, nor the spouses of officers or employees of the contractor or any entity affiliated with the contractor, have knowingly contributed more than $5,000 in aggregate to the campaign of a candidate elected in the election last preceding the date of contract award that has jurisdiction over this contract award.

c. In accordance with KRS 121.330(3) and (4), and if this is a non-bid contract, to the best of his/her knowledge, neither the contractor, nor any member of his/her immediate family, his/her employer, or his/her employees, or any entity affiliated with any of these entities or individuals, have directly solicited contributions in excess of $30,000 in the aggregate for the campaign of a candidate elected in the election last preceding the date of contract award that has jurisdiction over this contract.

As a duly authorized representative for the bidder, offeror, or contractor, I have fully informed myself regarding the accuracy of all statements made in this affidavit, and acknowledge that the Commonwealth is reasonably relying upon these statements, in making a decision for contract award and any failure to accurately disclose such information may result in contract termination, repayment of funds and other available remedies under law. If the bidder, offeror, or contractor becomes non-compliant with any statements during the affidavit effective period, I will notify the Finance and Administration Cabinet, Office of Procurement Services immediately. I understand that the Commonwealth retains the right to request an updated affidavit at any time.

Signature | William Jones (Printed Name)

Chief Executive Officer (Title) | 1/15/2020 (Date)

Company Name: WellCare Health Insurance Company of Kentucky, Inc.

Address: 13551 Triton Park Boulevard
Suite 1800
Louisville, KY 40223

Commonwealth of Kentucky Vendor Code (if known): KY0000171

Subscribed and sworn to before me by William Jones (Affiant) SVP Division President (Title)

of WellCare Health Insurance Company of Kentucky, Inc (Company Name) this 15 day of January, 2020.

Jeri Mock
Notary Public

[seal of notary]

My commission expires: 11/09/2020

Notary Public State of Florida
Jeri Mock
My Commission GG 046214
Expires 11/09/2020

ATTACHMENT A (2)

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS CLAIMING RESIDENT BIDDER STATUS

FOR BIDS AND CONTRACTS IN GENERAL:
The bidder or offeror hereby swears and affirms under penalty of perjury that, in accordance with KRS 45A.494(2), the entity bidding is an individual, partnership, association, corporation, or other business entity that, on the date the contract is first advertised or announced as available for bidding:

1. Is authorized to transact business in the Commonwealth;
2. Has for one year prior to and through the date of advertisement
   a. Filed Kentucky corporate income taxes;
   b. Made payments to the Kentucky unemployment insurance fund established in KRS 341.49; and
   c. Maintained a Kentucky workers' compensation policy in effect.

The BIDDING AGENCY reserves the right to request documentation supporting a bidder's claim of resident bidder status. Failure to provide such documentation upon request shall result in disqualification of the bidder or contract termination.

Signature	William Jones Printed Name
Chief Executive Officer Title	1/15/2020 Date

Company Name: WellCare Health Insurance Company of Kentucky, Inc.
Address: 13551 Triton Park Boulevard
Suite 1800
Louisville, KY 40223

Subscribed and sworn to before me by William Jones (Affiant) SVP Division President (Title)

of WellCare Health Insurance Company of Kentucky, Inc (Company Name) this 15 day of January, 2020

Jeri Mock
Notary Public

[seal of notary]

My commission expires: 11/09/2020

Notary Public State of Florida
Jeri Mock
My Commission GG 046214
Expires 11/09/2020

F.

COMPLETED AND SIGNED FACE OF SOLICITATION

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F. COMPLETED AND SIGNED FACE OF SOLICITATION

Please see the attached completed and signed face of solicitation for 60.6.F.

Commonwealth of Kentucky
SOLICITATION

Addenda: No **Addenda #:**

TITLE: Medicaid Managed Care Organization (MCO) - All Regions		
Date Issued: 1/10/20 **Record Date:** 2020-01-10	**Solicitation Closes Date:** 2/7/20 **Time:** 15:30	**Solicitation No:** RFP 758 2000000202
Online Bidding Prohibited: Yes		
For Information Call: Amy Monroe 502-564-4510	**Bid Receiving Location:** Finance - Office of Procurement Services Bid Clerk 702 Capitol Ave, Capitol Annex Room 095 Frankfort KY 40601	

Vendor Customer Number:	KY0000171
Vendor Name:	WellCare Health Insurance Company of Kentucky, Inc.
Phone Number:	502-253-5100
Fax Number:	502-253-5255
Email Address:	William.Jones@wellcare.com

Ordering	**Payment**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Contact Name:	**Contact Name:**
Contact Email:	**Contact Email:**
Contact Phone Number:	**Contact Phone Number:**

Ownership Type

__ Sole Proprietorship __ Partnership X Corporation __ Other_____

SIGNATURE OF AUTHORIZED AGENT IS REQUIRED UNLESS RESPONSE IS SUBMITTED ELECTRONICALLY. FAILURE TO SIGN SHALL RENDER THE BID INVALID.

Signature X _____ **FEIN#** KRS 61.878(1)(a) **Date** 1/15/2020

All offers subject to all terms and conditions contained in this solicitation.

G.

SIGNED FACE OF LATEST ADDENDUM OF THE SOLICITATION

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G. SIGNED FACE OF LATEST ADDENDUM

Please see the attached completed and signed face of the latest Addendum issued by the Commonwealth for RFP 758 2000000202.

Commonwealth of Kentucky
SOLICITATION MODIFICATION

Addenda: Yes **Addenda #:** 2

TITLE: Medicaid Managed Care Organization (MCO) - All Regions		
Date Issued: 1/27/20 **Record Date:** 2020-01-27	**Solicitation Closes Date:** 2/7/20 **Time:** 15:30	**Solicitation No:** RFP 758 2000000202
Online Bidding Prohibited: Yes		
For Information Call: Amy Monroe 502-564-4510	**Bid Receiving Location:** Finance - Office of Procurement Services Bid Clerk 702 Capitol Ave, Capitol Annex Room 095 Frankfort KY 40601	

Vendor Customer Number:	KY0000171
Vendor Name:	WellCare Health Insurance Company of Kentucky, Inc.
Phone Number:	502-253-5100
Fax Number:	502-253-5255
Email Address:	William.Jones@wellcare.com

Ordering	**Payment**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Contact Name:	**Contact Name:**
Contact Email:	**Contact Email:**
Contact Phone Number:	**Contact Phone Number:**

Ownership Type

__ Sole Proprietorship __ Partnership X Corporation __ Other_____

SIGNATURE OF AUTHORIZED AGENT IS REQUIRED UNLESS RESPONSE IS SUBMITTED ELECTRONICALLY. FAILURE TO SIGN SHALL RENDER THE BID INVALID.

Signature X _____ **FEIN#** KRS 61.878(1)(a) **Date** 1/28/2020

All offers subject to all terms and conditions contained in this solicitation.

H.

EEO FORMS

H. EEO FORMS

Please see attached the following requested, completed and signed EEO forms:

- **60.6.H. EEO Part I Employer Information Report**
- **60.6.H. EEO Part II Affidavit of Intent to Comply**
- **60.6.H. EEO Part III Subcontractor Report Form**

60.6.H EEO Forms

- EEO Part I Employer Information Report

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions BEFORE completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☒ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for each location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: Filed for WellCare Health Insurance Company of Kentucky, Inc.

Street Address:

City, State and Zip Code:

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? ☒ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
AR, AZ, CA, CT, DC, FL, GA, HI, IL, KY, LA, MI, MO, MS, NE, NJ, NY, SC, TN, TX, WA, WI

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	500	57	74	8	84		7	750	229	148	4	78	4	17	1960
Professionals (2)	841	176	195	4	281	3	20	2022	818	408	35	376	8	67	5254
Technicians (3)	79	32	31	1	11	1	6	97	98	46	3	21	1	8	435
Sales Workers (4)	90	58	110	1	41		1	67	81	140		32	1	5	627
Office, Clerical and Administrative Support (5)	190	159	134	2	39	2	11	965	923	563	35	87	9	69	3188
Craft Workers (6)	1							1							2
Operatives (7)	1	1	12	1	2										17
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	1702	483	556	17	458	6	45	3902	2149	1305	77	594	23	166	11483
Total from Previous Report	979	327	449	11	332	1	22	2205	1327	1052	70	430	11	66	7282

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify): ~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____
OR
c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 11483

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many 6

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4-4-2019
Date

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☒ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: WellCare Health Insurance Company of Kentucky, Inc.

Street Address: 1539 Greenup Ave, Suite 501

City, State and Zip Code: Ashland, KY 41101

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☒ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Commonwealth of Kentucky

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														Total (A – N)
	Male							Female							
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)								2							2
Professionals (2)								6							6
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)	1							2							3
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	1							10							11
Total from Previous Report	1							9							10

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify): ~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____
OR
c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 11483

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many 6

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4/4/2019
Date

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☒ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: WellCare Health Insurance Company of Kentucky, Inc.

Street Address: 360 E 8th Ave, Stadium Park Plaza, #311

City, State and Zip Code: Bowling Green, KY 42101

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☒ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Commonwealth of Kentucky

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														Total (A – N)
	Male							Female							
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)								3							3
Professionals (2)	1							5							6
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)								1	1						2
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	1							9	1						11
Total from Previous Report	1							16	3						20

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify):~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____

OR

b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____

OR

c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 11483

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many 6

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4-4-2019
Date

Signature of Certifying Official **(must be an official or manager; refer to the Instructions)**

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☒ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: WellCare Health Insurance Company of Kentucky, Inc.

Street Address: 450 Village Lane

City, State and Zip Code: Hazard, KY 41701

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☒ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Commonwealth of Kentucky

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														Total (A – N)
	Male							Female							
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	2							5							7
Professionals (2)	3							11							14
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)	3							9							12
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	8							25							33
Total from Previous Report	5							30							35

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify): ~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____

OR

b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____

OR

c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. _11483___

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many _6__

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4-4-2019
Date

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☒ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)— contains employment data for a specific location; a separate branch office/other report must be filed for each location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: WellCare Health Insurance Company of Kentucky, Inc.

Street Address: 2480 Fortune Dr, Suite 200

City, State and Zip Code: Lexington, KY 40509

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☒ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Commonwealth of Kentucky

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

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	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	1							3	1						5
Professionals (2)	1							15	3					1	20
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)								6	2						8
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	2							24	6					1	33
Total from Previous Report	4	1						27	6						38

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify): ~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____
OR
c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. _11483___

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many _6__

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4-4-2019
Date

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☒ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)— contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: WellCare Health Insurance Company of Kentucky, Inc.

Street Address: 13551 Triton Park Blvd, Suite 1200

City, State and Zip Code: Louisville, KY 40223

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☒ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Commonwealth of Kentucky

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

1	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	11							21	3			2		1	38
Professionals (2)	8	1						15	5			1			30
Technicians (3)															
Sales Workers (4)	1	1													2
Office, Clerical and Administrative Support (5)		2						22	11		1				36
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	20	4						58	19		1	3		1	106
Total from Previous Report	24	1			1			73	20			2			121

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify):~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____
OR
c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. _11483___

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many _6__

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4-4-2019
Date

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☒ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 7

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Comprehensive Health Management, Inc.

Street Address: 8735 Henderson Road

City, State and Zip Code: Tampa, FL 33634

2) Name of Branch Office/ Other location for which this form is filed: WellCare Health Insurance Company of Kentucky, Inc.

Street Address: 2200 East Parrish Ave, The Springs, Bldg C Ste 204

City, State and Zip Code: Owensboro, KY 42303

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Health insurance

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☒ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Commonwealth of Kentucky

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														Total (A – N)
	Male							Female							
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)								1							1
Professionals (2)	2							4							6
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)								2	2						4
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	2							7	2						11
Total from Previous Report	3							13	1						17

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify): ~~ADP Enterprise V5~~
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____
OR
c) If another method is indicated, enter the time period used for Section V: 12/8/2018 to 12/22/2018

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. ____

5) Does the company have any Kentucky locations? (check one) ☒ Yes ☐ No If the response is "Yes," indicate how many _6__

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Deborah Lee			Senior Director, Associate Experience	
Mailing Address				
8735 Henderson Road, Ren 5, 2nd floor				
City	State	Zip Code	Telephone Number	Fax Number
Tampa	FL	33634	(914) 597-2950	(813) 283-5270
E-mail Address				
Deborah.Lee@WellCare.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Deborah Lee, Senior Director Associate Experience
Print Name and Title of Certifying Official

4-4-2019
Date

Deborah Lee
Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): Initials: _____ Review Date: _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
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CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☒ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 1

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Avesis Incorporated

Street Address: 10324 S. Dolfield Road

City, State and Zip Code: Owings Mills MD 21117

2) Name of Branch Office/ Other location for which this form is filed:

Street Address:

City, State and Zip Code:

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Insurance benefit administration

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? ☒ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Nationwide

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	12	3	2	0	2	0	0	33	7	8	0	0	0	0	67
Professionals (2)	28	2	4	0	3	0	0	41	6	7	0	1	0	2	94
Technicians (3)	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Sales Workers (4)	10	0	0	0	0	0	0	12	2	7	0	1	0	0	32
Office, Clerical and Administrative Support (5)	30	7	17	1	1	0	2	143	51	78	2	8	4	5	349
Craft Workers (6)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operatives (7)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laborers and Helpers (8)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Service Workers (9)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total (1 – 9)	80	12	23	1	6	0	2	230	66	100	2	10	4	7	543
Total from Previous Report															

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☐ Other (specify): Human Resources
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____

OR

b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____

OR

c) If another method is indicated, enter the time period used for Section V: 3/1/2019 to 3/31/2019

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☒ Yes ☐ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 612

5) Does the company have any Kentucky locations? (check one) ☐ Yes ☒ No If the response is "Yes," indicate how many ____

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Megan Dunham			Sr. HR Business Partner	
Mailing Address				
10324 S. Dolfield Road				
City	State	Zip Code	Telephone Number	Fax Number
Owings Mills	MD	21117	410.413.9237	n/a
E-mail Address				
compliance@avesis.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Irwin Golob, VP Human Resources — 4/3/19

Print Name and Title of Certifying Official — Date

Signature of Certifying Official **(must be an official or manager; refer to the Instructions)**

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

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CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

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SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☒ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other **(required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data)**—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm ONE CONSOLIDATED REPORT 1

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2) CVS/CAREMARK

Street Address: ONE CVS DRIVE

City, State and Zip Code: WOONSOCKET, R.I. 02895

2) Name of Branch Office/ Other location for which this form is filed:

Street Address:

City, State and Zip Code:

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific, e.g.,** wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. HEALTHCARE

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? ☒ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
ALL STATES

2) Does the firm have a current Affirmative Action Plan? (check one) ☒ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	573	55	61	5	68	1	19	883	183	119	13	57	6	24	2067
Professionals (2)	1326	122	178	24	277	9	66	2947	534	385	38	593	18	95	6612
Technicians (3)	352	107	156	14	192	6	23	914	406	473	26	306	19	63	3057
Sales Workers (4)	267	11	22	2	5	1	7	537	35	43	3	20	4	11	968
Office, Clerical and Administrative Support (5)	860	435	426	18	133	11	76	3390	2742	1406	49	336	87	323	10292
Craft Workers (6)	19	1	0	1	4	1	2	0	0	0	0	0	0	0	28
Operatives (7)	4	2	8	0	2	0	0	0	0	0	0	0	0	0	16
Laborers and Helpers (8)	88	35	21	3	25	1	5	36	22	13	1	12	0	2	264
Service Workers (9)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total (1 – 9)	3489	768	872	67	706	30	198	8707	3922	2439	130	1324	134	518	23304
Total from Previous Report															

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☒ Other (specify): HRIS 3/12/19
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____
OR
c) If another method is indicated, enter the time period used for Section V: 3/12/19 to _____

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 24,000

5) Does the company have any Kentucky locations? (check one) ☐ Yes ☒ No If the response is "Yes," indicate how many ____

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
ROBERT GRACE			SR CONSULTANT DIVERSITY	
Mailing Address: 900 OMNICARE CENTER, 201 EAST 4TH STREET				
City: CINCINNATI	State: OH	Zip Code: 45202	Telephone Number: 513-719-7131	Fax Number:
E-mail Address: ROBERT.GRACE@CUSCAREMARK.COM				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

ROBERT GRACE SENIOR CONSULTANT EEO/AAP — 4/3/2019

Print Name and Title of Certifying Official — Date

Signature of Certifying Official **(must be an official or manager; refer to the Instructions)**

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

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Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions BEFORE completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☒ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other **(required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data)**—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 1

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Novu, Inc.
Street Address: 5401 Gamble Drive, Suite 300
City, State and Zip Code: St. Louis Park, MN 55416

2) Name of Branch Office/ Other location for which this form is filed: Novu LLC
Street Address: 5401 Gamble Drive, Suite 300
City, State and Zip Code: St. Louis Park, MN 55416

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. provider of consumer engagement services

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☒ Metropolitan Statistical Area? ☐ State? ☐ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary): Minneapolis – St. Paul – Bloomington, MN – WI

2) Does the firm have a current Affirmative Action Plan? (check one) ☐ Yes ☒ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☒ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	20							11							31
Professionals (2)	50	3			1			50	1	1		6			112
Technicians (3)															
Sales Workers (4)	6							1							7
Office, Clerical and Administrative Support (5)								2							2
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	76	3			1			64	1	1		6			152
Total from Previous Report															

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☒ Visual Survey ☐ Payroll ☐ Other (specify):_____
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: 3/1/19 to 3/22/19

OR

b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____

OR

c) If another method is indicated, enter the time period used for Section V: _____ to _____

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 160

5) Does the company have any Kentucky locations? (check one) ☐ Yes ☒ No If the response is "Yes," indicate how many ____

6) Does the company file a federal EEO-1 report? (check one) ☐ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Brooke Zinter			VP, Corporate Counsel	
Mailing Address				
5401 Gamble Drive, Suite 300				
City	State	Zip Code	Telephone Number	Fax Number
St. Louis Park	MN	55416	855-612-6688	N/A
E-mail Address				
brooke.zinter@novu.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Brooke Zinter, VP, Corporate Counsel — 3/22/2019

Print Name and Title of Certifying Official — Date

Brooke Zinter

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): Initials: _____ Review Date: _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☒ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other **(required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data)**—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 1

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Progeny Health, LLC

Street Address: 450 Plymouth Rd, S200

City, State and Zip Code: Plymouth Meeting, PA 19462

2) Name of Branch Office/ Other location for which this form is filed: N/A

Street Address:

City, State and Zip Code:

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Care Management Services

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? ☑ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
All States

2) Does the firm have a current Affirmative Action Plan? (check one) ☐ Yes ☑ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☑ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☑ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☑ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	6				1			14	3					1	25
Professionals (2)	6	1			1			108	9	3		6			134
Technicians (3)	5				1			3							9
Sales Workers (4)	1							2							3
Office, Clerical and Administrative Support (5)	2	1			1			18	10	1	1			1	35
Craft Workers (6)	0							0							—
Operatives (7)	0							0							—
Laborers and Helpers (8)	0							0							—
Service Workers (9)	0							0							—
Total (1 – 9)	20	2			4			145	22	4	1	6	0	2	206
Total from Previous Report															

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☒ Payroll ☐ Other (specify):_____
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: _____ to _____

OR

b) If payroll is indicated, enter the date of payroll used for Section V: 3/25/19 to 4/5/19

OR

c) If another method is indicated, enter the time period used for Section V: _____ to _____

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☒ Yes ☐ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 209

5) Does the company have any Kentucky locations? (check one) ☐ Yes ☒ No If the response is "Yes," indicate how many ____

6) Does the company file a federal EEO-1 report? (check one) ☒ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Gina Arnold			VP of Human Resources	
Mailing Address				
450 Plymouth Road, Suite 200				
City	**State**	**Zip Code**	**Telephone Number**	**Fax Number**
Plymouth Meeting	PA	19462	610 832-2001	484-362-6558
E-mail Address				
garnold@progenyhealth.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Robert W. Cox COO
Print Name and Title of Certifying Official

4/2/2019
Date

Robert W. Cox
Signature of Certifying Official **(must be an official or manager; refer to the Instructions)**

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☒ Single-Establishment—firm conducts business from a single location
- ☐ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other (**required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data**)—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm: 1

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): Devlin Consulting, Inc.

Street Address: 5505 W. Chandler Blvd

City, State and Zip Code: Chandler, AZ 85226

2) Name of Branch Office/ Other location for which this form is filed:

Street Address:

City, State and Zip Code:

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. HealthCare Overpayment Identification

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? ☒ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
Maricopa County Arizona, Omaha Nebraska

2) Does the firm have a current Affirmative Action Plan? (check one) ☐ Yes ☒ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☐ Yes ☒ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☒ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☒ No

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														Total (A – N)
	Male							Female							
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	3							2							5
Professionals (2)	4							8							12
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)															
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	7							10							17
Total from Previous Report															

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☒ Visual Survey ☐ Payroll ☐ Other (specify):_____
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: Feb 10 2019 to Apr 1 2019

OR

b) If payroll is indicated, enter the date of payroll used for Section V: _____ to _____

OR

c) If another method is indicated, enter the time period used for Section V: _____ to _____

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☒ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☐ Yes ☒ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 17

5) Does the company have any Kentucky locations? (check one) ☐ Yes ☒ No If the response is "Yes," indicate how many ____

6) Does the company file a federal EEO-1 report? (check one) ☐ Yes ☒ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Ted Devlin			President	
Mailing Address: 5505 W. Chandler Blvd				
City: Chandler	State: AZ	Zip Code: 85226	Telephone Number: 480-694-5964	Fax Number:
E-mail Address: ted.devlin@devlinconsulting.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Ted Devlin, President — Print Name and Title of Certifying Official

4/3/2019 — Date

Ted Devlin — Signature of Certifying Official **(must be an official or manager; refer to the Instructions)**

For Official Use Only (Minority/ Female Employment Utilization): **Initials:** _____ **Review Date:** _____

Form—EEO Part I

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

Effective: 26-Jun-07

EEO-1: EMPLOYER INFORMATION REPORT

Important Notice: To reduce/ eliminate processing delays, read the attached instructions **BEFORE** completing this form. Incomplete forms and forms that are not completed according to the instructions will not be processed. **A substitute or alternate version of this report will not be accepted or processed.**

SECTION I. TYPE OF REPORT

1) Type of Report (check one):
- ☐ Single-Establishment—firm conducts business from a single location
- ☑ Consolidated—firm operates from multiple locations; the report must be filed by the firm's headquarters office and must combine workforce data for all locations
- ☐ Branch Office/Other **(required for all Consolidated employers with business locations in Kentucky; also required for subsidiaries or affiliates filing EEO data)**—contains employment data for a specific location; a separate branch office/other report must be filed for **each** location in the Commonwealth of Kentucky

2) Total number of reports being filed by this firm _____

SECTION II. EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section II, #2): HMS Holdings Corp

Street Address: 5615 High Point Drive

City, State and Zip Code: Irving, TX 75038

2) Name of Branch Office/ Other location for which this form is filed: N/A

Street Address: _____

City, State and Zip Code: _____

SECTION III. ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. **Be specific**, e.g., wholesale computer supplies, vehicle insurance carrier, electrical contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. HMS provides a variety of coordination of benefits program integrity, and cost containment solutions to healthcare payors nationwide.

SECTION IV. GENERAL INFORMATION

1) Does the firm hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? ☑ Nationwide?

Identify the primary geographical area(s) from which the firm draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply. (attach a separate sheet if necessary):
TX, NV, OH, MA

2) Does the firm have a current Affirmative Action Plan? (check one) ☑ Yes ☐ No

3) Does the firm have a current Equal Employment Opportunity (EEO) policy? (check one) ☑ Yes ☐ No

4) Is the firm currently under federal, state or local review regarding its employment practices for any of its public contracts (check one)? If yes, attach a separate sheet fully explaining the situation and status of the review. ☐ Yes ☑ No

5) Within the past five (5) years, has the firm been declared ineligible for any public contract (check one)? If yes, attach a separate sheet fully explaining the situation. ☐ Yes ☑ No

SECTION VI. DATA COLLECTION

1) How was employment data in Section V obtained? (check one): ☐ Visual Survey ☐ Payroll ☑ Other (specify): HCM System Report.
(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

a) If visual survey is indicated, enter the date of visual survey used for Section V: N/A to _____
OR
b) If payroll is indicated, enter the date of payroll used for Section V: N/A to _____
OR
c) If another method is indicated, enter the time period used for Section V: 3/5/19 to 3/5/19

2) Does this firm employ apprentices or formal on-the-job trainees? (check one): ☐ Yes ☐ No

3) Does the firm normally hire additional employees to perform contract work (check one)? ☑ Yes ☐ No

4) List the maximum number of employees working for the firm at any one time during a typical 12 month period. 2500

5) Does the company have any Kentucky locations? (check one) ☐ Yes ☑ No If the response is "Yes," indicate how many ____

6) Does the company file a federal EEO-1 report? (check one) ☑ Yes ☐ No

SECTION VII. CERTIFICATION

Name of Person to Contact Regarding this Report			Title	
Stephanie Owens			Sr. Director HR Operations	
Mailing Address				
5615 High Point Drive				
City	State	Zip Code	Telephone Number	Fax Number
Irving	TX	75038	(972) 894-8495	
E-mail Address				
stephanie.owens@hms.com				

I certify that the information contained in this EEO-1: Employer Information Report, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.560 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Stephanie Owens, Sr. Director HR — 4-1-19

Print Name and Title of Certifying Official — Date

Signature of Certifying Official (must be an official or manager; refer to the Instructions)

For Official Use Only (Minority/ Female Employment Utilization): Initials: _____ Review Date: _____

SECTION V. WORKFORCE DATA: Report all full-time and permanent part-time employees including apprentices and on-the-job trainees unless specifically excluded in the instructions. Enter the appropriate figures in each space. Any blank spaces will be considered as zeros. No employee should be counted in more than one job category or in more than one race/ethnicity category. ***Reports with mathematical errors will not be processed and a determination about the company's certification status will be delayed.***

Job Categories	WORKFORCE DATA/NUMBER OF EMPLOYEES														
	Race/Ethnicity														
	Male							Female							Total (A – N)
	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	White (Not Hispanic or Latino)	Black or African American (Not Hispanic or Latino)	Hispanic or Latino	Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	Asian (Not Hispanic or Latino)	American Indian or Alaskan Native (Not Hispanic or Latino)	Two or more races (Not Hispanic or Latino)	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Officials and Managers (1)	201	20	15	Ø	20	1	7	187	40	14	1	17	3	6	532
Professionals (2)	301	47	28	3	122	4	5	389	89	42	Ø	100	7	16	1153
Technicians (3)															
Sales Workers (4)															
Office, Clerical and Administrative Support (5)	65	60	15	Ø	12	Ø	5	224	292	81	2	24	1	18	799
Craft Workers (6)															
Operatives (7)															
Laborers and Helpers (8)															
Service Workers (9)															
Total (1 – 9)	567	127	58	3	154	5	17	800	421	137	3	141	11	40	2484
Total from Previous Report															

2018 Report was a different form.

60.6.H EEO Forms

- EEO Part II Affidavit of Intent to Comply

Form—EEO Part II

Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Ben Orris
Type or Print Name

have authority to sign this affidavit on behalf of WellCare of Kentucky
Type or Print Company Name

Check one:

☑ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☐ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT:

Affix Notary Seal Below

Signature of Certifying Official
(must be an official or manager)

Ben Orris, Chief Operations Officer
Type or Print Name and Title of Certifying Official

3/15/19
Date

Commonwealth or State Kentucky

County of Jefferson

Subscribed and sworn to before me by Sherry L. Jozwiak
(Affiant)/(Title)

of WellCare of Kentucky (Company Name) this 15th day of March, 2019.

MY COMMISSION EXPIRES ON: (Date) November 13, 2022

NOTARY PUBLIC Sherry L. Jozwiak

SHERRY L. JOZWIAK
Notary Public
Kentucky - State at Large
My Commission Expires Nov 13, 2022

Form—EEO Part II Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Irwin Golob
Type or Print Name

have authority to sign this affidavit on behalf of Avesis Incorporated
Type or Print Company Name

Check one:

☒ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☐ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT: _____
Signature of Certifying Official
(must be an official or manager)

Affix Notary Seal Below
CYNTHIA D'AMELIO
NOTARY PUBLIC
BALTIMORE COUNTY
STATE OF MARYLAND
My Commission Expires March 09, 2021

Irwin Golob, VP Human Resources
Type or Print Name and Title of Certifying Official

4/3/19
Date

Commonwealth or State Maryland
County of Baltimore
Subscribed and sworn to before me by Irwin Golob VP, HR
(Affiant)/ (Title)
of Avesis, Inc (Company Name) this 3 day of April, 2019.

MY COMMISSION EXPIRES ON: (Date) 3-9-2021

NOTARY PUBLIC _____

Form—EEO Part II

Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Matthew C. Oesterle
Type or Print Name

have authority to sign this affidavit on behalf of CaremarkPCS Health, L.L.C.
Type or Print Company Name

Check one:

☒ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

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AFFIANT:

Signature of Certifying Official
(must be an official or manager)

Matthew C. Oesterle, Vice President & Sr. Legal Counsel
Type or Print Name and Title of Certifying Official

April 4, 2019
Date

Affix Notary Seal Below

OFFICIAL SEAL
KAREN CEBULA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/25/22

Commonwealth or State Illinois

County of Cook

Subscribed and sworn to before me by Matthew C. Oesterle, Vice President & Senior Legal Counsel
(Affiant)/ (Title)

of CaremarkPCS Health, L.L.C. (Company Name) this 4th day of April, 2019.

MY COMMISSION EXPIRES ON: (Date) 3-25-22

NOTARY PUBLIC Karen Cebula

Form—EEO Part II

Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Brooke Zinter
Type or Print Name

have authority to sign this affidavit on behalf of Novo, Inc.
Type or Print Company Name

Check one:

☐ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☒ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT:
Brooke Zinter
Signature of Certifying Official
(must be an official or manager)

Affix Notary Seal Below

Brooke Zinter, VP Corporate Counsel
Type or Print Name and Title of Certifying Official

KALEE ROSE WOTHE
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2024

March 22, 2019
Date

Commonwealth or State Minnesota
County of Hennepin
Subscribed and sworn to before me by Brooke Zinter VP Corporate Counsel
(Affiant) (Title)
of Novo, Inc. this 22nd day of March, 2019.
(Company Name)

MY COMMISSION EXPIRES ON: (Date) 1/31/2024

NOTARY PUBLIC KMRoth

Form—EEO Part II

Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Robert W. Cox
Type or Print Name

have authority to sign this affidavit on behalf of ProgenyHealth LLC
Type or Print Company Name

Check one:

☑ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☐ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT: Robert W. Cox
Signature of Certifying Official
(must be an official or manager)

Robert W. Cox, COO
Type or Print Name and Title of Certifying Official

4/2/2019
Date

Affix Notary Seal Below

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Kathy Piker, Notary Public
East Vincent Twp., Chester County
My Commission Expires March 28, 2021
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

Commonwealth or State Pennsylvania
County of Montgomery
Subscribed and sworn to before me by Robert W. Cox / Chief Operating Office
(Affiant)/ (Title)
of ProgenyHealth, LLC (Company Name) this 2nd day of April, 20 19.

MY COMMISSION EXPIRES ON: (Date) April 2, 2019

NOTARY PUBLIC Kathy Piker

Form—EEO Part II

Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Ted Devlin
Type or Print Name

have authority to sign this affidavit on behalf of Devlin Consulting, Inc.
Type or Print Company Name

Check one:

☒ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☐ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT: Ted Devlin

Affix Notary Seal Below

Signature of Certifying Official
(must be an official or manager)

Ted Devlin, President

Type or Print Name and Title of Certifying Official

4-5-19

Date

Commonwealth or State ARIZONA

County of MARICOPA

Subscribed and sworn to before me by THEODORE DEVLIN
(Affiant)/ (Title)

of DEVLIN CONSULTING this 5 day of APRIL, 2019.
(Company Name)

MY COMMISSION EXPIRES ON: (Date) AUG 29, 2020

NOTARY PUBLIC Frances J. Clark

OFFICIAL SEAL
FRANCES J. CLARK
Notary Public - State of Arizona
MARICOPA COUNTY
My Comm. Expires Aug. 29, 2020

Form—EEO Part II Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, Stephanie Owens
Type or Print Name

have authority to sign this affidavit on behalf of HMS Holdings Corp.
Type or Print Company Name

Check one:

☑ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☐ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT:

Affix Notary Seal Below

Signature of Certifying Official
(must be an official or manager)

Stephanie Owens Sr. Director HR
Type or Print Name and Title of Certifying Official

4-2-19
Date

Commonwealth or State TEXAS

County of DALLAS

Subscribed and sworn to before me by STEPHANIE OWENS, SR. DIRECTOR HR OPS
(Affiant)/ (Title)

of HEALTH MANAGEMENT SYSTEMS this 2nd day of APRIL, 2019.
(Company Name)

MY COMMISSION EXPIRES ON: (Date) JANUARY 21, 2021

NOTARY PUBLIC

TRACIE CARTER
My Notary ID # 125173079
Expires January 21, 2021

60.6.H EEO Forms

- EEO Part III Subcontractor Report Form

Form—EEO Part III

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE

Effective: 26-Jun-07

SUBCONTRACTOR REPORT FORM
Additional Reporting Sheet

A substitute or alternate version of this form will not be accepted or processed.

Business Name (REQUIRED): WellCare of Kentucky, Inc

Solicitation or Contract Number (REQUIRED): Contract Number: MA 7581600000005 / Solicitation Number 758 2000000202

Name of Subcontractor	Contact Person	Telephone Number (including area code)	Street Address, City, State and Zip Code	Subcontract Amount
Devlin Consulting	Ted Devlin	404-694-5694	600 Satellite Blvd, NW Suwanee , GA 30024	$1,399,808
Health Management Systems	Christina Dragonetti	212-857-5479	5615 High Point Drive, Irving, TX 75038	$608,000
Comprehensive Health Management, Inc.	General Counsel	813-206-2529	8735 Henderson Road, Ren 1 Tampa, Florida 33634	$235,048,900

Form—EEO Part III

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

Effective: 26-Jun-07

SUBCONTRACTOR REPORT FORM

Notice: Vendors/Contractors are required to report all subcontracts valued at $500,000 or more (Note: information is not required for contracts below the second tier). The subcontracts reported on this form must be for a specific line item(s) of work on a contract/project your firm has with the Commonwealth of Kentucky, i.e., you should not report contracts your firm has with a company to clean your office building, to provide security for your office, to routinely service your vehicles or equipment, to upgrade your warehouse, etc. Type or print legibly. Do not use pencil; use black or dark blue ink. A substitute or alternate version of this form will not be accepted or processed. Incomplete forms will not be processed.

1) Business Name (REQUIRED): WellCare of Kentucky, Inc

2) Solicitation or Contract Number (REQUIRED): Contract Number: MA 7581600000005 / Solicitation Number 758 2000000202

3) Project Name or Contract Description: Medicaid Managed Care Services

4) Indicate if your company has entered into agreements with subcontractors valued at $500,000 or more (check one):

☐ Our company **has not** entered into agreements with subcontractors valued at $500,000 or more (skip section 5 and complete section 6).

☒ Our company **has** entered into agreements with subcontractors valued at $500,000 or more (complete section 5 and section 6).

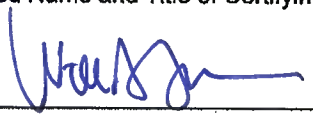
5) Provide subcontract information as follows (attach Additional Reporting Sheets if necessary):

Name of Subcontractor	Contact Person	Telephone Number (including area code)	Street Address, City, State and Zip Code	Subcontract Amount
Avesis Third Party Administrators, Inc	Phyllis Oppenheim	800-522-0258 ext 283	10324 South Dolfield Rd. Owings Mills, MD 21117	$97,992,026
CVS Caremark	Jason Stenta	401-770-1980	One CVS Drive, Woonsocket, Rhode Island 02895	$684,434,899
Novu, LLC	Jason Panos	800-337-9406	841 Prudential Drive, Suite 204, Jacksonville, FL 33207	$1,494,196
Progeny Health	Ellen Stang	610-832-2001	500 Plaza Drive, Secaucus, NJ 07094	$1,774,734

6) Certification: I certify that the information contained in this report and any Additional Reporting Sheets or other attachments, is true and accurate to the best of my knowledge and belief. Further, I am authorized to sign this form on behalf of the company. If necessary, the company will update this report should it enter into additional subcontracts valued at $500,000 or more.

William Jones, Chief Executive Officer

Printed Name and Title of Certifying Official



Signature of Certifying Official **(must be an official or manager)**

1/16/2020

Date

I.

PROPOSED SOLUTION

I. PROPOSED SOLUTION

Behind the Proposed Solution tab, you will find the Proposal Solution content in response to Section 60.7 of this RFP.

A.

Executive Summary

A. EXECUTIVE SUMMARY

Provide an Executive Summary that summarizes the Vendor's proposed staffing and organizational structure, technical approach, and implementation plan. The Executive Summary must include a statement of understanding and fully document the Vendor's ability, understanding and capability to provide the full scope of work. Address the following, at a minimum:

1. The Vendor's statement of understanding of the healthcare environment in the Commonwealth, the Kentucky Medicaid program and vision for this procurement, and needs of Medicaid Enrollees.
2. An overview of the Vendor's proposed organization to provide coordinated services under the Contract.
3. A summary of the Vendor's strategy and approach for administering services for Enrollees.
4. A summary of the Vendor's strategy and approach for establishing a comprehensive provider network.
5. A summary of innovations and initiatives the Vendor proposes to implement to achieve improved health outcomes for Enrollees in a cost effective manner. Include a discussion of challenges the Vendor anticipates and how the Vendor will work to address such challenges.

A. EXECUTIVE SUMMARY

WellCare of Kentucky has been privileged to serve the Kentucky Medicaid program and our Enrollees over the last eight years. We have embraced our role as a supporter to the Department for Medicaid Services (DMS) as an agent of change to transform the Kentucky Medicaid program, and to achieve the goal of better health outcomes for Kentuckians. Through the years, we have understood the important responsibility placed on our shoulders and have developed comprehensive, Kentucky specific, innovative programs that are improving health in Kentucky. Since we became National Committee for Quality Assurance (NCQA) accredited in Kentucky in 2014, **we have improved our accreditation scores from 79.0 in 2015 to *85.73* in 2018, have maintained a two-year Commendable NCQA accreditation status, and have the highest NCQA quality ranking in the Kentucky Medicaid program at 3.5. *In addition to having the highest quality rating, we also have the highest percentage of ratings of a 4 or higher in the 2019 – 2020 NCQA Accreditation Report, see Figure A-1.***

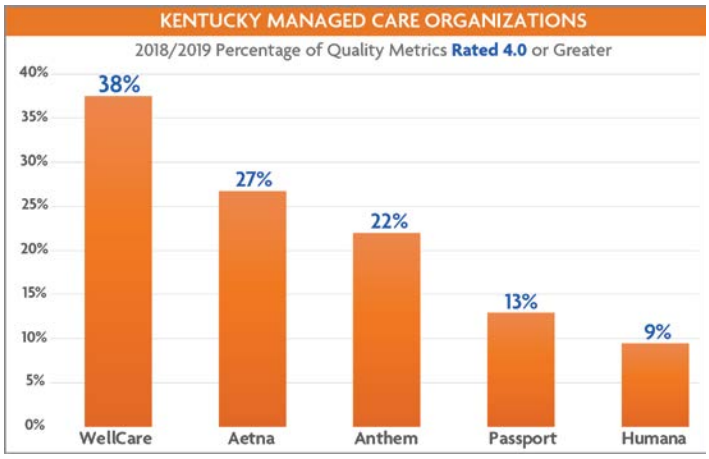


Figure A-1 WellCare of Kentucky Percentage of Quality Metrics

During our eight years of serving Enrollees in the Commonwealth, we have been and remain a stable and committed partner through various program launches, through large influxes of new Enrollees, the roll in of behavioral health services through Impact Plus, Medicaid expansion implementation, expansion into Region 3, and most recently, building an innovative and national leading community and work requirements platform and program to support the next phase of health evolution with our best in class Social Determinants Of Health (SDOH) program. We are excited to continue partnering with the administration, DMS, providers, community organizations, and all stakeholders in order to exceed the goals of the Kentucky Cabinet for Health and Family Services.

Kentuckians are entrenched in and care about their communities. WellCare of Kentucky appreciates and understands that each community has its own unique cultures and we are proud to be a part of the diversity that makes up the landscape of the Commonwealth. We also know that Kentucky Medicaid Enrollees' health is often directly tied to lifestyle and environmental conditions that are deeply ingrained in the generational poverty, isolation, and cultural nuances in both remote regions of rural Kentucky as well as the deep urban neighborhoods within Lexington and Louisville areas. Longstanding health challenges caused by high rates of smoking and obesity, along with higher rates of cancer and COPD, have been further exacerbated in recent years by behavioral health and substance use disorder (SUD) conditions. The scourge of Opioid SUDs has placed the Commonwealth at the heart of a national epidemic that requires all stakeholders, including managed care organizations (MCOs) to think differently about how we engage and empower individuals in recovery and resiliency while enhancing and supporting the system that serves them.

We have long collaborated with DMS to bring innovative solutions to address these unique challenges. We are proud to have played a role over the past eight years in the gains we have made as a state in national health rankings. But we know there's more work to be done and are eager to continue our collaborations on innovations as DMS sets a course forward to increase Empowerment for Enrollees, Partnership with Providers, Collaboration across stakeholder groups, Health Care quality enhancement, Innovation, and Cost effectiveness within the Medicaid program.

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc. (WellCare). On January 23, 2020 WellCare was acquired by Centene Corporation (Centene). WellCare is now a wholly owned subsidiary of Centene. **WellCare of Kentucky's leadership, staff, branding, and model for delivering services to the Commonwealth are not changing and we remain committed to partnering with DMS to ensure Kentucky's Enrollees, communities, providers and other stakeholders receive the integrated, whole-person care and services necessary to address all of their physical, behavioral, and social needs.** With the acquisition, WellCare of Kentucky is now also able to leverage the combined experience and best practices of our Centene affiliate health plans, which is now managing the care of more than 12.9 million Medicaid Enrollees across 30 states.

1. Understanding the Commonwealth, the Kentucky Medicaid program and vision for this procurement, and needs of Medicaid Enrollees.

WellCare of Kentucky looks forward to and hereby proposes to continue to serve the Commonwealth, DMS and the Enrollees in the Kentucky Medicaid program. WellCare of Kentucky's experienced leadership under Chief Executive Officer Bill Jones and Medical Director Howard Shaps, MD have full authority and accountability to deliver on contract commitments and continue our collaborative relationship with DMS. Being in Kentucky since Managed Care was implemented in 2011, WellCare of Kentucky is in the unique position of understanding the needs of our Medicaid Enrollees across the Commonwealth and partnering with DMS as we have evolved the program over the last eight years. Whether it was expanding Medicaid and integrating behavioral health in 2014 or working with the Commonwealth to increase the focus on Foster Care, WellCare of Kentucky has been at the Commonwealth's side throughout.

WellCare of Kentucky has always been committed to improving the health of Kentuckians by meeting them where they are on their health journey. We are dedicated to continuing our partnership with DMS to **ensure Kentuckians who are eligible for the Kentucky Medicaid Program and Kentucky Children's Health Insurance Program (KCHIP) are enrolling in the programs and have access to high quality and cost effective care and services**. We believe that health care is local and our approach begins with the 300 plus Kentuckians that serve as our team members, located throughout the Commonwealth in the same communities that our Enrollees and providers reside. With our six regional offices across the Commonwealth, we understand the issues, obstacles, and opportunities to provide better health care to our Enrollees. We also recognized early on that health care goes beyond the Enrollees physical and behavioral health needs. In 2011 WellCare of Kentucky implemented an industry leading SDOH program whereby we expanded our community relationships to serve the entire Medicaid population, even if they were not a WellCare of Kentucky Enrollee. Our Community Connections HelpLine (CCHL) made over 51,000 referrals to social resources in 2018 alone.

Making a Local Impact on SDOH
Since launching the Community Connections program in Kentucky, we have connected more than 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in emergency department visits, and a 53% decrease in inpatient spending.

WellCare of Kentucky also understands that, at the center of the Commonwealth's vision for improving the health and outcomes of Kentuckians, is a fully integrated model of care. Our model leverages one integrated care team covering all care needs including physical, behavioral, pharmacy and unmet social needs. This team is supported by one single technology system that is purpose-built to specifically serve Medicaid programs. The result is a comprehensive set of Enrollee data through a single on-line platform that can used by providers to access and maintain a complete health record for the people they serve. This allows providers to better meet and coordinate their needs and for WellCare of Kentucky to continually improve quality. This has resulted in WellCare of Kentucky achieving the highest Medicaid quality rating in Kentucky and one of only two current Managed Care Organizations in

the Commonwealth with a Commendable NCQA Accreditation rating in Medicaid. Further, WellCare of Kentucky understands the importance of behavioral health services when managing Enrollees care, which is why we do not outsource our Behavioral Health programs. We have a dedicated team of nurses, social workers and others that focus on our Enrollees behavioral health needs. This has earned WellCare of Kentucky the highest NCQA rating for Mental and Behavioral Health Quality in Kentucky for the last two years, see **Figure A-2**.

Versatility

WellCare of Kentucky has developed an evidence-based Population Health program to support DMS' efforts to move Kentucky out of the bottom third in state performance in conditions such as Diabetes, COPD, Heart Disease, Obesity, healthy pregnancies/low birth-weight babies, and colorectal cancer screening. In particular, Opioid SUD solutions are vitally important which includes interventions like our Lock-in program, improved metrics to monitor provider behavior and education of the community – a responsibility shared among all stakeholders.

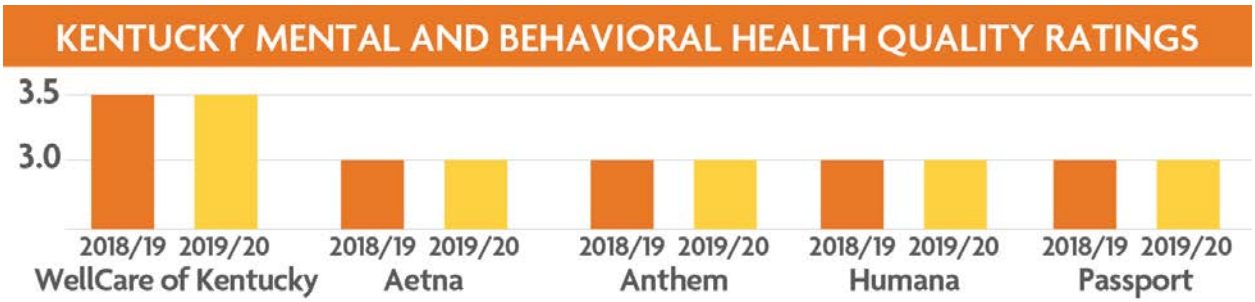


Figure A-2 Mental and Behavioral Health Quality Ratings

WellCare of Kentucky has maintained the largest network in Kentucky for Medicaid since 2011 with more than 34,500 participating providers. We believe that a collaborative approach with our providers yields the most innovative care, and the best outcomes. By doing so for the past eight years in Kentucky, **WellCare of Kentucky has earned the earned the highest 2019/20 NCQA Health Insurance Plan Rating among all Kentucky Medicaid MCOs.** Our network includes every hospital and FQHC across the Commonwealth and we are proud to be the only MCO to be continuously contracted with Appalachian Regional Hospital since inception. We also recognize the challenge of keeping providers in rural areas and have made investments in partnerships with the University of Kentucky, and Jefferson County Community Technical College to provide scholarships to doctors and nurses who decide to stay in a rural community to provide care.

We believe that our overall approach is why more Enrollees have chosen WellCare in Kentucky, each year for the past three years during open enrollment and why we have the lowest disenrollment rate in the Commonwealth.

With the highest Enrollee satisfaction scores of all the Kentucky Medicaid MCOs, our dedicated approach has made WellCare of Kentucky the plan of choice in the Commonwealth—with over 80% of Enrollees choosing our health plan as the best option.

2. *An overview of the Vendor's proposed organization to provide coordinated services under the Contract.*

WellCare of Kentucky's fully staffed, Kentucky based team puts the Enrollee at the center of everything we do. Our exclusive focus on government sponsored health programs enables WellCare of Kentucky to draw on programs, technology, and resources that are designed to serve low income and vulnerable populations. With the recent merger with Centene, we now have the opportunity to leverage the best practices of the combined organization that currently serves more than 12.9 million Medicaid managed care Enrollees, across 30 states.

While Kentucky has leveraged these national programs and infrastructure for the past eight years, WellCare's Shared Services organizations continue to innovate and improve our operating tools. Our care management system, CareCentral, has been enhanced to provide real-time information for the full array of data sources including clinical, behavioral, SDOH, pharmacy, HRAs, call center interactions Nurse Advice Line, Individual Care Plans, and ADT information from connected health systems and HIEs to provide a complete 360-degree view of each Enrollee. This tool completely integrates our in-house clinical and behavioral teams and empowers each associate who is serving an Enrollee to have the information necessary to effectively manage the Enrollee's unique needs at that time.

Our Community Connections program has a dedicated call center and specially designed SDOH tracking system built upon contractual relationships with over 30,000 service agencies across the country. Each Enrollee's interactions and referrals are documented and fed into CareCentral. We place Community Engagement Partners throughout Kentucky in order to understand those services that are most meaningful to our Enrollee's in each Community.

Our IT platform provides for Member and Provider access and will enable both Enrollees and Members to access CareCentral data through our portal as well as through our MyHealth app. Further, our systems are bi-directional, enabling Enrollees to receive notifications and reminders about care gaps and appointments and providers to have access to comprehensive, current patient profile information.

Our Population Health Management (PHM) program is an evidence-based, proactive approach centered on larger, socially grouped medical and behavioral needs and prevention efforts. Our program has seven clinical focus areas, or domains, each led by a clinical advisory board to review effectiveness, explore opportunities and innovations, and develop new programs and initiatives. Focus areas include Behavioral Health and SUD; Maternal and Child Health; Community and Long-Term Supports and Services (LTSS); High Acuity and Transitions; Medical Conditions; Advanced Illness; and Prevention and Wellness. Each one improves health outcomes through prevention and promoting healthy behaviors, early identification, and preventing deterioration or complexities. WellCare of Kentucky's population health domains align with DMS' population health condition priorities.

Our national ePMO (enterprise Project Management Organization) will be deployed to implement the new contract alongside our Kentucky based team. This team of experienced professionals is deployed for each new contract working with multiple populations and state programs. **Figure A-3** illustrates the range of this experience:

WELLCARE IMPLEMENTATION EXPERIENCE

The total is more than **1,880,000** members over 10 years.

Implementation Description	2019	2018	2017	2016	2015	2014	2013	2012	Pre 2012	Number of members Transitioned
WellCare Transition of Florida children with special healthcare needs, including foster care, to our statewide Children's Medical Services (CMS) Health Plan	✓									68,000 members
Staywell Transition of Florida Medicaid members, including the SMI and LTSS populations	✓									78,000 members
Harmony Health Plan Statewide Medicaid expansion into all Illinois counties		✓								190,000 members
Care 1st Health Plan Arizona Transition of Arizona members		✓								100,000 members
Missouri Care Statewide expansion of Medicaid managed care into all 115 counties			✓							179,000 members
WellCare of Nebraska Statewide implementation of Medicaid managed care for Heritage Health			✓							70,000 members
WellCare of South Carolina Transition of Medicaid members from Advicare Corp.				✓						30,000 members
WellCare of New York Statewide carve-in of behavioral health services for adult Medicaid members				✓	✓					71,000 members
WellCare of New Jersey Transition of 46k Healthfirst members & implementation of LTSS program						✓				46,000 members
Staywell Transition of Florida Medicaid members from FFS due to mandated managed care						✓				394,000 members
WellCare of Kentucky Transition of 43k members due to realignment of MCOs (open enrollment): enrollment of 28k members (Reg 3 expansion)							✓	✓		71,000 members
WellCare of Kentucky Transition of members due to realignment of MCOs							✓			63,000 members
`Ohana Health Plan Statewide implementation of the Hawaii QExA, QUEST and CCS programs								✓	✓	30,000 members
WellCare of Georgia Transition of Medicaid members									✓	490,000 members

Figure A-3 WellCare Implementation Experience

Additionally, we are now able to leverage our affiliate Centene health plans' past experience of successful implementations of more than 9.25 million Medicaid Enrollees across 23 states.

In addition to our national Shared Services resources, we have a team of over 300 associates located throughout the Commonwealth in our six offices, living and serving in the communities that our Enrollees and providers reside. We are the only MCO with Member and Provider facing staff deployed through six regional offices across the Commonwealth, including Nurses, Social Workers, Community Engagement Partners, Quality and Provider Relations staff. This local and integrated approach to our organizational structure, gives us the knowledge and flexibility to develop local programs that are more effective and meaningful to our Enrollees and providers. We established a Care Center located in Hazard that focuses on helping Enrollees navigate the Medicaid program and health care landscape. Our vision for this center is to improve Enrollee education, satisfaction, retention, and outcomes.

Our Leadership Team is the most tenured and experienced in Kentucky Medicaid and is solely focused on improving health outcomes for Kentuckians. We have built a culture that is

passionate about our Enrollees, the Commonwealth and our provider partners. Our stable team has less than 9% turnover and has achieved Highest Employee Engagement scores in the company for the past two years in addition to a top 10 finish in the 2018 and 2019 "Best Places to Work in KY".

3. A summary of the Vendor's strategy and approach for administering services for Enrollees.

Strategy – Our strategy for administering services for our Kentucky Enrollees centers around the 7 pillars listed below:

LOCAL, FIELD BASED ORGANIZATIONAL STRUCTURE

We continue to believe that our locally based team of nurses, social workers, quality, provider relations staff, and community advocates provides the best insights to the needs of the Commonwealth's Medicaid Enrollees. We live and work among our providers and Enrollees and understand their unique needs and focus on building individual relationships with them. Through these relationships, we are able to see the needs of the Enrollees, providers, and community up close. This allows us to identify and develop the right solutions, and build the trust needed to partner with providers so that we can improve health outcomes together – ultimately it is understanding our partners and communities, to build trust over time through outreach efforts, solid programs, and supports that truly improve health. This knowledge of our communities, providers, and Enrollees needs enables us to build and leverage tools that are a unique and customized solution for Kentucky.

INTEGRATED CARE MODEL

Our care model calls for a 360-degree view of our Enrollees, so every person that touches an Enrollee knows how to better serve them. We have an integrated care management program built by people who understand the complexity of health care and the factors that affect an Enrollee's wellbeing. This program is built to bring physical, behavioral and pharmacy care teams and programs together to better serve the whole person – while focusing intensely on social factors that prevent health improvement. Our Enrollee's ability to receive quality health care is dependent upon WellCare of Kentucky's collaboration with community stakeholders and local providers to consider all aspects of the Enrollee's health. This includes medical, behavioral, and social needs and a Care Team that looks across the entire spectrum, focusing on improved outcomes for our Enrollees. Our enrollee assessments, care planning and integrated care teams, provide the necessary structure to address each Enrollee's unique needs. Our balanced approach includes health promotion and wellness, targeted management of chronic conditions and complex care management programs.

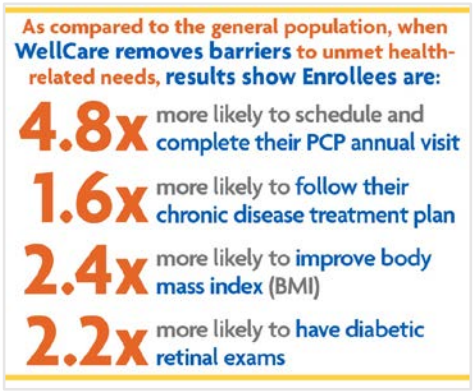
COMMUNITY CONNECTIONS

WellCare's Community Connections program (SDOH) began in Kentucky in 2011 and remains an industry leading program including formal contracts with community based organizations, trained outreach staff, dedicated CCHL (many of the CCHL staff have lived experiences from which to leverage Enrollee interactions) and a technology system that enables tracking of all

interactions as well as reporting contacts into Care Central. WellCare of Kentucky operates the most comprehensive and outcome based community program in the Commonwealth.

Using the social service data, the Community Engagement team identifies when services are needed and then mobilizes resources to (re)create the needed service by establishing community contracts to assess impact and pilot new outcome-focused payment models with community partners. Our team develops and implements innovative pilot programs focused on systemic, industry-leading solutions to drive social determinant integration into health care. Innovation pilot programs generate the data to evaluate the impact in local communities in three ways: improving health outcomes and increasing access to care, reducing avoidable costs by removing social barriers, and evaluating system effectiveness leading to social innovation.

Compared to demographically similar enrollees, individuals with social barriers removed are 4.8 times more likely to schedule and attend a PCP visit, 2.4 times more likely to improve BMI. Independent research on our Community Connections model has proven that such a dedicated focus to addressing SDOH results in a $450 savings for every social service accessed. We reinvest the health care savings from removing social barriers back into Kentucky communities through investments and contracting designed to increase data-sharing capabilities or sustain critical social services. Since 2011, WellCare of Kentucky's Community Connection Program has invested in nearly 400 innovative initiatives across the Commonwealth.



COMPREHENSIVE PROVIDER NETWORK

We have maintained the largest network in Kentucky because we understand that Enrollees value choice as one step in empowering Enrollees to engage in their health. Our network strength and stability have been achieved as a product of cultivating relationships and building trust – by being present in all Regions and demonstrating that we are committed to help them serve Enrollees. WellCare of Kentucky's presence in Region 8 throughout the past eight years is a specific illustration of establishing building of trust and stability, which leads to improved quality and health outcomes for our Enrollees. This is why **we have over 34,500 participating providers in our network and the highest satisfaction rating of (based on an external survey).**

COLLABORATIVE AND TRANSPARENT PARTNERSHIPS

Relationships with all of the Stakeholders that impact our Enrollees are held in high regard at WellCare of Kentucky. We understand the importance of being transparent with our providers, and partnering with them, community stakeholders, and DMS in order to provide the best solutions aimed at improving health outcomes. We understand that the best and most innovative solutions come from the collective participation and engagement of all of us that deeply care about the Enrollees in the Commonwealth.

TECHNICAL AND ANALYTICAL CAPABILITIES

Our technology platform is designed to serve Medicaid programs and provides comprehensive and complete views of each Enrollee. This allows us to provide meaningful data to our partners to effectively address our enrollee's needs. Our analytic tools and resources provide the capability to quickly identify trends, care gaps, and improvement opportunities.

POPULATION HEALTH PROGRAMS AND INNOVATIVE SOLUTIONS

Population Health is a core competency at WellCare of Kentucky. We have developed programs focused on several of the DMS' identified priorities with several successes to date. Other priority programs are in development. Our developed programs include Diabetes, Healthy Weight Management, Tobacco use, Infant Mortality and Low Birth Weight. Many of our programs are supported by our Health Coaches who conduct continuous telephonic outreach to educate our most vulnerable Enrollees on recommended critical screenings and preventive services. Our programs align with the overall objectives of keeping Kentuckians health, managing enrollees with emerging risks, ensuring enrollee safety, and managing chronic illnesses.

4. A summary of the Vendor's strategy and approach for establishing a comprehensive provider network.

WellCare of Kentucky's contracted network includes 100% of all hospitals, 99% of all eligible PCPs, 100% of all FQHCs, more than 2,300 behavioral health professionals and meets all contract geo-access requirements. We have continuously supported our providers across the Commonwealth by deploying Quality Practice Consultants, PCAs, and PRRs across the Commonwealth along with our Community Advocates that help the provider improve the health of their patients. By understanding the specific issues that our provider partners face in the unique and varied communities they serve in, we have been able to establish a supportive, collaborative relationship with our network that has been a cornerstone, and has led to WellCare of Kentucky maintaining the largest network in the State. **Our provider satisfaction scores demonstrate that our model is working with an overall satisfaction rate of 90.7% and a willingness to recommend WellCare of Kentucky of over 91.6% in 2019.**

We continuously look for ways outside of contracting to strengthen our network and our provider community in Kentucky. In the medically underserved part of Kentucky, WellCare of Kentucky will support increased adoption of EHR systems through grants to fund the data entry efforts for historical records. We understand the importance of small, rural practices and the challenges they face by having transparent, in person conversations with them. We also recognize the provider shortage in these areas. Since 2016, we have invested over $100,000 in scholarships to keep graduating doctors and nurses serving in Rural Kentucky. We believe that telehealth has huge potential. WellCare has successfully launched telehealth solutions in other states and is prepared to work with network providers to leverage the new law to improve access to care in rural areas as well as to support hard to find specialists such as psychiatry and dermatology.

In order to focus on program development and continuous improvement, WellCare of Kentucky recently established a ***Provider Advisory Group that includes over 20 providers from across the***

***Commonwealth*.** Our intent is to bring this group together, and hear our provider's voice in the development of new Population Health programs, changes to current programs to improve Healthy Weight Management, SUD, Pregnancy Health, and others. We also want to hear from them, how WellCare of Kentucky can be a better partner and improve the overall provider experience with us. Our objective is to create one team with WellCare of Kentucky and the provider community at the table, providing the best solutions to improve health outcomes and quality.

5. A summary of innovations and initiatives the Vendor proposes to implement to achieve improved health outcomes for Enrollees in a cost effective manner. Include a discussion of challenges the Vendor anticipates and how the Vendor will work to address such challenges.

WellCare of Kentucky has continued to work with providers, state agencies including DMS and other MCOs to improve overall health care quality and outcomes in a cost effective manner. The following summary of our innovations and initiatives has been presented throughout the Executive Summary and are repeated here:

INTEGRATED CARE MODEL AND POPULATION HEALTH

We will continue to build out our integrated care model and population health programs. We are currently building new or next version Population Health Programs including NICU, Maternity, Opioid 2.0, Neonatal abstinence, Healing Futures (child behavioral health), Smoking Cessation, Diabetes, COPD, and Hypertension. We are also exploring remote patient monitoring to receive biometric data and share it with our providers, deploying resources to an Enrollees' home in real time when a potential issue arises (e.g. blood sugar spike for Diabetics, oxygen monitor alert for Enrollees with COPD, etc.).

We continue to innovate in our SDOH of Health programs and will be expanding our WellCare Works program, to reach Enrollees in all 120 counties. We are proud that in 12 months we reached Enrollees in 109 counties covering 91% of the Commonwealth with our WellCare Works platform. We fully expect by mid-year 2020 that Enrollees in all 120 counties will have accessed our innovative solution to getting Enrollees back to work. Our latest innovation includes data-informed outcome-based contracting with community partners. These community contracts assess impact and connect to enterprise priorities including quality outcome data, Enrollee retention, and Enrollee and provider satisfaction. Utilizing our partnerships locally, Community Engagement Partners work with Community Based Organization to assess their capacity for connecting WellCare of Kentucky Enrollees to Case Management, their Primary Care Physician, Workforce Innovation Programs, and more. Based on that capacity, we provide payment to Community Based Organizations for the outcomes based in their community contract. The community level data analysis helps drive decisions around priorities, investment and innovation opportunities focused on systemic, industry-leading solutions to drive social determinant integration into health care. Innovation pilot programs generate the data to evaluate the impact in local communities by improving health outcomes and increasing access to care, reducing avoidable costs by removing social barriers, and evaluating system effectiveness leading to social innovation.

COMPREHENSIVE PAYER/PROVIDER ANALYTICS

WellCare of Kentucky recognizes that the amount and type of data available on an Enrollee or population is a powerful tool in improving health. We have already implemented an integrated system, built specifically for Medicaid that provides our team and our provider community a 360-degree view of the Enrollees they serve. We will continue to introduce innovations that include the integration of SDOH into our predictive analytics, earlier trend identification to support program development and individualized Enrollee intervention, and an improved risk stratification model that allows us to move even further towards prevention by including community factors in our scoring. We recognize the importance of the KHIE data and will begin to integrate that information into our platforms. Additionally, providers who do not have an EHR will be required to sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services so that they can share clinical information with Enrollees' other providers. We are also proposing to provide a grant of up to $1000 for our eligible independent providers who successfully implement EHRs for the first time. Our objective is to collaborate with our provider and stakeholder communities, share this data transparently, and drive quality improvement, improved outcomes, and increased Enrollee and provider engagement and satisfaction.

IMPROVED MEMBER ENGAGEMENT

We recognize that Enrollee engagement is critical to improving their health. WellCare of Kentucky has implemented a very successful Unable to Contact program, launched Enrollee education programs, and offered incentives for preventative and follow up care. While this has made a significant improvement in the outcomes for engaged Enrollees, we must continue to build on our success and broaden our reach. We will be introducing improvements to our Enrollee portal and social media strategy, which will improve communication and engage Enrollees in several different ways. The portal will be more interactive and easy to use and our multi-faceted social media approach will allow Enrollees to receive information in the way they are most likely to receive and consume it. We have recently received approval from DMS to launch a series of six member focus groups across the Commonwealth, beginning in February 2020, enabling a diverse representation of people to be heard on a number of key topics. This direct feedback will enable WellCare of Kentucky to continue to find better ways to engage our Enrollees, provide high quality care, and address gaps identified by our membership. We will also be implementing additional tools to measure the Enrollee experience that will inform our engagement strategy and toolset including our Health Coaches explained in detail in Section C.9 Quality Management and Health Outcomes. Finally, we recently completed a 3,200 square foot expansion to our Enrollee Care Center in Hazard that will help more Enrollees navigate their health care and connect them to solutions that improve their overall health.

INCREASED ACCESS AND AVAILABILITY

Introducing Telehealth more broadly across Kentucky is a key innovation that will improve access and availability for our Enrollees. Based on feedback from our providers, we will look to roll this out generally, but also with an emphasis on targeted programs or conditions such as stroke care, SUD treatment, and Diabetes. We understand the challenges of provider availability in rural Kentucky and have built a strong network of providers. However, we must

begin to introduce more innovation that improves access and addresses not only the limited number of providers in these areas, but the social barriers such as transportation, child care, etc. that prevent our Enrollees from seeing their providers. Our focus on telehealth will also be supplemented by a virtual high touch model that will allow our clinical and support teams to wrap around our provider and Enrollees to be sure that they get the integrated, whole person care they need.

NEXT GENERATION CONTRACTING MODELS

We understand the need to align our payment structures to drive improvements in quality and outcomes. We will be expanding our Value Based Contracting models to a broader array of provider types, not simply focused on mainstream providers like PCPs, Hospitals, and Specialists. We will examine the opportunity to better align our models with Population Health quality and outcome goals by introducing value based payment structures for Population Health issues such as SUD treatment and diabetes. For those providers that achieve quality and improved outcomes, we will look to expand our Gold Card program that removes authorization requirements for those providers, easing their administrative burden and driving improvements in quality, cost, and improved health.

Table A-1 below summarizes the challenges WellCare of Kentucky anticipates and how we will work to address such challenges.

Table A-1 Challenges and Initiatives

Challenge	Initiative	Response
Very low EHR adoption in rural areas, particularly Region 8	Electronic Health Record	WellCare of Kentucky will fund a pool of $100,000 per year with $1,000 grants to cover transition costs (file conversions) for PCPs implementing EHR solutions in Region 8. We would encourage other MCOs to participate in funding to increase grant size.
Availability of Providers in Rural KY	Telehealth	Investment and focus on keeping providers in Rural areas
Members move, change contact info	Unable to Contact	Build upon the early success of our UTC programs
Getting Enrollees to engage in their health and follow up	Member Engagement	Outbound center, quality programs focused on Enrollee engagement. Successes: Over 70% of our Enrollees have seen a PCP in 2018 and over 70% of our kids have had a PCP and dental visit.
Social Determinants continue to evolve	Expanding Social Determinants	Provider education to increase awareness and volume Enrollees utilizing Community Connections HelpLine (CCHL) and continue to expand our community partnerships

Challenge	Initiative	Response
Alignment of reimbursement to quality and outcomes	Value Based Contract Models	Intensify efforts through specialized provider relations outreach and education; expand provider interest with peer success stories

SUMMARY

WellCare of Kentucky is proud of the collaborative work we have done with DMS, Enrollees, providers, community organizations, and other stakeholders across Kentucky over the past eight years. We believe that we have the characteristics that DMS seeks for the next contract – Collaboration, Kentucky leading Quality, Enrollee satisfaction and Provider satisfaction, nimbleness when challenges arise and a strong, experienced Kentucky team. As the largest Medicaid plan in the Commonwealth, with the highest quality rating, the highest provider satisfaction, a top 10 place to work in Kentucky, and with more Enrollees choosing WellCare of Kentucky than any other MCO in the State, we feel that we are a partner that DMS can count on to deliver on its objectives and goals. We would be proud and honored to be a partner in the remaining work to be done to make the Kentucky Medicaid program the best in the country.

B.

Company Background

1. Corporate Experience

B.1. CORPORATE EXPERIENCE

a. Describe the Vendor's experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:

i. Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.

ii. Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.

iii. A summary of lessons learned from the Vendor's experience providing similar services to similar populations.

iv. How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.

B.1. CORPORATE EXPERIENCE

a. Describe the Vendor's experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:

WellCare of Kentucky has a rich history of fostering strong partnerships with providers, offering an integrated care model to all populations specified in the new Contract, establishing trusting partnerships with our state partners, and addressing barriers to care and services in local communities across the Commonwealth.

Since 2011, WellCare of Kentucky has collaborated with the Kentucky Department for Medicaid Services (DMS) as a managed care partner to strengthen and enhance achievement of its goals for the Medicaid managed care system. Together, we have focused on and implemented initiatives and programs to better coordinate and integrate quality care for Enrollees in Contract-specified populations throughout the Commonwealth. The driving force behind these innovative initiatives and programs has been our willingness to partner with Commonwealth staff, providers, and community-based organizations to empower and encourage Kentucky Enrollees to take an active role in their own health, make informed decisions about their health care, and close their care needs, ultimately leading to improved health outcomes. **We have been ranked #1 or #2 for both Enrollee and provider satisfaction for the last two years.** We have improved Kentucky Enrollee access to providers, resulting in an increase in Primary Care Provider visits **from 64.5% in 2013 to 70.1% in 2018**. Because of our focus on closing care needs and encouraging preventive care, **91% of our HEDIS measures, including all three Well-Child Visit measures, Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits, have improved year-over-year from 2013 to 2019**, WellCare of Kentucky has the highest percentage of HEDIS scores of 4 or greater among all Kentucky Medicaid managed care organizations (MCOs) in 2019, see **Figure B.1-1.**

WellCare of Kentucky uses an individualized, integrated approach to care for our Enrollees based on their unique physical, behavioral, pharmacy, and social needs. Our approach to integrated service delivery begins with our One Team philosophy—which has been the cornerstone of our organizational culture and the culmination of WellCare Health Plans, Inc.'s (WellCare's) 30 years of experience building a fully integrated, holistic approach to Enrollee care and population health management.

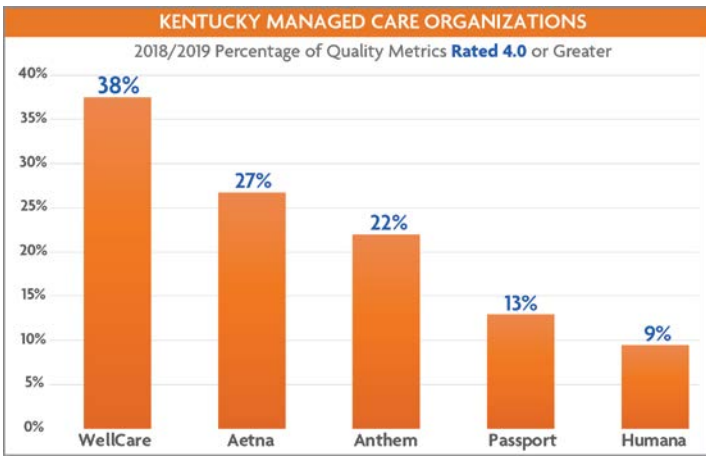


Figure B.1-1 *WellCare Percentage of Quality Metrics*

Our One Team philosophy applies to every aspect of our organization, from the executive leadership staff led by our Chief Executive Officer, William (Bill) Jones, to the fully integrated case management and care coordination team, to our Community Connections social determinants of health (SDOH) resource program, and across all functional areas and staff who support Kentucky Enrollees.

Person Centered

From the inception of our Kentucky Medicaid program, WellCare of Kentucky has championed the availability of integrated service delivery through a comprehensive, integrated network with Enrollees and providers supported by community-deployed associates. **Today, WellCare of Kentucky has the largest and most comprehensive provider network of all the current Kentucky Medicaid managed care organizations (MCOs).** Prior to and continuing after launching our Kentucky Medicaid program, we engaged with Kentucky's behavioral health community in an intentional process to assure Enrollees had access to services and to engage key stakeholders in relationships that facilitate collaboration and coverage. **During our tenure in Kentucky, we have consistently maintained the largest behavioral health network, which today includes more than 2,300 individual behavioral health professionals.** To assure comprehensive behavioral health services for Kentucky Enrollees, we made the decision in 2011 to insource behavioral health services because this was the best approach to meeting the Commonwealth's goals for fully integrated care--we have never subcontracted Medicaid behavioral health services in Kentucky. In addition, we also insource all of our pharmacy clinical programs, formulary design, utilization determinations, high risk care management and specialty drug management -- including medication therapy management, medication reconciliation and Enrollee adherence. Our community presence across the Commonwealth includes six regional offices in Daviess, Warren, Jefferson, Fayette, Boyd, and Perry counties. This helps us maintain close contact with regional Commonwealth staff, providers, and other local stakeholders like community mental health centers (CMHCs), hospitals, and residential treatment facilities. This community presence has been a significant factor in our achieving status as **the only MCO in the Commonwealth with a 3.5 NCQA rating for behavioral health-related metrics.**

Our provider network team supports providers through a number of specialized roles, including Quality Practice Advisors (QPAs), Provider Relations Representatives (PR Representatives), Operations Account Representatives (OARs), and Patient Care Advocates. These specialized roles are field-based and are a manifestation of our commitment to meet each provider where they need support.

To supplement the care offered by physical and behavioral health providers, we have made significant investments to incorporate community resources in the holistic care of our Enrollees. Our award-winning, proprietary Community Connections program began in Kentucky in response to the Commonwealth's goals for truly integrated care. This means addressing our Enrollees' unmet social resource needs. Community Connections improves the health, vitality, and engagement of our Enrollees and communities by empowering Enrollees and sustaining the social safety net throughout Kentucky. The program identifies available social safety net providers across all eight Kentucky regions, assesses existing and potential gaps in the social safety net network, and identifies ways to sustain Kentucky's safety net network. The program features a catalogue of community-based programs and services, staff and mechanisms to connect Enrollees to these resources, community outreach activities, and events, community planning councils, and a granting program. For example, **WellCare of Kentucky donated $100,000 to Volunteers of America (VOA) to open a new residential addiction treatment program in Manchester, Kentucky, for new and expectant mothers after VOA identified a need in eastern Kentucky. Previously, there had been no options for this population within an hour's drive of Clay County.** We describe the features and benefits of our Community Connections program and how we address SDOH in greater detail later in this section.

Addressing Enrollees' social needs is an important part of our integrated solution. When we connect Enrollees to social services like job, education, and utility assistance, we see:

- Improved medication adherence rates
- Increased independence
- Lower hospital admissions
- Improved physical and behavioral health outcomes

EXPERIENCE PROVIDING MANAGED CARE SERVICES TO THE POPULATIONS SPECIFIED IN THIS CONTRACT

WellCare of Kentucky has a long-time presence and longevity in Kentucky, **serving as the largest Kentucky Medicaid health plan based on enrollment with the highest year-over-year voluntary enrollment increases, serving 35.8% of Kentucky's total Medicaid managed care population, as of January 2020**. In 2012, we established six regional offices to put resources and services close to providers, Enrollees and stakeholders. During the 2012-2013 period, WellCare of Kentucky stood with DMS in two important ways: 1) We made sure the Commonwealth had a completely statewide MCO by serving Enrollees in Region 8; 2) We helped DMS roll in additional service and provider types into behavioral health.

We have a history of making sure our Enrollees do not have gaps or interruptions in services during Contract transitions. In 2011, WellCare of Kentucky implemented an industry-leading

Community Connections social determinants of health program whereby we expanded our relationships and collaborated with Kentucky's community-based organizations to better serve all of our Enrollees' holistic needs. WellCare of Kentucky values its relationship with the Commonwealth and considers our Kentucky contract one of our best examples of collaboration and stability. To illustrate our network stability, we are proud to be the only MCO to contract continuously with Appalachian Regional Hospital since inception of our Kentucky Medicaid program in 2011 and to maintain our contractual relationships with every Kentucky hospital system today.

Over the past eight years, our leadership staff and subject matter experts have worked with DMS to continually enhance its Medicaid managed care system to improve care for populations with chronic and complex conditions, align payment incentives with quality goals, and drive quality care to improve health outcomes. We design population health strategies to make sure Enrollees get care in the right place, in the right amount, and at the right time. We saw the following population health improvements from 2016 to 2018:

- *Asthma:* inpatient admits reduced by 10% and non-emergent Emergency Department visits reduced by 20%
- *Heart disease:* inpatient admits reduced by 6% and non-emergent Emergency Department visits reduced by 14%
- *Diabetes:* inpatient admits reduced by 4% and non-emergent Emergency Department visits reduced by 12%
- *Obesity:* inpatient admits reduced by 2% and non-emergent Emergency Department visits reduced by 17%
- *Tobacco Use:* inpatient admits reduced by 9% and non-emergent Emergency Department visits reduced by 16%
- *Infant Mortality:* Well-Child visits during the first 15 months post birth increased by 24% (ranked first of Kentucky Medicaid MCOs)
- *Behavioral Health and Substance Use:* inpatient admits reduced by 6% and non-emergent Emergency Department visits reduced by 18%

Today, we our experience comprises a full range of population health management and supporting services included in the current Contract scope of work for our Kentucky Medicaid Enrollees, which includes (as of January 2020) approximately:

- 215,071 individuals in the Temporary Assistance for Needy Families/Kentucky Children's Health Insurance Program (TANF/KCHIP) population
- 23,814 individuals in the Dual Eligible population
- 42,146 individuals in the Supplemental Security Income (SSI) population (adults and children)
- 8,260 individuals in the foster care and juvenile justice system and adoption assistance population
- 787 individuals in the Former Foster Care population
- 136,853 individuals in the Medicaid Expansion population

We serve diverse populations across the Kentucky and have the majority of complex Enrollees in Regions 7 and 8 - the most rural parts of eastern Kentucky. Our longevity and size enables us to deeply understand the needs of our specific populations in the disparate parts of the Commonwealth. For example, we understand that our TANF and KCHIP Enrollees prevalence of conditions vary by population type (i.e., child, adult, pregnant, etc.), as noted below. Our Dual Eligible Enrollees suffer from high degree of complex, chronic conditions that are often co-occurring, exacerbating their impact--most importantly their behavioral health.

TANF/KCHIP Population: A percentage of our total Kentucky Medicaid population, approximately 39%, are children in the TANF population, 8.35% are adults in the TANF population, 88% are TANF pregnant adults, and 2.35% are KCHIP Enrollees. With regard to chronic diseases for all of our TANF/KCHIP subpopulations, the most prevalent chronic condition is psychiatric. Specifically, our TANF/KCHIP subpopulations experience the following:

- Enrollees in our **KCHIP population** are generally healthy compared to the other Kentucky Medicaid populations we serve. The most prevalent chronic condition is psychiatric (14%). Other chronic conditions include asthma (6%), COPD (1%), hypertension (1%), and depression (4%).
- Like Enrollees in KCHIP, Enrollees in our **TANF-child population** are generally healthy compared to the other Kentucky populations we serve. Also like KCHIP, the most prevalent chronic condition in the TANF-child population is psychiatric (16% or 2% higher than KCHIP). They also experience pulmonary chronic conditions (13%).
- The most prevalent chronic conditions in the **TANF-adult population** are psychiatric conditions (27%). Other chronic conditions include cardiovascular (24%); gastro, hypertension, and depression (20%); and substance use disorder (13%).
- The most prevalent chronic conditions in the **pregnant TANF-adult population** are psychiatric conditions (19%). Other chronic conditions include depression (12%), gastro (11%), and substance use disorder (8%).

Our TANF subpopulations live in all eight DMS Regions with the highest concentration of our TANF Enrollees living in Region 8, Region 5, and Region 4 respectively.

Dual Eligible Population: Our Dual Eligible population experiences a high percentage chronic conditions, including co-occurring and co-morbid conditions. This population has the highest rate of cardiovascular chronic conditions (71%) of the Kentucky Medicaid populations we serve. They also experience high rates of hypertension (51%), pulmonary (42%), gastro conditions (42%), diabetes (34%), COPD (20%), depression (12%), and substance use disorder (12%). A significant majority of our Enrollees in the Dual Eligible population lives in Region 8 - almost four times as many Enrollees as other DMS Regions.

SSI Population: As of January 2020, our SSI population comprised 10.0% of our total Kentucky Medicaid membership with approximately 8.0% SSI adults and 2.0% SSI children. Worth noting 11.8% of our SSI population in Region 8 includes SSI adults, compared to the statewide average of 7.9% SSI adults. The most prevalent chronic condition in our SSI-child population is one or more psychiatric conditions (57%) -- a higher rate than any other Kentucky Medicaid population we serve. Our SSI-adult population Enrollees has the highest rate of hypertension (56%) and cardiovascular (61%) chronic conditions of the populations we serve. The SSI-adult population

also experiences a high rate of psychiatric conditions (39%). Our SSI population has the highest rate of asthma (13% of SSI adults and 12% of SSI children) than any other population we serve today. The majority of our SSI-adult and SSI-child population lives in Region 8.

Former Foster Care Population: As of January 2020 we have approximately 8,300 Enrollees in our Former Foster Care population. We have significant experience working with Department for Community Based Services (DCBS) and Department of Juvenile Justice (DJJ) to support Enrollees as they transition out of foster care and Medicaid managed care. We have processes already in place to maintain them in care to keep their health coverage as long as possible and to assist with their transition out of care and Medicaid to ensure continuity of care. Our foster care Enrollees remain on Medicaid for an average of 1.5 years following their 18th birthday, and adoption subsidy Enrollees remained for an average of 1.2 years. Our former foster care population receives treatment for the following primary chronic conditions: psychiatric conditions (34%), depression (22%), and substance use disorder (13%). Our experience demonstrates that youth aging out of foster care and the juvenile justice system as well as former foster care Enrollees have significant social service needs, which can be obstacles to their health, well-being, and positive outcomes if unaddressed. We facilitate Enrollee access to assistance through our Community Connections program, including social services and training. For example, WellCare of Kentucky will partner with Kentucky Partnership for Children and Families (KPCF) to offer our transition age and former foster care Enrollees (including youth with a documented history of behavioral health needs and youth that live in group homes and independent living settings) the training and mentoring they need to become leaders in their own lives and communities. KPCF's leadership academy for youth in foster care supports youth to gain the knowledge and skills necessary to not only access health care, but also establish life skills that improve self-sufficiency over time and support successful youth transition to adulthood. Enrollees in our former foster care population live in all regions with the highest concentration in Region 5 and Region 8.

Medicaid Expansion Population: In 2013, the Commonwealth moved to a statewide Contract that included Region 3 and added a new Enrollee eligibility category: Medicaid Expansion Enrollees. Kentucky implemented traditional Medicaid Expansion in January 2014 under the ACA, which led to a substantial increase in Medicaid enrollment. WellCare of Kentucky successfully passed the readiness review, also with no corrective actions, prior to the launch of the Region 3 and Medicaid Expansion populations. This successful transition to the new Contract provides evidence of our adaptability to a new regulatory environment and our ability to make quick business rule changes to accommodate new regulatory guidance and new programs. We made the technology investments necessary to handle the Medicaid Expansion population. This Contract more than doubled our Medicaid Expansion enrollment, from approximately 45,000 to 140,000 Medicaid Expansion Enrollees within six months of the program's launch. As of January 2020, we serve 136,853 Medicaid Expansion Enrollees, which is approximately 32% of our total Kentucky Medicaid membership. The majority of our Medicaid Expansion Enrollees live in Region 8, Region 5, and Region 4 respectively.

NATIONAL EXPERIENCE SERVING MEDICAID MANAGED CARE POPULATIONS

WellCare has provided Medicaid managed care services for state Medicaid programs for over three decades. WellCare provides health care services for more than 7 million Americans, including Medicare Advantage and Medicare Part D, in addition to more than 4.11 million Medicaid Enrollees nationwide, including populations similar to Kentucky Medicaid. In addition to Kentucky, as of year-end 2019 ,WellCare managed the care for Medicaid Enrollees in 11 other states, including Arizona, Florida, Georgia, Hawaii, Illinois, Michigan, Missouri, Nebraska, New Jersey, New York, and South Carolina. Further, today we are the largest Medicaid managed care plan in Kentucky, Florida, Georgia, Illinois, Michigan, and Missouri. During the last 24 months, WellCare won procurements for new Medicaid business in North Carolina for the statewide Medicaid program and in Florida for the Children's Medical Services (CMS) Health Plan, a program offering high-touch services for 68,000 children with special health care needs, including 250 foster care children who are medically fragile. We were also selected as the primary managed care organization for Florida's statewide Serious Mental Illness population.

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc. (WellCare). On January 23, 2020. WellCare was acquired by Centene Corporation (Centene). WellCare is now a wholly owned subsidiary of Centene. **WellCare of Kentucky's leadership, staff, branding, and model for delivering services to the Commonwealth are not changing and we remain committed to partnering with DMS to ensure Kentucky's Enrollees, communities, providers and other stakeholders receive the integrated, whole-person care and services necessary to address all of their physical, behavioral, and social needs.**

With the acquisition, WellCare of Kentucky is now also able to leverage the combined experience and best practices of our Centene affiliate health plans, which is now managing the care of more than 12.9 million Medicaid Enrollees across 30 states. Centene is a veteran leader in providing managed care services to and improving health outcomes for Medical Assistance and public sector populations. With over 35 years' experience, historically as of year end 2019, Centene's expertise includes providing Medicaid and Medicaid-related health plan coverage to 8.7 million individuals in 27 states through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), Modified Adjusted Gross Income (MAGI), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Substitute Care, Medicaid Expansion Populations, LTSS, and Medicare-Medicaid Plans (MMPs). Centene has built and retained partnerships with more than 994,310 physicians and 6,340 hospitals, many of them academic institutions, nationwide. Centene brings deep organizational expertise serving individuals with complex needs as well as supporting the providers who serve them.

We are a leader in helping Enrollees transition from other MCOs and fee-for-service (FFS) Medicaid programs to our health plans. The following matrix displays the range of this experience:

WELLCARE IMPLEMENTATION EXPERIENCE

The total is more than **1,880,000** members over 10 years.

Implementation Description	2019	2018	2017	2016	2015	2014	2013	2012	Pre 2012	Number of members Transitioned
WellCare Transition of Florida children with special healthcare needs, including foster care, to our statewide Children's Medical Services (CMS) Health Plan	✓									68,000 members
Staywell Transition of Florida Medicaid members, including the SMI and LTSS populations	✓									78,000 members
Harmony Health Plan Statewide Medicaid expansion into all Illinois counties		✓								190,000 members
Care 1st Health Plan Arizona Transition of Arizona members		✓								100,000 members
Missouri Care Statewide expansion of Medicaid managed care into all 115 counties			✓							179,000 members
WellCare of Nebraska Statewide implementation of Medicaid managed care for Heritage Health			✓							70,000 members
WellCare of South Carolina Transition of Medicaid members from Advicare Corp.				✓						30,000 members
WellCare of New York Statewide carve-in of behavioral health services for adult Medicaid members				✓	✓					71,000 members
WellCare of New Jersey Transition of 46k Healthfirst members & implementation of LTSS program						✓				46,000 members
Staywell Transition of Florida Medicaid members from FFS due to mandated managed care						✓				394,000 members
WellCare of Kentucky Transition of 43k members due to realignment of MCOs (open enrollment): enrollment of 28k members (Reg 3 expansion)							✓	✓		71,000 members
WellCare of Kentucky Transition of members due to realignment of MCOs							✓			63,000 members
`Ohana Health Plan Statewide implementation of the Hawaii QExA, QUEST and CCS programs								✓	✓	30,000 members
WellCare of Georgia Transition of Medicaid members									✓	490,000 members

Figure B.1-2 WellCare Implementation Experience

WellCare's national experience (as of yearend 2019) managing transitions of care encompasses Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, and South Carolina, totaling more than 1,880,000 Enrollees to WellCare, as illustrated in **Figure B.1-2.** We are also preparing to implement our Medicaid program in North Carolina. WellCare has an extensive array of resources and full scalability to accept large or small groups of transitioning Enrollees and provide covered services. We designed our standardized processes and advanced platforms to support growth. This ability to scale is a key aspect of our operational practices. Our expert national transition team supports local transition activity for large groups.

WellCare shares and customizes, as needed, best practices and innovations among our Medicaid programs nationwide. From the beginning, Kentucky's diverse and unique geography and demographics inspired WellCare of Kentucky to innovate and create transformative initiatives to meet the needs of Enrollees. WellCare of Kentucky has a stable and knowledgeable leadership and operational management team. For the last two years, WellCare of Kentucky made the top ten list of "Best Places to Work in Kentucky." Our Kentucky Medicaid leadership team comprises thought leaders with significant managed care and Kentucky

Medicaid expertise. They have spearheaded many of WellCare's most innovative programs, including:

Snapshot of WellCare's National Managed Care Experience

- 30 years of nationwide managed care experience
- 12 Medicaid managed care contracts nationwide
- In January 2018, Fortune magazine named WellCare Health Plans, Inc. as one of the "World's Most Admired Companies."
- All of WellCare's health plans eligible for quality accreditation are NCQA accredited.
- WellCare is the number one or two health plan status in over 80% of our Medicaid programs for NCQA Quality Ratings
- The only national Medicaid managed care plan to be re-awarded 100% of rebid Medicaid contracts

WellCare at Home: Our field-based WellCare at Home program is a critical component of our fully integrated, person-centered, community-based approach to care coordination and case management. This program originated in Kentucky and proved the value that a high-touch, in-home approach brings to increasing Medicaid Enrollee satisfaction and to improving health outcomes. Relying on Care Managers who are nurses or social workers, WellCare at Home is fully integrated and tailored to each Enrollee's needs by considering their physical health, behavioral health, pharmacy, and social resource needs. In 2015, we expanded our WellCare at Home program nationwide to all of our other WellCare Medicaid affiliates.

Reach Program: Our unable-to-contact program combines high-tech data collection and mining of contact information with in-person outreach to find and engage Enrollees. It improves our ability to locate and engage high-risk Enrollees in case management. We intensified our unable-to-contract program in the Eastern Region of Kentucky when we deployed local enrollee outreach coordinators (community health workers) to find people in Region 8. **This resulted in a 19.6% reduction in Emergency Department care and a 21.4% reduction in overall medical expenses for Kentucky Enrollees engaged.** Today, these efforts have evolved to include mining of rich data sources of our internal data (e.g. eligibility, clinical notes), outside data bases (e.g. pharmacy, physician offices) and the use of a comprehensive data search company, Lexus/Nexus. This data and the ability to permanently store and display this information at every customer service, clinical and quality interaction, powers our field and community outreach.

Community Connections: Our comprehensive, industry-leading, closed loop SDOH program described later in this section comprises a rich, in depth registry of national and Kentucky community resources, a call center of trained community health workers, and our rich approach to community engagement.

WellCare of Kentucky's eight plus years of Kentucky Medicaid program experience combined with our WellCare and Centene affiliate health plan's national experience is unmatched – especially our Kentucky staff's knowledge of Commonwealth agencies and the Kentucky Medicaid program as well as our local presence and successful execution of the required scope of services. This knowledge and long-term experience, when combined with our proposed population health management solutions, provides the Commonwealth with a best in class solution to meeting the current and future needs of the Kentucky Medicaid managed care program.

WellCare Core Values
- Partnership
- Integrity
- Accountability
- One Team

i. Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.

OUR EXPERIENCE IMPLEMENTING POPULATION HEALTH MANAGEMENT PROGRAMS AND INITIATIVES

Population Health Management is the aggregation of Enrollee data across health information technology resources, the analysis of that data into a single, actionable Enrollee record, and the actions through, which WellCare and providers can improve clinical and cost outcomes. Based on clinical best practices, our population health strategy is grounded in an eight-year history in Kentucky, collaborating with providers, community partners, and DMS and other state agencies. Our programs take an integrated approach to promote wellness and prevention, improve chronic condition management and self-management, and includes partnerships with communities to improve population health through intervention channels at the Enrollee, provider, and system levels to deliver the highest impact to our most vulnerable populations.

Population Health Management begins with our successful experience maintaining a single and centralized Enrollee record in our integrated case management/care coordination system, CareCentral. Fully integrated with our claims systems, CareCentral shows users an Enrollee's integrated health record, health history, diagnosis and treatment, outreach efforts, information received from providers, assistance with scheduling appointments, assessment data, medication history, health-related social resource needs, claims history, authorizations, and care plans. CareCentral captures all of this behavioral, medical, pharmacy and social determinant information into a single, 360 degree Enrollee view. CareCentral helps us integrate care delivery for our Enrollees. CareCentral aggregates health data from electronic health records, claims, and other sources; standardizes data in one central place; and analyzes data for population health management purposes. With all of the data in one place and all of our staff working in one place, we can run advanced predictive analytics and risk stratification. This risk stratification uses non-traditional data sources, such as medication adherence and social resources, to improve our predictive accuracy. This approach helps us quickly identify, outreach, and engage in case management for Enrollees who are at high-risk of needing intensive and costly services.

In addition, part of our care delivery model is to use data to make sure providers are delivering the best quality population health outcomes. CareCentral supports population health care

delivery by informing recommendations to improve Enrollee health, e.g., identifying and quickly engaging Enrollees at high-risk for hospital/facility readmission or our high-risk pregnant Enrollees. In addition, value-based programs reward providers with incentive payments based on the quality of care provided rather than the services delivered. These rewards are paired with dynamic clinical information, such as diagnosis, care plans, care gaps, provided to groups through file transfers, on our provider portals and in printed format. These tools can be configured and drilled down by Enrollee, family, condition, care gap, PCP, group or zip code. Our goal aligns with DMS' goal to provide better care for Enrollees, improve population health management, and reduce health care costs.

WellCare's Population Health Management Program

Our Population Health Management program is an evidence-based, proactive approach centered on larger, socially grouped medical and behavioral needs and prevention efforts. Our program has seven clinical focus areas, or domains, each led by a clinical advisory board to review effectiveness, explore opportunities and innovations, and develop new programs and initiatives. Focus areas include: Behavioral Health and Substance Use Disorder (SUD); Maternal and Child Health; High Acuity and Transitions; Medical Conditions; Advanced Illness; and Prevention and Wellness. Each one improves health outcomes through prevention and by promoting healthy behaviors, early identification, and preventing deterioration or complexities. WellCare's population health domains align with DMS' population health condition priorities. All programs emphasize empowering individuals to improve their health and engage in their health care. We employ a person-centered approach that addresses medical and non-medical drivers of health while reducing inappropriate utilization and costs.

Within the seven domains, our approach considers behavioral, socioeconomic, physical environment and health care factors as well as the care delivery systems and Enrollee care experience. Each one provides the clinical expertise to evaluate our populations and develop programs to meet the needs of our membership. Our strategic efforts focus on both the delivery of health care and improving and maintaining wellness. The ultimate goal is to improve outcomes and reduce costs over the long term.

Through **data analytics**, we identify opportunities to create and implement evidence-based, best practice initiatives that deliver cost-effective care that is both innovative and high quality. Our population health strategy involves establishing a manageable set of clinical priority areas, and creating a consistent, WellCare-wide care management and coordination model. With this strategy, we aim to improve the health of the population, ensure positive care experiences for Enrollees, and engage all stakeholders in an integrated delivery system working toward the same objectives. A key element of our population health strategy is **aligning clinical outcomes and performance metrics for each domain**. Through our population health domains, we align all parts of the organization to manage the health of all of our Enrollees. This alignment creates a synergy of effort across the organization in working to achieve Enrollee-centric objectives and exceeding regulatory contract requirements.

We have experience implementing population health programs, including but not limited to:

- Breath of Life Asthma
- Obesity
- Tobacco Cessation
- Cancer
- Low Birth Weight and Preterm Birth
- Pregnancy Intendedness
- Diabetes
- Heart Disease (Coronary Artery Disease, Congestive Heart Failure, Hypertension)
- Early Childhood Intervention
- Mental Health and Substance Use Disorder

We incorporate **industry-leading metrics** to measure the overall health of our population against national outcomes and competitive benchmarks in each state. We develop prevention and disease management programs to address priority conditions and populations within each clinical focus area. Our Chief Medical Officer, Howard Shaps, MD, MBA, WellCare of Kentucky, and our in-house clinical management team direct these programs, supported by our national advisory groups and framework, to deliver improved outcomes at a lower cost.

Results: We measure the success of our population health management programs by assessing outcomes related to:

- Improved Enrollee perception of health at discharge from care coordination as evidenced by an increased score on the short-form health survey (SF-12/SF-10)
- Positive Enrollee satisfaction results
- HEDIS care gap reduction
- Impatient admission rate reduction
- Inpatient readmission rate reduction
- Medication adherence
- Increase in lower-cost primary care services and a reduction in high-cost Emergency Department utilization

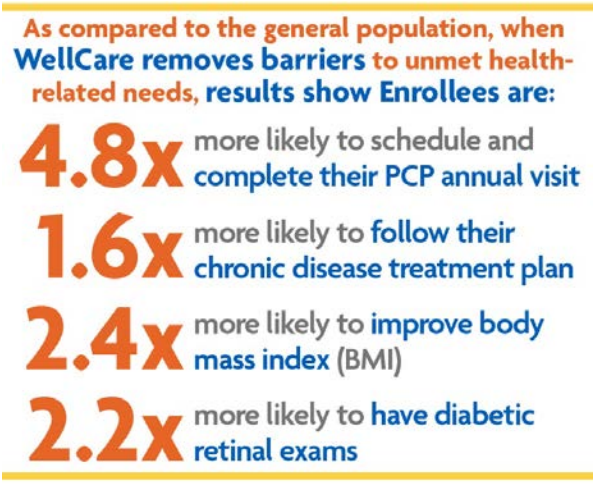
WellCare of Kentucky has a strong commitment to transparency, flexibility, and innovation in care and service delivery. In Kentucky, we are a market leader and innovator when designing and implementing population health management programs to improve Enrollee health outcomes, control costs, and bringing advanced technology to the Medicaid program. WellCare of Kentucky has seen a **64% reduction in Admissions for Children with Asthma and a 51.8% reduction in Admission for Adults with Asthma.** Further evidence of our population health program success in Kentucky is our Comprehensive Diabetic Care, **with 87% of Enrollees receiving HbA1c testing (4% above the national average) and 92% receiving appropriate kidney monitoring. Nearly 60% of Enrollees had an annual diabetic eye exam – a 22.2% increase between 2016 and 2018.**

WellCare of Kentucky is also a leader among MCOs in addressing healthy weight management. We rank first for HEDIS measures related to adult BMI and nutrition and physical activity counseling. **Our rank for the HEDIS Child BMI measure improved by almost 49 percentage**

points between 2013 and 2018, reflecting significant success getting body mass index (BMI) scores to trigger engagement in the Healthy Weight Management program. We attribute these successes to our Healthy Weigh Management program interventions, particularly provider education.

HOW WE ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

Since 2011, WellCare of Kentucky has worked with the Commonwealth to broaden our MCO role beyond administering health care in the lives of Kentucky's most vulnerable citizens. This approach meant developing community partnerships statewide and becoming a driving force behind stabilizing and enhancing the capabilities of the network of social services in the Kentucky communities we serve, helping to address hunger, homelessness, job training, education, and other social determinants that have an impact on an individual's health and well-being. We designed our Community Connections program in Kentucky with the intention of partnering with community resources and helping Enrollees navigate the local social support network to receive the care and services they need. A program priority includes identifying community-based solutions to fill gaps in the network of social services.



Addressing Enrollees' social needs is integral to providing truly comprehensive care on our Kentucky Medicaid program. Because of this, our Kentucky staff includes Elizabeth Starr, Enrollee Services Manager within our leadership structure. Ms. Starr has unmatched experience as a LCSW advocating for individuals with high needs to get necessary care and social services. Ms. Starr oversees a statewide team of community engagement partners and supervisors who live and work in the Kentucky communities they serve.

Nationally since 2008, WellCare has maintained a leading role in addressing the social determinants of health. We were among the first Medicaid managed care plans to fully incorporate social resource needs into every element of our integrated care model and operations. From those early days, we have continued to invest in new technology, training, and operations to enhance our ability to identify and address social needs, as evidenced by the development of our Community Connections program in collaboration with the Commonwealth.

Our proprietary, industry-leading Community Connections program links our Enrollees and families to social services, such as food banks or meal delivery, housing assistance, financial assistance, transportation, education support, legal assistance, and employment services. Rather than just focusing on Enrollees with complex health conditions, our Community Connections program considers the social and economic factors of all Enrollees and their

families or guardians. This program integrates social resource needs into every element of case management and care coordination through the following features:

- An up-to-date registry of community resources available across more than 70 domains used by WellCare staff and providers to link Enrollees directly to needed services. **This database encompasses more than 335,000 resources, including community-based public assistance organizations, services, and health-related activities and events.**
- The Community Connections Hotline (CCHL) provides telephonic social service coordination support through peer coaches and liaisons to help screen for eligibility for service, identify additional needs, connect callers to appropriate services and follow up.
- WellCare of Kentucky places our community engagement partner staff in every region of the Commonwealth to identify emerging needs of the communities in which they live to solve for social service gaps and support care management activities.
- Use of closed-loop referrals to social services, whereby our staff tracks the outcomes of referrals that are made through the Community Connections program and provides Enrollees with additional help, as needed. We recently redesigned our Community Connections platform to enhance community data-sharing capabilities.
- To advance community health outcomes through our Community Connections program, WellCare's strategic plan includes investing in existing community resources and implementing new Community Health Investment Programs. This proprietary contracting and investment model supports social service resource organizations by sharing data and targeting investments that have proven efficacy for the Medicaid populations we serve.

Points of Light, the world's largest organization dedicated to volunteer service, has named WellCare Health Plans, Inc. one of the 50 Most Community-Minded Companies in America for 2019. This is the third consecutive year WellCare made the coveted list, which is based on The Civic 50 annual survey. Among WellCare's philanthropic contributions, we invested more than $1 million in the communities we serve through our Community Connections program, providing grants to sustain community-based organizations that foster and promote health, well-being, and quality of life.

Care Managers, Care Coordinators, and other WellCare of Kentucky staff refer Enrollees and families, as needed or requested, to our Community Connections Hotline team for assistance connecting to social services. Our Enrollee-facing staff have the training and capability to access and search the Community Connections database of community-based organizations, including organizations like SNAP, WIC, and Head Start. They refer Enrollees and families/guardians to community-based resources. This aligns with the goal to help improve health outcomes for our Enrollees and lower the overall cost of health care.

Through our Community Connections program, if a Care Manager identifies an Enrollee with an urgent need for a social resource need like food, shelter, or help with utilities, the Care Manager may make a referral to a community-based organization prior to engaging that

Enrollee in care management activities. For example, a woman dealing with domestic violence may need to find support for that situation before agreeing to let a Care Manager come to the home to support a child with a special health care need.

WellCare of Kentucky engages in partnerships and actively helps Enrollees connect to community resources that the Medicaid program does not cover. We meet with community-based leadership teams to understand the services they offer, learn about where their gaps are, and then collaborate to find ways to close those gaps. We forge community partnerships to improve health care by 1) improving case management and care coordination, access, and service delivery 2) strengthening the community and safety-net infrastructure, and 3) preventing illness and reducing disparities. Our experience shows even the best interventions may be ineffective at helping Enrollees with complex health problems unless we first address their basic and social needs. Some of our Kentucky Enrollees have a history of homelessness, food insecurity, childhood instability and trauma, early loss of parents or other caregivers, histories of sexual or physical abuse, and early substance abuse. We recognize the ways these needs influence Enrollee and family interactions with the health care delivery system and how these factors can become barriers to accessing care. **The Robert Wood Johnson Foundation and the University of South Florida evaluated our Community Connections program and concluded that Enrollees receiving referred services are 4.8 times more likely to complete their annual Primary Care Provider visit, while also reducing the total cost of care.**

Integrating Social Service Referrals into the Delivery of Care

Our Community Connections program enhances our WellCare at Home field-based care management approach. We know that quite often what affects an Enrollee getting the care they need is tied to social aspects of their lives. If a family wakes up and their electricity has been cut off, they will not prioritize getting their child to a well-child checkup that day. Data indicates Enrollees who experience homelessness are at greater risk of using the Emergency Department and that some diabetes-related hospital admissions can be attributed to food insecurity. Our care management program focuses on connecting Enrollees to community resources, enabling them to address barriers to allow them to take full advantage of covered benefits and services and to promote healthy behaviors and self-care. By connecting Enrollees to community resources, we can remove barriers so that an Enrollee's health care needs become a realistic focus. **Since launching the Community Connections Program in Kentucky, we have connected more than 31,000 people to over 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in Emergency Department visits and a 53% decrease in inpatient spending (Robert Wood Johnson study of our Community Connections program, 2016).**

All Enrollee-facing staff, including Care Managers, Care Coordinators, field outreach coordinators, Enrollee Services representatives, and CCHL staff, complete training modules on how to assist Enrollees and families or guardians with removing barriers to social needs and how to refer Enrollees to community resources. In addition to completing WellCare of Kentucky's required new-hire training, as part of care management and care coordination

training, our staff completes **Health Services Referral Tracker 2.0** to learn how to empower our Enrollees to reach optimal social health and independence. Our staff gains insight into the Community Connections program and learns how it provides Enrollees with access to resources that successfully remove their social barriers. In this module, care management and care coordination staff learn the basics of Community Connections platform use, including:

- Searching for social service organizations
- Searching for community activities
- Referring Enrollees to services
- Follow up
- Gaps in services

In addition to completing WellCare of Kentucky's required new-hire training, our CCHL staff complete an 11-day comprehensive training that includes but is not limited to the following modules:

- Community Connections Helpline
- Navigating the Community Connections Command Center
- Connecting with our Enrollees
- Building Enrollee Connections
- Cultural Competency
- Disability Awareness
- Behavioral Health Overview
- Communications Skills
- Effective Listening

In-person training for CCHL staff includes spending time in the Community Connections Hotline office for on-the-job training with department peer trainers/coaches.

Care Managers, Care Coordinators, Field Outreach Coordinators, Enrollee Services Representatives, and CCHL staff offer telephonic referral to and coordination of social service resources, as needed. Our staff uses evidence-based motivational interviewing to establish trusting relationships with Enrollees. We connect with Enrollees at their own pace and often resolve their most pressing needs before trying to complete a full assessment and coordinating other services. Social services are often essential to achieving an Enrollee's health care goals. We educate providers and community-based organizations about our CCHL and encourage them to refer our Enrollees and families to the hotline.

Our CCHL is available five days a week and uses our comprehensive registry of community social supports to link Enrollees to community-based services. As needed, CCHL staff and our Field Outreach Coordinators refer Enrollees to telephonic or local Care Managers to address medical or behavioral health needs in addition to social resource needs.

Care Managers who identify an Enrollee with social needs connect them to services directly using through our Community Connections program database or by referring Enrollees or families to the CCHL to identify resources. Our Kentucky Care Managers assist Enrollees with filling out and submitting applications for food and nutrition services like Women, Infants, and Children (WIC), SNAP, Head Start, Temporary Assistance for Needy Families, Child Care Subsidy, and Low Income Energy Assistance, as needed. The following Enrollee success story demonstrates how assistance with whole person needs leads to improved health outcomes.

Enrollee Success Story Assisting with Medical and Social Needs

In January 2017, our care manager received a referral from our field outreach coordinator (FOC) after an outbound outreach call. The grandmother of our Enrollee who is six years old with Cerebral Palsy told the FOC that her family needed utility assistance and follow-up on durable medical equipment (DME) needed to improve her granddaughter's mobility at home and in school. During a face-to-face visit in the child's home, the care manager completed a care needs assessment with the child, with father and grandmother present. During the assessment, the child's father mentioned there was a woman named Pam who talked to them about getting crutches, wheelchair, and replacing the wheels on a walker. The child's father stated he did not know who Pam was or if/how she was going to help, so he gave the care manager Pam's phone number to see what she could find out. The child's father shared that the reason they needed help with their utility bill was because they had received a cut-off notice and were concerned about keeping the heat on for the child. They owed the utility company over $400. The care manager searched our community resource database and gave the father contact information for the Low Income Home Energy Assistance Program (LIHEAP) for assistance with utilities. She also contacted Pam and found out that she worked with a DME company and was assisting the family in providing all equipment needed, including the walker wheels, a wheelchair, and crutches. The care manager called the child's father, informing him that Pam worked for the Patient Aid Medical Equipment Company, which was going to provide the DME. Utility assistance from LIHEAP resulted in the family only having to pay $25 of the $400 bill, and they avoided disconnection of utilities. The care manager's follow up and monitoring showed that the utility assistance intervention improved our Enrollee and family's quality of life and everyday care of the child. Coordination of DME medical equipment improved the child's activities of daily living (ADLs). Timely interventions reduced the father's stress and ultimately improved our Enrollee's health outcomes.

Follow up on Referrals and Tracking Social Referrals to Closure

Care Managers and Care Coordinators follow up on Enrollee referrals; adjust referrals as necessary; measure an Enrollee's health outcomes, including those related to social service referrals; and track Enrollee social referrals to closure. The CCHL team conducts follow-up calls regarding social service referrals for Enrollees who are not participating in care management.

Addressing Social Resources in Each of Kentucky's Medicaid Regions

Our evidence-based Community Connections program is built on community-based organizations, which we support through targeted grants and program funding; data sharing contracts that allow us to share HIPAA-compliant Enrollee referrals and service feedback; program effectiveness evaluation through our interconnected data platform to aid in program expansion, refinement; and additional grant funding.

Research, hot spotting, and relationship building helps us integrate social resources. To retain an understanding of Commonwealth, regional and local needs, we maintain an electronic library of information from internal and external sources to perform community-based assessments of health disparities sorted by ethnicity, race, gender and geography. This system includes data based on input from our local community engagement partners, community-based organizations, providers and associations, Commonwealth agency partners, and State Health Improvement Plans. Our community engagement partners have a deep understanding of local communities and work directly with care coordinators and the CCHL team to solve specific Enrollee access issues and identify referral resources to address social needs. We augment this information with population health data drawn from external sources, including CMS.

Figure B.1-3. In April 2019, WellCare of Kentucky sponsored the Prevent Child Abuse Kentucky 2019 Community Awards with $10,000 to further community support statewide.

We conduct field-based provider summits and regional sessions with key providers, which help us focus on in-person relationship and trust building activities. This helps us understand local organizational capacity and needs and identify the key social programs that fill social resource needs.

Table B.1-1 presents key social service partnerships we have established in Kentucky by region.

Table B.1-1 Key Social Service Partnerships in Kentucky

List of Key Kentucky Social Service Partnerships
Region 1
• Pennyrile Allied Community Services (PACS) • Marshall County School System • Paducah Cooperative Ministries • Provider Enrichment Services

• The Gentry House
Region 2
• Crossroads, Inc. • The Help Office • Owensboro Regional Suicide Prevention Coalition • Aaron McNeil House • Audubon Area Community Services - Owensboro Regional Recovery
Region 3
• Eastern Area Community Ministries • Coalition for the Homeless • Continuum of Care KY Balance of State • Orphan Care Alliance • Volunteers of America
Region 4
• HOTEL INC • Phoenix Wellness • Community Farmers Market • BRIGHT Coalition • Adair County WATCH
Region 5
• Kentucky Coalition Against Domestic Violence • Kentucky Faith Based Coalition • God's Pantry Food Bank • Bluegrass Community Action Partnership • Prevent Child Abuse Kentucky (**Figure B.1-3**)
Region 6
• Brighton Center • Welcome House • Safety Net Alliance • Northern Kentucky Community Action Commission • Care Mission
Region 7
• Hope Central • Clean Start • CAReS – Community Assistance and Referral Services, Inc.

• Safe Harbor of Northeast Kentucky • Hillcrest-Bruce Mission
Region 8
• Kentucky Homeplace – University of Kentucky Center for Excellence in Rural Health • Housing Development Alliance • Come-Unity Cooperative Care • Operation UNITE • Shaping Our Appalachian Region

ii. Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.

THREE INITIATIVES WE IMPLEMENTED TO SUPPORT IMPROVED ENROLLEE HEALTH OUTCOMES

Our WellCare of Kentucky Medicaid team comprises thought leaders who have piloted and subsequently implemented many of WellCare's most innovative programs and initiatives designed to improve health outcomes. We have shared and implemented these initiatives, which became best practices, with our other Medicaid programs. These initiatives consistently deliver improved health outcomes and have the added benefit of being cost effective and resulting in sustained change. In this section, we describe three initiatives that we launched in Kentucky and implemented across the organization to improve Enrollee health outcomes.

Initiative #1: WellCare at Home

Home-based care is a critical component of WellCare of Kentucky's integrated, person-centered, community-based case management and care coordination model. WellCare at Home originated in Kentucky and expanded to all WellCare Medicaid health plans after a successful a successful pilot and expansion in Kentucky. WellCare at Home is grounded in WellCare's organizational mission to help Enrollees live better, more independent lives in the community, supporting our Medicaid customers' goal of high-quality delivery of care, improved health outcomes, cost-effectiveness, and Enrollee and provider satisfaction. This fully integrated care model considers an Enrollee's physical health, behavioral health, pharmacy, long-term services and supports, and unmet health-related social resource needs under a single fully insourced infrastructure with a single line of accountability, single integrated technology system, and fully integrated local and national staff. WellCare at Home includes a broad array of care coordination services, including prevention and population Health management, complex local case management, condition-specific care coordination (e.g., high-risk obstetrics, NICU, etc.), discharge planning and care transitions, health coaching, and telephonic field outreach coordination programs. We employ Care Managers who are nurses and social workers. They build a trusted relationship with Enrollees, assess their situation and conditions, and convene a multidisciplinary team to help address unmet needs.

WellCare of Kentucky provides and oversees localized case management and care coordination, which includes local, in-person coordination and support, supplemented by other WellCare resources. Our WellCare at Home team comprises registered nurses, licensed clinical social workers, field outreach coordinators, and care coordinators. WellCare of Kentucky has three Enrollee outreach coordinators in Region 8 to help locate and engage Enrollees we identify as high risk and who can benefit from care coordination. Our staff lives and works in the communities they serve, reaching Enrollees in remote, rural areas, and in urban centers. WellCare at Home, supported by our advanced CareCentral case management/care coordination system, ensures the administration of a seamless continuum of case management and care coordination from initial screening through follow-up and monitoring at a point of care closest to the Enrollee.

The in-person focus facilitates monitoring for our most medically complex and high-needs Enrollees in ways that telephonic outreach does not. The WellCare at Home model is especially beneficial in communities that are rural or experience challenges due to geography.

Results: Our approach to meeting the Commonwealth's expectations and requirements for the population health management and case management/care coordination continuum is informed through our understanding of how to best find, identify, stratify, and engage Enrollees in our integrated, person-centered case management/care coordination program. After implementing our high-touch, in-person WellCare at Home model across WellCare health plan affiliates, **from 2015-2017, our field-based care model reduced preventable admissions by 26% and preventable Emergency Department visits by 8% while increasing use of less expensive outpatient services and increasing Enrollee compliance with medication adherence.**

To enhance our WellCare at Home model, WellCare repeats a data-driven clinical review process monthly as part of a continuous quality improvement effort. Results inform program enhancements and long-term strategic planning to achieve the next level of performance. For example, **nationally, we recently added 200 additional local care coordinators to our programs and as a result experienced a 20% decrease in inpatient admissions, a 13% decrease in readmission, and a 13% decrease in Emergency Department utilization.**

Initiative #2: Leveraging our Community Connections Program to Improve Health Outcomes by Addressing Social Service Needs

We leverage our Community Connections program to improve health outcomes by addressing social service needs. The following examples are just a few of the initiatives we support to achieve improved health outcomes. These initiatives also decrease costs resulting from a reduction in Enrollee inappropriate utilization of high-cost Emergency Department services and in-patient services.

Team Ultra in Marshall County, Kentucky, is an example of how we apply the features of our Community Connections program to a specific community initiative by supporting a community-based organization to achieve improved health outcomes.

Figure B.1-4: Team Ultra

Marshall County is a rural area in Kentucky and the opportunities for after-school activities, outside of organized team sports, are limited. The Marshall County Health Department created Team Ultra in response to a request from the Kentucky Department of Public Health to increase physical activity in school-aged children, see **Figure B.1-4**. The mission of Team Ultra is to teach students about physical activity, good nutrition, and upstanding character traits. We collaborated with Team Ultra and provided grants to fill the funding gap to ensure all students in the county who wanted to participate could. The program began with one elementary school and has grown into all six of the county's elementary and middle schools.

Between September 1, 2016 and January 6, 2019, 136 students received 2,441 total services from Team Ultra. Among the WellCare of Kentucky Enrollees who participated, the average age was 11.5; 53.2% were boys and 46.8% were girls.

One-year post intervention, we observed the following reduction in health care utilization/costs and improvement in health outcomes:

- 21.5% reduction in Emergency Department visit costs
- 35.9% reduction in Emergency Department visits
- 32.5% reduction in non-emergent Emergency Department visits
- 98.3% increase in routine child health exams (from 28% to 56%)
- 81% reduction in visits related to acute lower respiratory infections

Kentucky Homeplace: From December 2016 to June 2017, WellCare of Kentucky partnered with community-based partner, Kentucky Homeplace, to support their mission of helping rural people of Kentucky remove barriers to accessing appropriate health services. Developed by the University of Kentucky Center for Excellence and now serving 30 counties, it focuses on health literacy, with community health workers providing health coaching and emphasizing preventive care and education through programs like the Stanford model for Chronic Disease Self-Management (CDSMP) and Diabetes Self-Management (DSMP). These six-week classes were offered in all counties and the pilot resulted in a sizable reduction in health care utilization. **Outcomes included a 62% reduction in avoidable Emergency Department visits, a 72% reduction in avoidable inpatient admissions, and a 70% reduction in inpatient days.**

Workforce sustainability: WellCare of Kentucky makes data-informed decisions about where and when we focus our efforts to provide assistance with social resource needs. For example, unemployment rates fell in 94 Kentucky counties between March 2018 and March 2019, but rose in 19 counties, and stayed the same in seven counties, according to the Kentucky Center for Statistics (KYSTATS), an agency of the Kentucky Education and Workforce Development Cabinet. Magoffin County recorded the Commonwealth's highest unemployment rate at 12.3 percent, followed by Lewis County, 9.1 percent; Carter County, 8.3 percent; Menifee County, 8 percent; Elliott and Wolfe counties, 7.6 percent each; Breathitt and Harlan counties, 7.4 percent each; Martin County, 7.3 percent; and Lawrence and Owsley counties, 7.2 percent each. This information told us where to provide Enrollees with extra assistance for training and employment needs.

WellCare contracts nationally with 573 employment and education, community action, and transportation programs to facilitate Enrollee access to workforce sustainability. We identify community-based organizations as community partners to assist with multi-level community improvement. Core pathways identified to drive change include access for adults to education and training to obtain and keep a living wage job; access to transportation; access to safe and affordable housing; and access to affordable and healthy foods. **Our national data shows that Enrollees we assisted in finding training and employment through our Community Connections' WellCare Works program had 19.7% fewer Emergency Department visits.**

Tobacco cessation experience through a collaboration with the Smoke Free Adair County Coalition: WellCare of Kentucky supports smoke-free initiatives across the Commonwealth by working with community partners to improve the well-being of our Enrollees and their communities. Partnering with key stakeholders in Adair County, we worked with the University of Kentucky's Center for Smoke-free Policy to assist the county with their goal of implementing a smoke-free town policy. Following the recommendations of the Center, Adair County formed a youth coalition focusing on promoting the new policy, which was supported by WellCare of Kentucky with a $5,000 financial sponsorship. As a result, the newly formed Smoke-Free Adair County Coalition purchased local advertising and marketing materials to raise awareness of the smoke-free ordinance. **In the spring of 2017, WellCare provided $20,000 in Hyper-Local Resources Grants to support projects that reduce smoking across Kentucky to 15 separate non-profit organizations.**

Results: Since launching the Community Connections Program nationally, we connected 125,710 people to 589,762 social services across the country, including more than 35,000 people to over 165,000 services across the Commonwealth. We have seen a direct impact in utilization of high-cost services for Enrollees referred to services through the program; for example we saw **a 26% reduction in Emergency Department visits, a 53% decrease in inpatient spending (Robert Wood Johnson study of our Community Connections Model, 2016).**

Outcomes

Initiative #3: Opioid Prevention and Treatment

Like other states, Kentucky is experiencing the opioid crisis first hand. In 2017, the CDC ranked Kentucky fifth in the nation for the highest rates of death due to drug overdose with 37.2 deaths per 100,000 residents. In Kentucky, the rate of babies born addicted to drugs and alcohol is climbing. In 2016, Kentucky's Department of Health recorded 1,257 cases of neonatal abstinence syndrome (NAS), representing more than 100 cases per month. More than half of those babies required pharmacological treatment. Many Kentucky children and teens enter foster care when their family is going through an opioid crisis. WellCare of Kentucky implemented a successful pilot to develop an enhanced pharmacy lock-in program that expanded traditional inputs.

To address this challenge affecting the communities we serve, WellCare of Kentucky continues to lead our efforts to develop an evidence-based, comprehensive opioid prevention and treatment program. This initiative supports Enrollees by promoting:

- Safer prescribing of opioids through provider profiling and reporting, overdose prevention with naloxone distribution and smaller dosing except for specific disease categories
- Management of chronic pain with opioid-sparing pharmacologic and non-pharmacologic modalities
- Early detection of opioid misuse and intervention, Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Increased access to substance use disorder and opioid use disorder (SUD/OUD) treatment options

Our suite of pharmacy-related clinical components for Enrollees experiencing SUD/OUD includes programs for polypharmacy, management of antipsychotic medications for children, medication adherence and reconciliation, medication therapy management, and our One Provider-One Pharmacy program.

One Provider-One Pharmacy Program: As part of WellCare's new, national ACT for Opioids Program, we identify Enrollees with relevant behavior patterns by analyzing high numbers of controlled substance claims; multiple prescribers of controlled substances; prescriptions filled at multiple pharmacies; excessive utilization; emergency department utilization; and the geographic distribution of controlled substance prescribers and pharmacies. In 2018, we expanded our identification for applicability of this program to include frequent Emergency Department use for certain diagnoses, which improved overall program effectiveness. Once we identify an at-risk Enrollee who meets lock-in criteria, we enroll them in the One Provider-One Pharmacy program, also known as the Lock-In Program, where Enrollees are locked-in to one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines.

Medication Reconciliation: Our WellCare of Kentucky pharmacists contact Enrollees post-discharge telephonically or through support of their local integrated care coordinator. Our pharmacists work with the Enrollee's Primary Care Provider as they perform medication reconciliation to ensure appropriate medication adherence and eliminate dangerous or unnecessary prescriptions.

Managing Antipsychotic Medications for Children: Our Pediatric Antipsychotic Utilization program identifies potential drug therapy issues, including excessive dose and multiple medication therapies for children ten and under in the Medicaid population. When this staff identify drug therapy issues, they suggest recommendations to the provider via outreach. The program goal is to identify antipsychotic use in Enrollees less than 10 years old and identify potential drug therapy problems. Communication is directed at the provider level to inform prescribers for Enrollees with potential therapeutic opportunities. **In 2019, we performed targeted medication reviews for 860 Medicaid Enrollees under 10 years old,** through this program.

Lower back pain management: Care Coordinator/Care Manager conduct outreach for selected Enrollees with low back pain who have been prescribed opiates. Nationally, low back pain is the most common reason behind opioid prescriptions, and our analysis shows that approximately 67% of our Enrollees with low defense for acute low back pain, which generally resolves in six to eight weeks with appropriate treatment, we developed a specialized low back pain care

management program. The program integrates access to non-pharmaceutical methods and, when opioids are necessary, works with providers on best practices and with Enrollees to monitor use, safe storage, and disposal of unused medications.

Predictive analytics: We conduct Care Coordination/Care Manager outreach upon proactive identification of Enrollees who are prescribed opioids and who are at risk of opioid misuse or abuse. We use a similar approach to provider profiling to identify potential risk of over-prescribing and provide education to the practice.

Point of sale pharmacy edits: This is a best practice to assist with controlling over utilization of opioid drugs at the point of sale. Combined with quantity limits and prior authorization criteria, point of sale pharmacy edits help us ensure safe opioid prescribing for Enrollees. We adhere to the CDC seven-day limit guideline, unless state-specific requirements are more stringent. We follow state and federal guidelines to ensure Enrollees have the best access to providers who prescribe buprenorphine. Our Medicaid formulary is structured to reduce the use of long-acting opioids that have potential for misuse, including OxyContin.

Medication-assisted treatment (MAT): We take steps to improve access to MAT for Enrollees diagnosed with OUD and who need timely access to treatment. Our Pharmacy Benefit relations team communicates with Enrollees about the availability of MAT and Naloxone (also known as Narcan), a medication designed to rapidly reverse an opioid overdose.

Results: Three examples of WellCare's national experience with opioid use and the interventions, impact, and outcomes we achieved when addressing opioid misuse at our health plans across the country includes: Kentucky Enhanced Pharmacy Lock-in Program, Illinois Initiation and Engagement in Treatment (IET) for Alcohol and Other Drug Dependence (IET) Incentive Program and Arizona Embedded Behavioral Health Provider:

- *Kentucky Enhanced Pharmacy Lock-in Program*: As mentioned above, WellCare of Kentucky implemented a pilot to develop an enhanced pharmacy lock-in program that expanded traditional inputs. By widening the scope of Enrollee activity, **the pilot program drove a 55% drop in opioid prescribing and an average medical savings of $150 PMPM. In addition, the program showed a 35% reduction in cyclobenzaprine prescriptions and a 30% reduction in benzodiazepine prescriptions**. By tracking their progress, we received a larger set of clinical outcomes data showing that opioid claims dropped 16% while MAT prescribing increased 6%. In addition, we donated $35,000 to support addiction recovery programs, including to Addiction Recovery Care (ARC), and donated 1,000 nasal atomizers to pharmacies.
- *Illinois Initiation and Engagement in Treatment (IET) for Alcohol and Other Drug Dependence (IET) Incentive Program:* At our Illinois health plan, WellCare offers providers and Enrollees a financial incentive to participate in the IET program. The program promotes timely completion of behavioral health services by offering a bonus for Enrollees successfully referred to and engaged in SUD treatment following a new episode of substance dependence. Providers receive a $50 referral fee for referring and linking Enrollees to an initial appointment following a new diagnosis and receive additional incentives based on follow-up care attendance. **As a result, we saw an 11.3% increase in initiation and a 34% increase in engagement over the course of 2017.**

- *Arizona Embedded Behavioral Health Provider:* In Arizona, WellCare partners with an integrated pain management clinic and a BH provider to help those suffering from chronic pain who are at a higher risk for opioid use. An embedded behavioral health practitioner in the pain management office provides Enrollee care. We provide enhanced support through integrated data sharing, care management services, and helping Enrollees meet their unmet social needs, such as homelessness, unemployment, and transportation. Previous studies of similar programs have shown significant improvement in care compliance, a decrease in prescription opiate use, better management of behavioral health, a decrease in Emergency Department utilization and admissions, and an increase in Enrollee and provider satisfaction. Currently underway, the program is tracking Emergency Department use, inpatient hospital days, and total cost of care for Enrollees.

We will monitor the Illinois and Arizona programs to identify sustainable results; and, if successful, we will present these programs to DMS for implementation in Kentucky.

WellCare will continue to strengthen the components of our overall opioid prevention and treatment program as we analyze the effectiveness of the program and take action on our findings and keep current with industry best practices. Our comprehensive opioid programs and supporting initiatives are currently **helping over 2,800 People of Kentucky with results from 2018 that include a 27% drop in opioid utilization, a 47% increase in Medication-Assisted Therapy (MAT), a 25% increase in maintenance medications, and a 33% decrease in Emergency Department utilization.**

iii. A summary of lessons learned from the Vendor's experience providing similar services to similar populations.

LESSONS LEARNED FROM OUR EXPERIENCE PROVIDING SIMILAR SERVICES TO SIMILAR POPULATIONS

WellCare has nationwide Medicaid experience inclusive of Kentucky Medicaid experience providing similar services to similar populations. WellCare has a proven record of successful operations for Medicaid population and subpopulations served, both in Kentucky and nationally. While every state is unique, we have learned through experience that some lessons learned can be applied universally to develop an effective strategy for managing the foster care population. As noted earlier, WellCare of Kentucky has been a market leader and innovator in developing innovative solutions and sharing them as best practices across WellCare's other Medicaid programs. We tailor our operations and programs to fit the priorities and delivery systems within each state and effectively address specific challenges. The continued application of lessons learned reinforces our commitment to help our Kentucky Medicaid Enrollees live better, healthier lives.

Table B.1-2 presents lessons learned from our experience providing similar services to populations similar to those who will be enrolled in Kentucky SKY.

Table B.1-2 Lessons Learned

Lessons Learned
Transparency in data sharing with providers allows for continuous feedback from all key stakeholders and fosters integrated, whole-person care.
Our experience in Kentucky and nationwide tells us mental health conditions and substance use disorders are prevalent in our Kentucky and nationwide Medicaid populations. Enrollees often experience co-occurring and co-morbid conditions. They have significant social service needs, which can be obstacles to health, well-being, and positive outcomes if unaddressed. Since 2011 in Kentucky, we have always used a fully integrated approach that in-sourced behavioral health management and created a single system of care that includes physical, behavioral, pharmacy, and social needs in Kentucky. Further, and unlike most other Medicaid plans, we do not outsource the management of pharmacy prior authorizations of the preferred drug list. This approach continues to deliver significant benefits across the care continuum as evidenced by our industry-leading quality outcomes, our strong clinical results, our success in providing for social needs, and the cost savings that result. Our fully integrated model of care leverages one integrated care team covering all care needs. This team is supported by one single technology system, CareCentral, which is purpose-built to specifically serve Medicaid programs. The benefit is put all relevant clinical and quality information in the hands of our diverse, integrated Enrollee, clinical and provider support teams who can use this information to support our Enrollees and providers at the every interaction using best available information. This tool also gives DMS' staff a clear and transparent view into the clinical approach we deliver and for which WellCare is accountable. For providers, the approach and tools we use deliver a comprehensive set of Enrollee data through a single on-line provider portal platform that providers can use to access and maintain a complete health record for the Enrollees they serve. This allows providers to better meet and coordinate their needs, concentrating on care rather than administration. **Nationally, this has resulted in WellCare being the number one or two plan in over 80% of WellCare's Medicaid state programs for NCQA Quality Ratings.** WellCare provides and oversees localized case management and care coordination through our WellCare at Home model, which includes local, in-person case management/care coordination resources. Our case management/care coordination leadership team focuses on accountability, collaboration, excellence, innovation, and a long-term commitment to delivering on the goals of the communities we serve. We closely monitor metrics to determine success of our case management/ care coordination approach, including metrics like direct Enrollee feedback, HEDIS, CAHPS, cost, and utilization. WellCare repeats a data-driven clinical review process monthly as part of continuous quality improvement efforts. Results inform program enhancements and long-term strategic planning to achieve the next level of performance. **For example, nationally, we recently added 200 additional local case management/care coordinators to our Medicaid programs and as a result experienced a 20% decrease in inpatient admissions per thousand Enrollees, a 13% decrease in**

Lessons Learned
readmission per 1,000 Enrollees, and a 13% decrease in Emergency Department utilization.
We need to understand and address regional needs and priorities for Medicaid populations in urban and rural areas.
We have learned that outreach must begin early, be extensive, and involve all stakeholders. Through our efforts in every WellCare market to become knowledgeable of the people and regions we serve, we have developed a thorough and comprehensive view of regional nuances, needs, and priorities that have informed virtually all aspects of Medicaid solutions. Our Medicaid Enrollees in urban and rural areas have different concerns - with access to care a potential issue in rural and remote areas of a state. We appreciate the value of local knowledge and hire local staff from within the state and local communities, collocate staff in state agency offices, collaborate with stakeholders, hold focus groups with Enrollees prior to contract go-live, and hold provider summits to discuss important topics like regional needs and priorities as well as continuity of care. We build cultural and regional understanding into our training program for all of our Enrollee-facing staff and for providers. For example, the majority of our Kentucky Medicaid Enrollees (27%) live in Region 8, with 18% of Enrollees in Region 5, and 10% of Enrollees in Region 7, demonstrating the presences of WellCare of Kentucky in Kentucky's eastern rural counties. We deploy resources through our six regional hubs and beyond, including field-based Care Managers, quality practice advisers, provider relations representatives, patient care advocates, and Community Connections staff to provide face-to-face support to our Enrollees and providers as needed. We learned that geography and urban versus rural populations affect hospital readmission rates. Due to our long-standing experience in Kentucky since 2011, we recognize that health disparities among Enrollees rural areas contribute to a higher readmission rate compared to Enrollees in other Regions. We observe higher admission rates for Enrollees living in the eastern part of Kentucky, particularly in Regions 7 and 8. In eastern Kentucky, we serve the largest number of Medicaid Enrollees with complex conditions, compared to other Kentucky health plans. And we built our population health and other programs with these Enrollees in mind. Worth noting, we have always had the highest number to Medicaid Enrollees in Region 7 and Region 8. We are in eastern Kentucky to help DMS improve outcomes, and this is why we deploy a special unable-to-contact program with locally based community health workers, provide support for community programs, and implement value-based programs for providers like Appalachian Regional Healthcare. Our focus on addressing issues in rural Kentucky includes the importance of behavioral health in integrated care; an emphasis on continuing relationships and contacts with CMHCs and FQHCs; and maintaining contracts with all Critical Access Hospitals and FQHCs, which are an important part of the Medicaid delivery system. We are particularly proud of our collaboration with DMS to expand the Medicaid program to include CMHCs and behavioral health benefits. WellCare has successfully implemented telehealth solutions in other states. We are working with network providers to leverage the Kentucky's new law to improve access to care in rural areas and to support access to hard-to-find specialists, such as psychiatry and dermatology.

Lessons Learned
Delivering fully integrated care and improved health outcomes means addressing social determinants of health.
Our Community Connections team partners with community-based organizations, outreaches to Enrollees to educate the community about availability of social services, and educates Enrollees and families how to call our CCHL line to access social resources. Our Community Connections program links Enrollees to social services, such as food banks or meal delivery, housing assistance, financial assistance, transportation, education support, legal assistance, and employment services. We designed the Community Connections program to partner with community resources and help individuals navigate the local social support network to receive the care and services they need. A program priority is to identify local, community-based solutions to fill gaps in the network of social services. Care Coordinators and other WellCare of Kentucky staff refer Enrollees and families, as needed or requested, to the CCHL team for assistance connecting to social services. We train Care Managers and Care Coordinators and give them the capability to access and search the Community Connections database of community-based organizations, which includes organizations like SNAP, WIC, and Head Start. They refer Enrollees and families/guardians to community-based resources and follow up to measure the impact of these services on our Enrollees' health outcomes as part of our closed-loop referral process. When we connect Enrollees to the social services they need, they are five times more likely to schedule and go to their annual PCP visit, resulting in vital preventive care and screenings. **As validated by Robert Wood Johnson Foundation's Center for Public Health Systems and Services Research at University of Kentucky in 2015, there is $450 savings in health care costs per social service accessed.** This aligns with the Commonwealth's goal to help improve health outcomes for our Kentucky Enrollees and lower the overall cost of health care
We have learned the value of provider education and support.
We have learned that the more we support providers, the better they can help our Enrollees, which in turn improves health outcomes. This is why we invest heavily in provider-facing staff and prioritize inclusion of providers on MDTs. We support providers with a team of 15 PR representatives supported by Operations Account Reps (OARs), 16 Quality Practice Advisors (QPAs), four hospitals services specialists, and three provider relations managers, serving our provider network out of six regional offices. When a provider joins our network, a PR Representative contacts the provider and conducts an orientation, explains their role as a primary point of contact and advocate for the provider, and discusses with them how they can best support the provider on an ongoing basis. The PR Representative educates providers about the covered and value-added services we offer. Our PR Representatives are fully accountable to their provider relationships, are the key owner of the relationship and the provider's advocate to ensure they receive the support they need when they need it. **In 2019, WellCare of Kentucky PR Representatives made over 6,600 visits to provider offices to educate providers and their staff. In an independent provider satisfaction survey in 2019, Kentucky Medicaid providers rated our PR representatives highest in the state in their ability to answer provider questions and resolve problems.**

Lessons Learned

PR Representatives work in partnership with our QPAs to help engage practices to improve quality measures and provide more cost-efficient care. QPAs are trained nurses who review HEDIS measures, clinical practice guides, and provide toolkits that support ongoing quality improvement activities. Like our PR Representatives, QPAs live and work in the regions they serve. They are assigned to specific practices and are aligned with the provider relations team. They frequently make joint meetings with providers to assure they receive the best possible services in person (in their offices), in the most efficient manner. They help with scheduling transportation to bring Enrollees to the practice, and help with Enrollee reminders to avoid no-shows. They educate providers about special program services, the value-added services we offer, the importance of the EPSDT program and closing care needs, and provide targeted training on relevant topics like trauma-informed care. They also connect providers to Care Managers and patient care advocates (PCAs) as needed.

In 2019 alone, WellCare of Kentucky's QPAs made over 6,000 visits to provider offices to advance the Commonwealth's quality measures.

We train QPAs on DMS' priority measures and collaborate with providers to ensure they understand their quality progress reports. On a monthly basis, the Provider Relations, Network Management, Care Management, and QPA teams hold a "P360" huddle meeting reviewing our top providers' performance in quality and cost measures by region. These meetings focus on a 360 degree view of the practices, including all aspects of quality and cost, and include interdisciplinary teams such as pharmacy and clinical teams. Through P360 huddle meetings, the team reviews the practice panel clinical performance, including a heat map of care gaps. They then use that information to focus on certain practices or develop condition/service specific campaigns. The team collaborates to develop a targeted plan for each provider to enhance practice quality and outcomes.

Patient care advocates provide local support of our quality improvement program. PCAs are WellCare of Kentucky employees who are physically located in select network provider offices and focus on connecting Enrollees to care, including accessing detailed Enrollee and provider reports and scheduling appointments for targeted Enrollees with identified gaps in care like immunizations, ADHD follow-up, asthma medication adherence, and EPSDT well child visits. Through our HEDIS and care gap discussions with providers, we found many were engaged and eager to address gaps in care but lacked resources needed to conduct Enrollee outreach and follow up. PCAs address this need. Our PCA program is a service enhancement for providers and a best practice.

We learned that when Care Managers include providers on multidisciplinary teams, we improve communication among those involved in an Enrollee's care and our Enrollees experience better health outcomes. Enrollees trust their providers, so they are often the first to know our Enrollees have social resource needs. We educate providers about our Community Connections program, how community-based resources remove barriers to health and have a positive effect on an Enrollee's health, and the process for referring Enrollees to these resources.

By meeting providers where they are with value-based contracting, we support them by maximizing their income as they bring higher quality care to the People of Kentucky.

We learned that training is not a once and done process. For example, during preparation for the anticipated Kentucky HEALTH Waiver transition (with was subsequently cancelled), we learned we

Lessons Learned

needed to strengthen provider training to include longer-term refresher training via webinar in addition to short-term, focused training sessions.

We learned that collaboration is more than just bringing stakeholders together.

Communication and collaboration is key. We learned the value and benefits of shared decision-making, giving all stakeholders (including Enrollees, parents/guardians, and providers) a strong voice and a real opportunity to contribute during care and service planning. We collocate WellCare of Kentucky staff in state agency offices throughout the Commonwealth. Further, WellCare of Kentucky's Provider Engagement Model is a direct reflection of the lessons we have learned around provider support. Provider engagement combines “high touch” with “high tech” through the most extensive physical presence of any Kentucky Medicaid health plan along with 24/7 provider support available through multiple channels. Having six regional WellCare of Kentucky throughout the Commonwealth increases collaboration, timely response to issues or concerns, and increased knowledge and insight into the Kentucky Medicaid population and subpopulations we serve.

We learned that Enrollee empowerment, engagement, and satisfaction improve when we offer multimodality outreach methods and reach out to Enrollees in the way(s) they prefer.

We must use multiple outreach methods to reach Enrollees for early health risk assessments and needs assessments. We have a full complement of staff throughout each state and in every region to maximize our local engagement. We customize our methods of outreach (in-person, telephonic, social media, chat, text messaging, Enrollee portal) to connect with Enrollees in the way most effective for them. In an Enrollee's record, we can log Enrollee preferences, including how they like us to contact them. We encourage participation by promoting multiple modes for gathering information from our Enrollees. For example, in most markets Enrollees can complete the initial HRA screening in a variety of ways. Our flexibility is key to increasing Enrollee empowerment, engagement rates, satisfaction, and to our ability to support Enrollees in closing care gaps. **Compared to other Kentucky Medicaid MCOs, we have the highest Enrollee satisfaction as measured by the CAHPS survey in 2019.**

We learned that Enrollee health outcomes improve when we offer provider incentive programs and value-based contracting.

We learned that incenting providers to participate in our quality programs is an effective way to coordinate with them in improving Enrollee health outcomes. We offer the following incentives for providers:

Partnership for Quality (P4Q) program: Providers receive bonus payments for closing care needs on key HEDIS performance measures and timely completion of appointment agendas, which allow our Physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment. In 2018, providers closed 118,316 care needs as part of WellCare of Kentucky's P4Q

100% of Kentucky Medicaid Enrollees are assigned to PCPs participating in our P4Q program, and more than 50% of all VBP payments are LAN Level 3

Lessons Learned

program. WellCare of Kentucky introduced a Behavioral Health P4Q program in 2019 to better align with DMS' goal of improving behavioral health-related health outcomes among the Medicaid Enrollees. In only five months, 738 care needs closed at the participating CMHCs and more than $30,000 in bonus payments were paid out to providers in June 2020 as a result of the new behavioral health P4Q program.

Value-Based Purchasing (VBP) program: We offer value-based payment arrangements across the spectrum of Health Care Payment (HCP) Learning & Action Network (LAN) categories including shared savings/shared risk and full risk for providers who have the infrastructure and capabilities to become effective at improving overall health outcomes and managing cost. Our P4Q program supports providers in preparing for advanced VBP programs by serving as a LAN Level 2 structure.

Peak Performance program: We developed this program in 2017 to reward high volume paneled Kentucky Medicare providers for high performance in HEDIS measures with a focus on certain measures in need off more dramatic year end improvement. Our data exchange and drill-down capabilities include a quality team to assist in EMR interchange. The quality team provides reports that are configurable and have drill-down capability by Enrollee, zip code, Primary Care Provider, group, diagnosis, family, and procedure code. Providers have access to real-time Enrollee care gaps, updated every week. Providers have ability to enter non-standard data linked to a chart. Using the provider portal, providers can also view appointment agendas, which allow Physicians to understand, in a single report, everything that they need to address for each Enrollee during an appointment including all known diagnoses and associated care needs derived from evidence-based guidelines. As a result of the Peak Performance program, **79% of participating Kentucky providers, representing nearly 7,000 Enrollees, improved their quality scores from 2017 to 2018**. Due to program success, we are developing a process to implement this program in our Medicaid programs to enhance our suite of Medicaid provider supports to achieve high quality health outcomes.

We learned we had to address the growing Opioid problem in Kentucky and in other Medicaid markets.

As part of WellCare's new, national ACT for Opioids Program, we identify Enrollees with relevant behavior patterns by analyzing high numbers of controlled substance claims; multiple prescribers of controlled substances; prescriptions filled at multiple pharmacies; excessive utilization; emergency department utilization; and the geographic distribution of controlled substance prescribers and pharmacies. Once we identify an at-risk Enrollee, we enroll them in the One Provider-One Pharmacy program, where they are "locked-in" to one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines.

We learned the value of expanding the reach of our Lock-In Program to address overutilization of high-cost Emergency Department services and to improve health outcomes. WellCare of Kentucky's Lock-In Program supports adult Enrollees (18 years old and older) who need help managing their health care needs. It limits overuse of medical and pharmacy benefits by making sure an Enrollee receives these benefits at an appropriate frequency and by ensuring care and services are medically necessary. Locking-in Enrollees to a specific provider and one pharmacy helps us closely monitor the services an Enrollee receives. Data pulled in April for 2019 Q1 shows 1,112 WellCare of Kentucky

Lessons Learned
Enrollees were active participants in the Lock-In Program. **The program drove a 55% drop in opioid prescribing and an average medical savings of $150 PMPM.**

iv. How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.

APPLYING OUR EIGHT YEARS OF EXPERIENCE AND LESSONS LEARNED IN KENTUCKY

We have numerous examples of strategies we implemented on the Kentucky Medicaid program through an initiative or pilot program that delivered sustainable positive health outcomes. Many of them have been implemented as best practices across WellCare's other state Medicaid health plans, such as:

- Integrated, field-based case management and care coordination program, WellCare at Home
- Community Connections social resource program
- Pharmacy Lock-In Program
- Reach unable-to-contact program using community health workers
- Healthy Rewards Enrollee incentive program reloadable debit cards or gift cards for stores to purchase needed personal, home, baby, and family-related items that promote good health behaviors for practicing healthy behaviors

We continually apply lessons learned and expand or build on programs that are already delivering successful results in Kentucky or our other Medicaid programs, including:

- Enhance Kentucky Medicaid telehealth capabilities
- Evolve, enhance, or expand population health management programs to address newly identified trends in diseases or chronic conditions, embrace the digital era to make boost progress in health outcomes, involve all stakeholders involved in an Enrollee's care, and promote health and wellness strategies for Enrollees during all stages of life, not simply when they become sick
- Continue to empower and engage Enrollees by meeting them where they are physically, culturally and through technology and other modalities that support their engagement
- Continue to enhance our advanced data analytics and decision support capabilities and capability to share data pertinent to all factors that influence a person's health with stakeholders
- Continue building on our WellCare at Home program by expanding case management and care coordination services like our opioid program and our NICU graduates program
- Continue enhancing our partnership with providers to help them be successful by streamlining the administrative burden of working with MCOs and empowering providers with data and other supports to deliver the highest quality care to Enrollees
- Expand use of provider incentive programs to drive quality and improved health outcomes

- Leverage our established Reach unable-to-contact program to educate Enrollees on the value and importance of colorectal cancer screenings to prevent colon cancer

We continually learn from our experiences and those of our affiliate health plans across the country. We will continue to apply this knowledge and experience to the Kentucky Medicaid managed care program, to provide our Enrollees with the most innovative, best in class solutions that improve outcomes, quality, and satisfaction. WellCare of Kentucky actively supports DMS' goal to develop collaborative efforts and initiatives with the contracted MCOs and state agency partners to implement targeted approaches to improve the health of Enrollees in a cost efficient and effective manner. Working together, we can have a stronger impact on behavioral health issues like mental health and substance abuse and social resource needs, which are prevalent and serve as barriers to improved health outcomes in the Kentucky Medicaid population.

2. Corporate Information

B.2. CORPORATE INFORMATION

a. **Provide required 42 CFR 455.100-107 disclosures:**

i. (1)The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(2) Date of birth and Social Security Number (in the case of an individual).

(3) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

ii. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

iii. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

iv. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity)."

b. **Indicate the Vendor's form of business (e.g., corporation, nonprofit corporation, partnership, etc.) and provide the Indicate following information:**

i. Names and contact information for all officers, directors, and partners.

ii. Relationship to parent, affiliated and/or related business entities and copies of management agreements with parent organizations.

iii. Provide copies of the Vendor's articles of incorporation, bylaws, partnership agreements, or similar business entity documents, including any legal entity having an ownership interest of five percent (5%) or more.

iv. Provide the Vendor's Uniform Certificate of Authority or application for the Uniform Certificate of Authority, as well as copies of reports filed with the Kentucky Department of Insurance during the prior twelve (12) months, if applicable.

c. **Demonstrate financial viability for the Vendor and each Subcontractor, as evidenced by sustained bottom line profitability and no current areas of significant financial risk for the past three (3) calendar years or the Vendor or Subcontractor's fiscal years. For the Vendor and each Subcontractor, provide copies of financial statements from the most recently completed and audited year.**

d. Provide a statement of whether there is any pending or recent (within the last ten (10) years) litigation against the Vendor or sanctions, including but not limited to the following:

i. Litigation involving the Vendor's failure to provide timely, adequate, or quality Covered Services. If any litigation listed, include damages sought or awarded or the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether the pending or recent litigation will impair your organization's performance in a Kentucky Medicaid Managed Care Contract.

ii. Sanctions for deficiencies in performance of contractual requirements related to an agreement with any federal or state regulatory entity. Include monetary sanctions the Vendor has incurred pursuant to contract enforcement from any state, federal, or private entity, including the date, amount of sanction, and a brief description of such enforcement, corrective action, and resolution.

iii. Any Securities Exchange Commission (SEC) filings discussing any pending or recent litigation. Include information for Parent Company, affiliates, and subsidiaries. The Vendor may exclude workers' compensation cases.

Include information for the Parent Company, affiliates, and subsidiaries. The Vendor may exclude workers' compensation cases.

e. For the Vendor, Parent Company, subsidiaries and all Subcontractors list and describe any Protected Health Information (PHI) breaches (within the past five years) that have occurred and the response. Do not include items excluded per 45 CFR 164.402.

f. Has the Vendor ever had its accreditation status (e.g., National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Accreditation Association for Ambulatory Health Care (AAAHC)) in any state for any product line adjusted down, suspended, or revoked (within the past five years)? If so, identify the state and product line and provide an explanation. Include information for the Vendor's Parent Company and subsidiaries.

g. Provide a listing of Medicaid managed care contracts held in the past ten (10) years for which the Vendor, Vendor's Parent Company, and subsidiaries has:

i. Voluntarily terminated all or part of the contract under which it provided health care services as the licensed entity.

ii. Had such a contract partially or fully terminated before the contract end date (with or without cause).

iii. Had a contract not renewed.

iv. Withdrawn from a contracted service are.

v. Had a reduction of enrollment levels imposed?

B.2. CORPORATE INFORMATION

a. Provide required 42 CFR 455.100-107 disclosures:

i. (1) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

WellCare of Kentucky is an indirect wholly owned subsidiary of Centene Corporation, Inc. (Centene). The ownership follows, along with their primary business addresses,

All other WellCare business addresses and P.O. Box addresses are included in **Table B.2.a.i.1-2 WCG Health Management Business Locations** and **Table B.2.a.i.1-3 WCG Health Management Business P.O. Boxes.** Centene's business addresses and P.O. boxes are include as **Attachment B.2.a.i.1 Centene Business locations and P.O. Boxes.**

The stock of CNC is publicly traded on the New York Stock Exchange under the symbol "CNC." Information regarding beneficial owners of 5% or more of Centene's publicly traded stock is available on Schedules 13G filed by such beneficial owners with the SEC with respect to Centene's stock, and currently ownership of 5% or more of stock is detailed in **Table B.2.a.i.1-1 Centene Stock Ownership > 5%.**

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. Provided below are the names of companies who owned 5% or more of the voting shares of CNC as of the dates noted herein:

Table B.2.a.i.1-1 Centene Stock Ownership > 5%

Business or Last Name	FEIN	Ownership Percentage
The Vanguard Group, Inc., et al. PO Box 2600; V26 Valley Forge, PA 19482-2600	52-0556948	7.65% (as of February 1, 2020)
BlackRock, Inc., et al. 55 East 52nd Street New York, NY 10055	32-0174431	5.51% (as February 1, 2020)
T Rowe Price Associates Inc. 100 East Pratt St Baltimore, MD 21202	52-0556948	5.19 % (as February 1, 2020)
Capital Group Companies, Inc. 333 South Hope Street, 55th Floor Los Angeles, CA 90071	95-1411037	7.9% (as of February 1, 2020)

Table B.2.a.i.1-2 WCG Health Management Business Locations includes a complete list of the business locations of WCG Health Management, Inc. and its affiliates. Please note we have omitted a couple of locations currently under lease which are vacant and for which sublessors are being sought.

A complete list of the business locations of Centene and its other affiliates is included as **Attachment B.2.a.i.1 Centene Business locations and PO Boxes**.

Table B.2.a.i.1-2 WCG Health Management Business Locations

Entity Name	Address
Accountable Care Coalition of Arizona, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Central Georgia, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Chesapeake, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Coastal Georgia, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Community Health Centers II, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Community Health Centers,	4888 Loop Central Drive, Suite 300,

Entity Name	Address
LLC	Houston, Texas 77081
Accountable Care Coalition of DeKalb, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Florida Partners, LLC	8735 Henderson Road, Tampa, Florida 33634
Accountable Care Coalition of Georgia, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Hawaii LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Maryland Primary Care, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Maryland, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Mississippi, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Mount Kisco, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of New Jersey LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of North Texas, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Northeast Georgia, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Northwest Florida, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Pennsylvania LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of South Carolina, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Southeast Partners, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Southeast Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Southeast Wisconsin, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Syracuse, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Tennessee, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of the North West Region, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Accountable Care Coalition of the Northwest Region II, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas
Accountable Care Coalition of the Tri-Counties, LLC	4888 Loop Central Drive, Suite 300,

Entity Name	Address
	Houston, Texas 77081
Accountable Care Coalition of Western Georgia, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
American Progressive Life and Health Insurance Company of New York	One New York Plaza, 15th Floor New York, NY 10004
American Progressive Life and Health Insurance Company of New York	The Lofts, 18 Division St, Suite 310 Saratoga Springs, NY 12866
America's 1st Choice California Holdings, LLC	8735 Henderson Road, Tampa, Florida 33634
APS Healthcare Holdings, Inc.	8735 Henderson Road, Tampa, Florida 33634
APS Healthcare, Inc.	8735 Henderson Road, Tampa, Florida 33634
APS Parent, Inc.	8735 Henderson Road, Tampa, Florida 33634
AWC of Syracuse, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Care 1st Health Plan Arizona, Inc.	Two Gateway, 432 N 44th St, Floors 1, 2 & 3, Phoenix, AZ 85008
Care 1st Health Plan Arizona, Inc.	One Gateway, 426 N. 44th St., Suite 120, Phoenix, AZ 85008
Care1st Health Plan Administrative Services, Inc.	Two Gateway, 432 N 44th St, Floors 1, 2 & 3, Phoenix, AZ 85008
Care1st Health Plan Administrative Services, Inc.	One Gateway, 501 N. 44th St., Suite 120, Phoenix, AZ 85008
Chrysalis Medical Services, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Collaborative Health Systems of Maryland, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas
Collaborative Health Systems of Virginia, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Collaborative Health Systems, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Comprehensive Health Management, Inc.	8735 Henderson Road, Tampa, Florida 33634
Comprehensive Health Management, Inc.	Ren 1 - 1st, 2nd, 3rd Floor, 8725 Henderson Road, Tampa, FL 33634
Comprehensive Health Management, Inc.	Ren II, 1st - 3rd Floors, 8735 Henderson Road, Tampa, FL 33634
Comprehensive Health Management, Inc.	Ren V, MMR, 8745 Henderson Road, Tampa, FL 33634
Comprehensive Health Management, Inc.	Ren V, MMC facility, 8745 Henderson Road, Tampa, FL 33634
Comprehensive Health Management, Inc.	Ren V, Suite 220 & 300, 8745 Henderson Road, Tampa, FL 33634
Comprehensive Health Management, Inc.	Ren IV, 1st - 3rd Floors, 8715 Henderson

Entity Name	Address
	Road, Tampa, FL 33634
Comprehensive Health Management, Inc.	Tampa International Business Center - TIBC I, 5301 W Idlewild Ave., Tampa, FL 33634
Comprehensive Health Management, Inc.	Tampa International Business Center - TIBC II, 5519 W Idlewild Ave., Tampa, FL 33634
Comprehensive Health Management, Inc.	Tampa International Business Center - TIBC III, 5520 Idlewild Ave., Tampa, FL 33634
Comprehensive Health Management, Inc.	Tampa International Business Center - TIBC IV, 5730 N Hoover Blvd., Tampa, FL 33634
Comprehensive Health Management, Inc.	Tampa International Business Center - TIBC V, 5570 W Idlewild Ave, Suite 150, Tampa, FL 33634
Comprehensive Health Management, Inc.	WITT, 3901, 3926 & 3960 Premier North Dr., Tampa, FL 33618
Comprehensive Health Management, Inc.	WITT Expansion, 3926 Premier N. Drive, Tampa, FL 33618
Comprehensive Health Management, Inc.	Woodland Corporate Center, (One Call Medical Sublease) 4631 Woodland Corporate Blvd., Tampa, FL 33614
Comprehensive Health Management, Inc.	601 Massachusetts Ave NW, Suite 410, Washington, DC 20001
Comprehensive Health Management, Inc.	400 Executive Drive Suite 110 Brookfield, WI 53005
Comprehensive Reinsurance, Ltd.	Building 4, 2nd Floor, 23 Lime Tree Bay Avenue, P.O. Box 1051, Grand Cayman KY1-1102, Cayman Islands, Cayman Islands
Comprehensive Reinsurance, Ltd.	8735 Henderson Road, Tampa, Florida 33634
WellCare of California, Inc.	10803 Hope Street, Suite 100, Cypress, California 90630
Essential Care Partners, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Exactus Pharmacy Solutions, Inc.	8735 Henderson Road, Tampa, Florida 33634
Exactus Pharmacy Solutions, Inc.	4110 George Road, Suite 300, Tampa, Florida 33634
Golden Triangle Physician Alliance	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Harmony Behavioral Health IPA, Inc.	8735 Henderson Road, Tampa, Florida 33634
Harmony Behavioral Health, Inc.	8735 Henderson Road, Tampa, Florida 33634
Harmony Health Management, Inc.	8735 Henderson Road, Tampa, Florida 33634

Entity Name	Address
Harmony Health Plan, Inc.	128 Millport Circle, Suite 200, Greenville, SC 29607
Harmony Health Plan, Inc.	200 Center Point Circle, Suite 180, Columbia, SC 29210
Harmony Health Plan, Inc.	300 S. Riverside, Suite 500, Chicago, IL 60606
Harmony Health Plan, Inc.	4780 I-55 North, Suite 450, Jackson, MS 39211
Harmony Health Plan, Inc.	1001 N. University, Suite 150, Little Rock, AR 72207
Harmony Health Plan, Inc.	7100 Commerce Way, Suites: 202, 285, & 295, Brentwood, TN 37027
Harmony Health Plan, Inc.	5209 Linbar Dr., Suite 615, Nashville, TN 37211
Harmony Health Plan, Inc.	Eastgate Office Building, 5118 Park Ave, Suite 450, Memphis, TN 38117
Harmony Health Systems, Inc.	8735 Henderson Road, Tampa, Florida 33634
Heritage Health Systems of Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Heritage Health Systems, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Heritage Physician Networks	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
HHS Texas Management, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
HHS Texas Management, L.P.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
HHS Texas Management, L.P.	Atrium Building, 2300 Highway 365, Suite 320 + 390, Nederland, TX 77627
HHS Texas Management, L.P.	The Points at Waterview, 3400 Waterview Pkwy, Suite 109 Richardson, TX 75080
Hudson Accountable Care, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Maine Community Accountable Care Organization, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Maine Primary Care Holdings, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Maryland Collaborative Care Transformation Organization, Inc.	8735 Henderson Road, Tampa, Florida 33634
Maryland Collaborative Care, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Meridian Health Plan of Michigan, Inc.	1 Campus Martius, Detroit, MI 48226
Meridian Management Company, LLC	1 Campus Martius, Detroit, MI 48226
WellCare of Michigan Holding Company	1 Campus Martius, Detroit, MI 48226

Entity Name	Address
MeridianRx, LLC	1 Campus Martius, Detroit, MI 48226
MeridianRx IPA, LLC	1 Campus Martius, Detroit, MI 48226
MeridianRx of Indiana, LLC	3815 River Crossing Parkway, Suite 100, Indianapolis, Indiana 46240
Meridian Network Services, LLC	1 Campus Martius, Detroit, MI 48226
Meridian Health Plan of Michigan, Inc.	Kennedy Square, 777 Woodward Avenue, Detroit, MI 48226
Meridian Health Plan of Illinois, Inc.	300 S. Riverside, Suite 500, Chicago, IL 60606
Meridian Health Plan of Michigan, Inc.	2350-2500 Meijer Drive, Troy, MI 48084
Mid-Atlantic Collaborative Care, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Northern Maryland Collaborative Care, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Ohana Health Plan, Inc.	8735 Henderson Road, Tampa, Florida 33634
Ohana Health Plan, Inc.	949 Kamokila Boulevard, 3rd Floor, Suite 350, Kapolei, Hawaii 96707
One Care by Care1st Health Plan of Arizona, Inc.	Two Gateway, 432 N. 44th St., Floors 1, 2 & 3, Phoenix, AZ 85008
One Care by Care1st Health Plan of Arizona, Inc.	One Gateway, 501 N. 44th St., Suite 120 Phoenix, AZ 85008
Penn Marketing America, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Premier Marketing Group, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Quincy Coverage Corporation	44 South Broadway, Suite 1200, White Plains, New York 10601
SelectCare Health Plans, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
SelectCare of Texas, Inc.	The Points at Waterview 3400 Waterview Pkwy Suite 109 Richardson, TX 75080
SelectCare of Texas, Inc.	Atrium Building 2300 Highway 365 Suite 320 + 390 Nederland, TX 77627
SelectCare of Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
SelectCare of Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
The WellCare Community Foundation	8735 Henderson Road, Tampa, Florida 33634
The WellCare Management Group, Inc.	8735 Henderson Road, Tampa, Florida

Entity Name	Address
	33634
UAM Agent Services Corp.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
UAM/APS Holding Corp.	8735 Henderson Road, Tampa, Florida 33634
Universal American Corp.	400 Executive Drive, Suite 110, Brookfield, WI 53005
Universal American Corp.	8735 Henderson Road, Tampa, Florida 33634
Universal American Financial Services, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
Universal American Holdings, LLC	8735 Henderson Road, Tampa, Florida 33634
Virginia Collaborative Care, LLC	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
WCG Health Management, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Associate Assistance Fund, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance Company of America	1001 N. University, Suite 150 Little Rock, AR 72207
WellCare Health Insurance Company of Kentucky, Inc.	2480 Fortune Drive Suite, 200, Lexington, KY 40509
WellCare Health Insurance Company of Kentucky, Inc.	13551 Triton Park Blvd, Suite 1800, Louisville, Kentucky 40223
WellCare Health Insurance Company of Kentucky, Inc.	Stadium Park Plaza, 360 E 8th Ave, #311, Bowling Green, KY 42101
WellCare Health Insurance Company of Kentucky, Inc.	1539 Greenup Ave, 501, Ashland, KY 41101
WellCare Health Insurance Company of Kentucky, Inc.	450 Village Lane, Hazard, KY 41701
WellCare Health Insurance Company of Kentucky, Inc.	2200 E. Parrish Ave, Suite 204, Owensboro, KY 42303
WellCare Health Insurance Company of Louisiana, Inc.	11603 Southfork Drive, Building C, Baton Rouge Louisiana 70816
WellCare Health Insurance Company of New Hampshire, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance Company of Oklahoma, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance Company of Washington, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance Company of Wisconsin, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance of Arizona, Inc.	949 Kamokila Boulevard, 3rd Floor, Suite 350, Kapolei, Hawaii 96707
WellCare Health Insurance of Arizona, Inc.	Waterfront Plaza, 500 Ala Moana Blvd Suite 1-D, Honolulu, HI 96813

Entity Name	Address
WellCare Health Insurance of Arizona, Inc.	194 Kilauea Ave. Suites 102 & 103, Hilo, HI 96720
WellCare Health Insurance of Arizona, Inc.	Queen Ka'ahumanu Ave., 285 W. Ka'ahumanu Ave, Suite 101 B Kahului, Hawaii 96732
WellCare Health Insurance of Arizona, Inc.	Quail Run, 11603 Southfork Building C, Baton Rouge, LA 70816
WellCare Health Insurance of Arizona, Inc.	Metairie Center, 2424 Edenborn Ave, Suite 430, Metairie, LA 70001
WellCare Health Insurance of Arizona, Inc.	Ambassador Plaza, 2865 Ambassador Caffery Pkwy, #121 Lafayette, LA 70506
WellCare Health Insurance of Arizona, Inc.	88 Kanoelehua Ave Suite A105 Hilo, HI 96720
WellCare Health Insurance of Connecticut, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance of Connecticut, Inc.	2319 Whitney Avenue, Sixth Floor, Hamden, Connecticut 06518
WellCare Health Insurance of New Hampshire, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance of New York, Inc.	One New York Plaza, 15th Floor, New York, New York 10004
WellCare Health Insurance of North Carolina, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Insurance of North Carolina, Inc.	Raleigh Oaks Shopping Center, 2720 Lake Wheeler Rd., Ste. 123, Raleigh, NC 27603
WellCare Health Insurance of North Carolina, Inc.	1 Glenwood Avenue, Raleigh, NC 27603
WellCare Health Insurance of Tennessee, Inc.	7100 Commerce Way, Suite 285, Brentwood, Tennessee 37027
WellCare Health Plans of Arizona, Inc.	432 N. 44th St., Suite 100, Phoenix, AZ 85008
WellCare Health Plans of California, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Plans of Kentucky, Inc.	13551 Triton Park Boulevard, Suite 1800, Louisville, Kentucky 40223
WellCare Health Plans of New Jersey, Inc.	550 Broad Street, Suite 1200, Newark, New Jersey 07102
WellCare Health Plans of New Jersey, Inc.	3150 Brunswick Pike, Suite 260, Lawrenceville, NJ 08648
WellCare Health Plans of Tennessee, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Plans of Tennessee, Inc.	7100 Commerce Way, Suite 285,

Entity Name	Address
	Brentwood, Tennessee 37027
WellCare Health Plans of Vermont, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Plans of Wisconsin, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Health Plans of Wisconsin, Inc.	400 Executive Drive, Suite 110, Brookfield, WI 53005
WellCare Health Plans, Inc.	8725 Henderson Road, Tampa, Florida 33634
WellCare National Health Insurance Company	8735 Henderson Road, Tampa, Florida 33634
WellCare National Health Insurance Company	Loop Central I, 4888 Loop Central Dr., Suite 3, 4, 7, 8, 9, Houston, TX 77081
WellCare of Alabama, Inc.	Cummings Research Park, 7027 Old Madison Pike, NW, Suite 108, Huntsville, Alabama 35806
WellCare of Arkansas, Inc.	1001 N. University, Suite 150, Little Rock, AR 72207
WellCare of Connecticut, Inc.	2319 Whitney Avenue, Sixth Floor, Hamden, Connecticut 06518
WellCare of Florida, Inc.	3031 N. Rocky Point Drive W, Suite 600, Tampa, Florida 33607
WellCare of Florida, Inc.	200 W Waters Ave, Tampa, FL 33604
WellCare of Florida, Inc.	2201 Lucien Way, Suite 400, Maitland, FL 32751
WellCare of Florida, Inc.	Town Corral Shopping Center, 1060 North John Young Parkway, Suite 1060, 1062, & 1066, Kissimmee, FL 34741
WellCare of Florida, Inc.	3280 Commercial Way, Springhill, FL 34606
WellCare of Florida, Inc.	7890 US 19, Pinellas Park, FL 33781
WellCare of Florida, Inc.	Forest Oaks Shopping Center, 5007 N. Davis Highway, Suite 10 Pensacola, FL 32503
WellCare of Florida, Inc.	1380 6th Street NW, Winter Haven, FL 33881
WellCare of Florida, Inc.	2525 S Monroe St, Unit 1, Tallahassee, FL 32301
WellCare of Florida, Inc.	2726 NE 14th St., Ocala, FL 34470-4821
WellCare of Florida, Inc.	5115 Normandy Blvd, Unit 1, Jacksonville, FL 32205
WellCare of Florida, Inc.	5113 US Hwy 19, Suite 9, New Port Richey, FL 34652
WellCare of Florida, Inc.	4901 Palm Beach, Suites 12 & 13, Ft. Myers, FL 33905

Entity Name	Address
WellCare of Florida, Inc.	Colonial Plaza, 9552 SW 160th St., Miami, FL 33157
WellCare of Florida, Inc.	Miami Gardens Shopping Plaza, 4680 NW 183rd St Miami Gardens, FL 33055
WellCare of Florida, Inc.	Hiawassee Plaza, 6801-E W. Colonial Dr., Orlando, FL 32818
WellCare of Florida, Inc.	Cross County Plaza, 4278 Okeechobee Blvd., Plot #502 West Palm Beach, FL 33409
WellCare of Florida, Inc.	Ren VII, 8641 Henderson Road, Tampa, FL 33634
WellCare of Florida, Inc.	Lauderhill Mall, 1299C NW 40th Ave., #12C, Lauderhill, FL 33313
WellCare of Florida, Inc.	Lauderhill Mall, 1341 NW 40th Ave Lauderhill, FL 33313
WellCare of Florida, Inc.	Creighton Commons, Shopping Center, 2620 Creighton Rd., Pensacola, FL 32504
WellCare of Georgia, Inc.	211 Perimeter Center Parkway NW, Suite 800, Atlanta, Georgia 30346
WellCare of Georgia, Inc.	Riverfront Building, 33 West 11th Street, Ste 101, Columbus, GA 31901
WellCare of Georgia, Inc.	3156 Perimeter Pkwy, #102, Augusta, GA 30909
WellCare of Georgia, Inc.	1000 Business Center Drive, #50, Savannah, Georgia 31405
WellCare of Indiana, Inc.	3815 River Crossing Parkway, Suite 100, Indianapolis, IN 46240
WellCare of Kansas, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of Maine, Inc.	110 Main Street, Suite 1510, Saco, ME 04072
WellCare of Mississippi, Inc.	4780 I-55 North, Suite 450, Jackson, MS 39211
WellCare of Missouri Health Insurance Company, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of New Hampshire, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of New York, Inc.	544 Nostrand Avenue, Brooklyn, NY 11216
WellCare of New York, Inc.	One New York Plaza, 15th Floor, New York, New York 10004
WellCare of New York, Inc.	9108-16 Roosevelt Avenue, Queens, NY 11373
WellCare of New York, Inc.	1365 St. Nicholas Ave., New York, NY 10033
WellCare of New York, Inc.	765 61st Street, Brooklyn, NY 11220

Entity Name	Address
WellCare of New York, Inc.	35 East Broadway, New York, NY 10002
WellCare of New York, Inc.	135-16 Roosevelt Ave, Flushing, NY 11354
WellCare of New York, Inc.	100 Main St., Hempstead, NY 11550
WellCare of New York, Inc.	1043 Southern Blvd., Bronx, NY 10459
WellCare of New York, Inc.	347 Main Street, Suite 101, Poughkeepsie, NY 12601
WellCare of New York, Inc.	80 State Street, Suite 100, Albany, NY 12207
WellCare of New York, Inc.	47 Court St., Buffalo, NY 14202
WellCare of New York, Inc.	100 S. Bedford Rd., Mt. Kisco, NY 10549
WellCare of New York, Inc.	225 Greenfield Pkwy, Suite 208, Liverpool, NY 13088
WellCare of North Carolina, Inc.	1 Glenwood Avenue Raleigh, NC 27603
WellCare of North Carolina, Inc.	Raleigh Oaks Shopping Center, 2720 Lake Wheeler Rd., Ste. 123 Raleigh, NC 27603
WellCare of Ohio, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of Oklahoma, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of Pennsylvania, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of Puerto Rico, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of South Carolina, Inc.	128 Millport Circle, Suite 200, Greenville, SC 29607
WellCare of South Carolina, Inc.	200 Center Point Circle, Suite 180, Columbia, South Carolina 29210
WellCare of South Carolina, Inc.	5 Farrs Bridge Rd., Greenville, SC 29617
WellCare of Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
WellCare of Texas, Inc.	7800 Ricchi, 7800 Stemmons Fwy, Suite 125, Dallas, TX 75247
WellCare of Texas, Inc.	Zaraplex Shopping Center, 1700 Zaragoza, Suite 140, El Paso, TX 79936
WellCare of Texas, Inc.	Park North, 742 NW Loop 410, Suite 117, San Antonio, TX 78216
WellCare of Washington, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare of Virginia, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Pharmacy Benefits Management, Inc.	8735 Henderson Road, Tampa, Florida 33634
WellCare Prescription Insurance, Inc.	4110 George Road, Suite 300,Tampa,

Entity Name	Address
	Florida 33634
Windsor Health Group, Inc.	7100 Commerce Way, Suite 285,Brentwood, Tennessee 37027
Worlco Management Services, Inc.	The Lofts, 18 Division St, Suite 310, Saratoga Springs, NY 12866

Table B.2.a.i.1-3 WCG Health Management Business P.O. Boxes includes a complete list of P.O. Boxes of WCG Health Management, Inc. and its affiliates.

Table B.2.a.i.1-3 WCG Health Management Business P.O. Boxes

Department	PO Box No.	Zip Code	Plus 4
Georgia Claims	31224	33631	3224
Provider Relations	31366	33631	3366
Billing	31367	33631	3367
Appeals and Grievances	31368	33631	3368
Configuration	31369	33631	3369
Ops. Cust. Serv. Front End	31370	33631	3370
	31371	33631	3371
Claims FL, NY, CT, LA, IL, IN	31372	33631	3372
	31373	33631	3373
	31374	33631	3374
Enrollment	31378	33631	3378
Executive	31379	33631	3379
Human Resources/Training	31380	33631	3380
IT/App. Dev./Info. Sys./Telecom/Data Mgmt./Data Integrity	31381	33631	3381
PDP	31382	33631	3382
PDP Appeals	31383	33631	3383
Grievances	31384	33631	3384
PDP Customer Service	31385	33631	3385
Legal/Regulatory & Compliance	31386	33631	3386
Staywell Marketing/Healthy Kids	31387	33631	3387
HealthEase Marketing/Healthy Kids	31388	33631	3388
Medicare Marketing	31389	33631	3389
Accounts Payable	31390	33631	3390

Department	PO Box No.	Zip Code	Plus 4
Finance/Actuarial/Acct. Payroll/Purchasing/Planning and Analysis	31391	33631	3391
Credentialing	31400	33631	3400
Health Serv. In/Out Patient/Behavioral Health/ UM/Pharmacy/QI/Subrogation	31401	33631	3401
Harmony Behavioral Health	31402	33631	3402
MTM	31403	33631	3403
Marcom	31404	33631	3404
PFFS	31405	33631	3405
Retro Review	31406	33631	3406
Internal Audit/SIU/Risk Management	31407	33631	3407
Claims South Carolina	31408	33631	3408
Texas Expansion	31579	33631	3579
Appeals (Additional)	31580	33631	3580
Regulatory	31578	33631	3578
Pharmacy	31577	33631	3577
Ambassador Program	31558	33631	3558
LTC	31413	33631	3413
	31414	33631	3414
	31415	33631	3415
Mailing Services	31581	33631	3581
	31582	33631	3582
	31364	33631	3364

(2) Date of birth and Social Security Number (in the case of an individual).

No individual holds an ownership or control interest in the disclosing entity. Please see Section B.2.a.iv. for a list of managing employees.

(3) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

For administrative services, WellCare of Kentucky contracts with an affiliate entity, Comprehensive Health Management, Inc. (CHMI), 8735 Henderson Road, Tampa, Florida 33634. FEIN: 59-3547616. Like WellCare of Kentucky, CHMI is a wholly-owned subsidiary of The WellCare Management Group, Inc. The tax identification numbers of entities with an ownership and control interest in the disclosing entity and Comprehensive Health Management, Inc. are as follows:

ii. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

No person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

iii. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

The owners of WellCare of Kentucky own other companies that offer Medicare and/or Medicaid health plans. The name and address of the other companies offering health plans are set forth below in **Table B.2.a.iii-1 Other WellCare Disclosing Entities.** Except where indicated, these companies are owned by The WellCare Management Group, Inc. **Table B.2.a.iii-2 Centene Disclosing Entities** includes the disclosing entities that are owned by Centene.

Please note the owners of WellCare of Kentucky also have ownership interests in a specialty pharmacy and in certain accountable care organizations ("ACOs"). We do not believe these ACOs are disclosing entities and therefore have not included them below. However, such information is available upon request.

Table B.2.a.iii-1 Other WellCare Disclosing Entities

Name	Address
American Progressive Life & Health Insurance Company of New York	One New York Plaza 15th Floor New York, NY 10004
Care 1st Health Plan Arizona, Inc.	501 Gateway 501 N. 44th Street Phoenix, AZ 85008
Exactus Pharmacy Solutions, Inc. (*owned by WellCare Pharmacy Benefits Management, Inc., which is in turn owned by The WellCare Management Group, Inc.*)	4110 George Road Suite 100 Tampa, FL 33634
Harmony Health Plan, Inc. (*owned by Harmony Health Systems, Inc., which is in turn owned by The WellCare Management Group, Inc.*)	300 S. Riverside, Suite 500, Chicago, IL 60606
Meridian Management Company, LLC (f/k/a/ Caidan Management Company, LLC) (a/k/a Meridian	1 Campus Martius Suite 700

Name	Address
Administration Company, LLC in certain states)	Detroit, MI 48226
Meridian Health Plan of Illinois, Inc. (The WellCare Management Group, Inc. has indirect ownership through Meridian Management Company)	300 S. Riverside, Suite 500, Chicago, IL 60606
Meridian Health Plan of Michigan, Inc. (The WellCare Management Group, Inc. has indirect ownership through Meridian Management Company)	1 Campus Martius Suite 700 Detroit, MI 48226
MeridianRx, LLC	1 Campus Martius Suite 700 Detroit, MI 48226
One Care by Care1st Health Plan of Arizona, Inc.	501 Gateway 501 N. 44th Street Phoenix, AZ 85008
SelectCare Health Plans, Inc.	4888 Loop Central Drive Suite 300 Houston, TX 77081
SelectCare of Texas, Inc.	4888 Loop Central Drive Suite 300 Houston, TX 77081
WellCare Health Insurance Company of America	124 West Capitol Avenue Suite 1900 Little Rock, Arkansas, 72201
WellCare Health Insurance Company of Kentucky, Inc. d/b/a WellCare of Kentucky	13551 Triton Park Blvd., Suite 1800 Louisville, Kentucky 40223
WellCare Health Insurance of Arizona, Inc. d/b/a ‘Ohana Health Plan	949 Kamokila Blvd. Suite 350 Kapolei, HI 96707
WellCare Health Insurance of Connecticut, Inc.	2319 Whitney Avenue, Sixth Floor, Hamden, Connecticut 06518
WellCare Health Insurance of New York, Inc.	One New York Plaza 15th Floor New York, NY 10004
WellCare Health Insurance Company of New Hampshire, Inc.	8735 Henderson Road Tampa, FL 33634
WellCare Health Insurance of North Carolina, Inc.	8735 Henderson Road Tampa, FL 33634
WellCare Health Plans of Arizona, Inc.	432 N. 44th Street Suite 100 Phoenix, AZ 85008
WellCare Health Plans of New Jersey, Inc.	550 Broad Street Suite 1200 Newark, NJ 07102
WellCare National Health Insurance Company	4888 Loop Central Drive

Name	Address
	Suite 300 Houston, TX 77081
WellCare of California, Inc. (f/k/a Easy Choice Health Plan, Inc.)	10803 Hope Street Suite B Cypress, CA 90630
WellCare of Alabama, Inc.	Cummings Research Park 7027 Old Madison Pike, NW, Suite 108 Huntsville, Alabama 35806
WellCare of Connecticut, Inc. (*owned by WellCare of New York, Inc., which is in turn owned by The WellCare Management Group, Inc.*)	2319 Whitney Avenue Sixth Floor Hamden, CT 06518
WellCare of Florida, Inc. (also does business as Staywell Health Plan of Florida)	8735 Henderson Road Tampa, FL 33634
WellCare of Georgia, Inc.	211 Perimeter Center Parkway, Suite 800 Atlanta, GA 30346
WellCare of Maine, Inc.	110 Main Street, 5th Floor Saco, Maine 04072
WellCare of Missouri, Inc.	8735 Henderson Road Tampa, FL 33634
WellCare of New Hampshire, Inc.	8735 Henderson Road Tampa, FL 33634
WellCare of New York, Inc.	One New York Plaza 15th Floor New York, NY 10004
WellCare of North Carolina, Inc.	1 Glenwood Avenue Raleigh, NC 27603
WellCare of South Carolina, Inc.	200 Center Point Suite 180 Columbia, SC 29210
WellCare of Tennessee, Inc.	8735 Henderson Road Tampa, FL 33634
WellCare of Texas, Inc.	4888 Loop Central Drive, Suite 300, Houston, Texas 77081
WellCare of Washington, Inc.	8735 Henderson Road Tampa, FL 33634
WellCare Prescription Insurance, Inc.	8735 Henderson Road Tampa, FL 33634

Table B.2.a.iii-2 Centene Disclosing Entities includes the disclosing entities that are owned by entities in the Centene group of companies other than subsidiaries of The WellCare Management Group, Inc.

Table B.2.a.iii-2 Centene Disclosing Entities

Name	Address
Absolute Total Care, Inc.	1441 Main St., Columbia SC 29201
Allwell from Arizona Complete Health	956 E. Fry Blvd., Sierra Vista, Arizona 85635
Allwell from Arkansas Health & Wellness	1001 Technology Drive, Little Rock, AR 72223
Allwell from Buckeye Health Plan	4349 Easton Way, Columbus, OH 43219
Allwell from Home State Health	11720 Borman Drive, Woodlands Plaza I, St. Louis, MO 63146
Allwell from Louisiana Healthcare Connections	8585 Archives, Blvd., Twelve United Plaza, Baton Rouge, LA 70809
Allwell from MHS Health Wisconsin	801 South 60th St., West Allis, WI 53214
Allwell from Magnolia Health	111 East Capitol Street, Jackson, MS 39201
Allwell from Peach State Health Plan	1100 Circle 75 Parkway, Atlanta, GA 30339
Allwell From PA Health & Wellness	300 Corporate Center Drive, Camp Hill, PA 17011
Allwell from SilverSummit Healthplan	2500 North Buffalo Drive, Las Vegas, NV 89128
Allwell from Sunflower Health Plan	8325 Lenexa Drive, Four Pine Ridge Plaza Building, Lenexa, KS 66214
Allwell from Sunshine Health	1301 International Parkway, Sunrise, FL 33323
Allwell from Superior HealthPlan	5900 E. Ben White Blvd., Austin, TX 78741
Allwell from Western Sky Community Care	5300 Homestead NE, Albuquerque, NM 87110
Arkansas Health and Wellness Health Plan, Inc.	1001 Technology Drive, Little Rock, AR 72223
Arkansas Total Care, Inc.	1001 Technology Drive, Little Rock, AR 72223
Health Net of Arizona, Inc. d/b/a Arizona Complete Health-Complete Care Plan	956 E. Fry Blvd., Sierra Vista, Arizona 85635
Buckeye Community Health Plan, Inc.	4349 Easton Way, Columbus, OH 43219
Buckeye Health Plan Community Solutions, Inc.	4349 Easton Way, Columbus, OH 43219
California Health and Wellness Plan	1740 & 1760 Creekside Oaks Drive, Sacramento, CA 95833
Coordinated Care Corporation d/b/a Managed Health Services, Inc.	550 N. Meridian Street, Indianapolis, IN 46204
Coordinated Care of Washington, Inc.	1145 Broadway Plaza, Tacoma Financial Center, Tacoma, WA 98402
New York Quality Healthcare Corporation d/b/a Fidelis Care	95-25 Queens Blvd, Queens Office Tower, Rego Park, NY 11374
Granite State Health Plan, Inc. d/b/a New Hampshire Health Families	2 Executive Park Drive, Bedford Executive Park, Bedford, NH 03110
Health Net of California, Inc.	11031 Sun Center Dr, Rancho Cordova, CA 95670

Name	Address
Home State Health Plan, Inc.	11720 Borman Drive, Woodlands Plaza I, St. Louis, MO 63146
Iowa Total Care, Inc.	1080 Jordan Creek Parkway. Westfield Office Bldg., West Des Moines, IA 50266
Louisiana Healthcare Connections, Inc.	8585 Archives, Blvd., Twelve United Plaza, Baton Rouge, LA 70809
Magnolia Health Plan, Inc.	111 East Capitol Street, Jackson, MS 39201
Managed Health Services Insurance Corp.	801 South 60th St., West Allis, WI 53214
Michigan Complete Health, Inc.	800 Tower Drive, Troy, MI 48098
Nebraska Total Care, Inc.	2525 N. 117th Ave., Omaha, NE 68164
Peach State Health Plan, Inc.	1100 Circle 75 Parkway, Atlanta, GA 30339
Pennsylvania Health and Wellness, Inc.	300 Corporate Center Drive, Camp Hill, PA 17011
SilverSummit Healthplan, Inc.	2500 North Buffalo Drive, Las Vegas, NV 89128
Sunflower State Health Plan, Inc.	8325 Lenexa Drive, Four Pine Ridge Plaza Building, Lenexa, KS 66214
Sunshine State Health Plan	1301 International Parkway, Sunrise, FL 33323
Superior HealthPlan, Inc.	5900 E. Ben White Blvd., Austin, TX 78741
Superior HealthPlan Community Solutions, Inc.	5900 E. Ben White Blvd., Austin, TX 78741
Trillium Advantage	1800 Millrace Drive, University of Oregon Research Park, Eugene, OR 97403
Trillium Community Health Plan, Inc.	1800 Millrace Drive, University of Oregon Research Park, Eugene, OR 97403
Western Sky Community Care, Inc.	5300 Homestead NE, Albuquerque, NM 87110

The stock of Centene, WellCare of Kentucky's ultimate parent, is publicly traded. The disclosing entity does not have access to information regarding the ownership interests in other entities that may be held by any beneficial holders of 5% of Centene's publicly traded stock.

iv. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity)."

Table B.2.a.iv-1 Officers and Directors of WellCare of Kentucky includes the requested information on any managing employee of WellCare of Kentucky.

Table B.2.a.iv-1 Officers and Directors of WellCare of Kentucky

Name	Title(s)	Business Address	SSN	DOB
Andrew L. Asher	Director	WellCare Health Plans 8735 Henderson Road Tampa, FL 33634		
Michael Haber	Vice President Secretary	WellCare Health Plans 8735 Henderson Road Tampa, FL 33634		

Name	Title(s)	Business Address	SSN	DOB
Goran Jankovic	Vice President Treasurer	WellCare Health Plans 8735 Henderson Road Tampa, FL 33634		
William Jones	Director President	WellCare of Kentucky 13551 Triton Park Blvd. Suite 1200 Louisville, KY 40223		
Michael Troy Meyer	Director Vice President Chief Accounting Officer Assistant Treasurer	WellCare Health Plans 8735 Henderson Road Tampa, FL 33634		
Tammy L. Meyer	Vice President Assistant Secretary	WellCare Health Plans 8735 Henderson Road Tampa, FL 33634		
Stephanie A. Williams	Vice President Chief Financial Officer	WellCare Health Plans 8735 Henderson Road Tampa, FL 33634		

Table B.2 a.iv-2 Officers and Directors of Centene Corporation In ad
officers and directors of Centene Corporation, the ultimate parent of WellCare of Kentucky, Inc., may be "managing employees" for purposes of this disclosure. These executive officers and directors are as follows:

Table B.2.a.iv-2 Officers and Directors of Centene Corporation

Name and Title(s)	Business Address	SSN	DOB
Orlando Ayala *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Kenneth A. Burdick *Executive Vice President, Markets & Products*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Jessica L. Blume *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
H. James Dallas *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Mark J. Brooks *Executive Vice President and Chief Information Officer*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Brandy L. Burkhalter *Executive Vice President, Operations*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Robert K. Ditmore *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		

Name and Title(s)	Business Address	SSN	DOB
Frederick H. Eppinger *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Richard A. Gephardt *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Jesse N. Hunter *Executive Vice President, Mergers and Acquisitions & Chief Strategy Officer*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Christopher R. Isaak *Senior Vice President, Corporate Controller and Chief Accounting Officer*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Michael F. Neidorff *Chairman, President and Chief Executive Officer*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
William L. Trubeck *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
John R. Roberts *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Lori J. Robinson *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Jeffrey A. Schwaneke *Executive Vice President, Chief Financial Officer and Treasurer*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
David L. Steward *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
David P. Thomas *Executive Vice President, Markets*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Tommy G. Thompson *Director*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		
Keith H. Williamson *Executive Vice President, Secretary & General Counsel*	Centene Corporation 7700 Forsyth Blvd Clayton, MO 63105		

b. Indicate the Vendor's form of business (e.g., corporation, non partnership, etc.) and provide the following information:

WellCare Health Insurance Co. of Kentucky, Inc. is a corporation.

i. Names and contact information for all officers, directors, and partners.

Table B.2.b.i-1 WellCare of Kentucky Contact Information includes contact information for all officers, directors, and partners.

Table B.2.b.i-1 WellCare of Kentucky Contact Information

Name	Director/Officer	Contact Information
Andrew Lynn Asher	Director	Drew.Asher@wellcare.com
Michael Warren Haber	Officer	Michael.Haber@wellcare.com
Goran Jankovic	Officer	Goran.Jankovic@wellcare.com
William Andrew Jones	Officer	William.Jones@wellcare.com
Michael Troy Meyer	Officer	Michael.Meyer@wellcare.com
Tammy Lynn Meyer	Officer	Tammy.Meyer@wellcare.com
Stephanie Williams	Officer	Stephanie.Williams@wellcare.com

ii. Relationship to parent, affiliated and/or related business entities and copies of management agreements with parent organizations.

WellCare of Kentucky is an indirect wholly owned subsidiary of Centene Corporation, Inc. ("CNC").The ownership path is as follows:

WELLCARE HEALTH INSURANCE COMPANY OF KENTUCKY (WHICKY) AND COMPREHENSIVE HEALTH MANAGEMENT, INC. (CHMI) MANAGEMENT SERVICES AGREEMENT

In order to maximize efficiency and cost effectiveness, WellCare centralizes operations in CHMI, its third party administrator. On behalf of The WellCare Group of Companies, CHMI performs all

administrative and management functions for health plan subsidiaries including those services specifically outlined below. These services are provided to the health plan subsidiaries through Management Services Agreements, which for any given health plan are reviewed and approved for use by the appropriate state regulatory agency that oversees plan operations.

Please see **Attachment 60.7.B.2.b.ii-1 Org Chart.**

Please see **Attachment 60.7.B.2.b.ii-2 WHICKY-CHMI Management Services Agreement**. (provided electronically)

Please see **Attachment 60.7.B.2.b.ii-3 Amended Management Service Agreement**.

CHMI generally supervises and manages the day-to-day operations of the health plans, including but not limited to:

- The provision of accounting and financial services
- Management of information and computer systems, including maintenance and upgrading of all such equipment
- Data processing
- Design and administration of benefits
- Adjudication and processing of claims
- Provision of customer service
- Provision of provider network credentialing services
- Coordination of communications to members and providers
- Provider network contracting and management
- Product marketing services
- Other services that are customarily associated with the provision of the foregoing and the operation of a health plan

INCOME TAX ALLOCATION AGREEMENT

The purpose of the Income Tax Allocation Agreement is for Centene and its subsidiaries to establish a method for allocating the consolidated federal income tax liability of the Centene group of companies (and, when applicable, certain consolidated or combined state income or franchise tax liabilities among the companies joining in those consolidated or combined state income tax returns) in an agreed fashion and to compensate any company for use of its net operating and net capital losses, and tax credits utilized in computing consolidated federal taxable income, (and, when applicable, consolidated or combined state taxable income or franchise tax base) and to provide for the allocation and payment of any refund arising from a carryback of net operating or capital losses, or tax credits generated in subsequent taxable years. Subject to all applicable laws, regulatory requirements and any other restrictions, WHICKY and each other subsidiary agrees to pay Centene for all years or portions of years that

such subsidiary is included in the consolidated federal income tax return, the portions of the consolidated federal income tax liability attributable to such subsidiary.

Please see **Attachment 60.7.B.2.b.ii-4 Income Tax Allocation Agreement**

Please see **Attachment 60.7.B.2.b.ii-5 Joint Enterprise Agreement** (provided electronically)

iii. Provide copies of the Vendor's articles of incorporation, bylaws, partnership agreements, or similar business entity documents, including any legal entity having an ownership interest of five percent (5%) or more.

Please refer to **Attachment 60.7.2.b.iii-1 WHICKY Articles of Incorporation**

Please refer to **Attachment 60.7.2.b.iii-2 WHICKY Bylaws** (provided electronically)

Please refer to **Attachment 60.7.2.b.iii-3 WHP Articles**

Please refer to **Attachment 60.7.2.b.iii-4 WHP Bylaws** (provided electronically)

Please refer to **Attachment 60.7.2.b.iii-5 WCGHM Articles**

Please refer to **Attachment 60.7.2.b.iii-6 WCGHM Bylaws** (provided electronically)

Please refer to **Attachment 60.7.2.b.iii-7 TWMG Articles**

Please refer to **Attachment 60.7.2.b.iii-8 TWMG Bylaws**(provided electronically)

Please refer to **Attachment 60.7.2.b.iii-9 Centene Articles** (provided electronically)

Please refer to **Attachment 60.7.2.b.iii-10 Centene Bylaws** (provided electronically)

The stock of Centene is publicly traded on the New York Stock Exchange under the symbol "CNC." Information regarding beneficial owners of 5% or more of Centene's publicly traded stock is available on Schedules 13G filed by such beneficial owners with the SEC with respect to Centene's stock, and currently ownership of 5% or more of stock is detailed in **Table B.2.b.iii-1 Centene Stock Ownership > 5%**.

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. Provided below are the names of companies who owned 5% or more of the voting shares of CNC as of the dates noted herein:

Table B.2.b.iii-1 Centene Stock Ownership > 5%

Business or Last Name	FEIN	Ownership Percentage
The Vanguard Group, Inc., et al. PO Box 2600; V26 Valley Forge, PA 19482-2600	52-0556948	7.65% (as of February 1, 2020)
BlackRock, Inc., et al. 55 East 52nd Street New York, NY 10055	32-0174431	5.51% (as February 1, 2020)
T Rowe Price Associates Inc. 100 East Pratt St	52-0556948	5.19 % (as February 1, 2020)

Business or Last Name	FEIN	Ownership Percentage
Baltimore, MD 21202		
Capital Group Companies, Inc. 333 South Hope Street, 55th Floor Los Angeles, CA 90071	95-1411037	7.9% (as of February 1, 2020)

BLACKROCK INC.

The Articles and Bylaws of BlackRock, Inc. are publicly available and have been attached.

- Please refer to **Attachment 60.7.2.b.iii-11 BlackRock Articles 1** (provided electronically)
- Please refer to **Attachment 60.7.2.b.iii-12 BlackRock Articles 2**
- Please refer to **Attachment 60.7.2.b.iii-13 BlackRock Bylaws** (provided electronically)

T. ROWE PRICE GROUP, INC.

The Charter and Bylaws of T. Rowe Price Group, Inc., the ultimate parent of T. Rowe Price Associates Inc. are publicly available and have been attached.

- Please refer to **Attachment 60.7.2.b.iii-14 TRowePrice Articles** (provided electronically)
- Please refer to **Attachment 60.7.2.b.iii-15 TRowePrice Bylaws** (provided electronically)

THE VANGUARD GROUP, INC. AND CAPITAL GROUP COMPANIES, INC.

The Vanguard Group, Inc. and Capital Group Companies, Inc. are privately held and their articles and bylaws are not available.

iv. Provide the Vendor's Uniform Certificate of Authority or application for the Uniform Certificate of Authority, as well as copies of reports filed with the Kentucky Department of Insurance during the prior twelve (12) months, if applicable.

- Please refer to **Attachment B.2.b.iv-1 Certificate of Authority**
- Please refer to **Attachment B.2.b.iv-2 NAIC 213 WHICKY – Q3 2019** (provided electronically)
- Please refer to **Attachment B.2.b.iv-3 NAIC 213 WHICKY – Q2 2019** (provided electronically)
- Please refer to **Attachment B.2.b.iv-4 NAIC 213 WHICKY – Q1 2019** (provided electronically)
- Please refer to **Attachment B.2.b.iv-5 NAIC 213 WHICKY – 2018 Annual Statement** (provided electronically)
- Please refer to **Attachment B.2.b.iv-6 Q2 2019 Prompt Pay 53**
- Please refer to **Attachment B.2.b.iv-7 Q1 2019 Prompt Pay 53**
- Please refer to **Attachment B.2.b.iv-8 Q1 2019 Supplemental Report**
- Please refer to **Attachment B.2.b.iv-9 Q4 2018 Prompt Pay**
- Please refer to **Attachment B.2.b.iv-10 Q4 2018 Supplemental Report**

- Please refer to **Attachment B.2.b.iv-11 Q3 2018 Report 53**
- Please refer to **Attachment B.2.b.iv-12 Q3 2018 Report 53 Supplemental**
- Please refer to **Attachment B.2.b.iv-13 Q2 2018 Prompt Pay Report**
- Please refer to **Attachment B.2.b.iv-14 Q2 2018 Supplemental Report**

c. Demonstrate financial viability for the Vendor and each Subcontractor, as evidenced by sustained bottom line profitability and no current areas of significant financial risk for the past three (3) calendar years or the Vendor or Subcontractor's fiscal years. For the Vendor and each Subcontractor, provide copies of financial statements from the most recently completed and audited year.

WellCare of Kentucky's net income the past three years has been:

- 2018 - $126.7M
- 2017 - $80.2M
- 2016 - $42.2M

We believe this information is evidence of sustained bottom line profitability. In addition, we are submitting the complete financial statement for 2018 as **Attachment B.2.c-1 WellCare of Kentucky, Inc. - Financial Stmt.** (provided electronically)

Attachment B.2.c-2 WellCare of Kentucky Internal Control Letter is another document to demonstrate we have no areas of financial risk.

Subcontractors of WellCare of Kentucky have submitted financial viability documents; they are provided in **Attachment B.2.c Subcontractor Financial Statements.** (provided electronically)

d. Provide a statement of whether there is any pending or recent (within the last ten (10) years) litigation against the Vendor or sanctions, including but not limited to the following:

i. Litigation involving the Vendor's failure to provide timely, adequate, or quality Covered Services. If any litigation listed, include damages sought or awarded or the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether the pending or recent litigation will impair your organization's performance in a Kentucky Medicaid Managed Care Contract.

Based upon a review of available records, we have created **Table B.2.d.i-1 WellCare Litigation**, which represents our best efforts to include a responsive list of litigation involving the Vendor and its affiliates, and subsidiaries. Additionally, litigation involving two of our subcontractors, CVS and Avesis, immediately follows Table B.2.d.i-1.

The litigation involving our parent company, Centene Corporation, is included as **Attachment B.2.d.i Centene Litigation.**

The disclosed matters arose in the ordinary course of our business and none were, or are, material, financially or otherwise. To summarize, over 85 percent of the responsive matters resolved without any settlement value, and less than 10 percent involved settlement values greater than $500,000. Additionally, over 20 percent of the cases listed involve Medicaid Fair Hearings. To the best of our knowledge and belief, no pending litigation will impair our organization's performance under a managed care contract in Kentucky.

Note that we interpret the requirement to provide information relating to “litigation involving the Vendor’s failure to provide timely, adequate, or quality Covered Services” as excluding litigation involving employment matters and other actions not related to the provision of benefits to enrollees.

An opinion of counsel as to the degree of risk presented by any pending litigation and whether the pending or recent litigation will impair WellCare's performance in a Kentucky Medicaid Managed Care Contract is presented below.

Tamara L. Meyer
Vice President, Assistant General Counsel,
Litigation, Regulatory & Health Plan Operations

January 29, 2020

Re: Item 60.7 B.2.d.i (Statement of Litigation/Opinion of Counsel);
RFP 758 2000000202

To Who It May Concern:

The Vendor and its parent company, affiliates, and subsidiaries maintain sufficient insurance coverage and reserves that cover any actual or potential adverse judgment relating to the attached litigation disclosures. It is my opinion that the degree of risk presented by any pending litigation is not material. More specifically, to the best of my knowledge and belief, any pending or recent litigation will not impair our organization's performance in a Kentucky Medicaid Managed Care Contract

Sincerely,

Tamara L. Meyer
Vice President, Assistant General Counsel,
Litigation, Regulatory & Health Plan Operations

Office: 8735 Henderson Road | Renaissance 1 | Tampa, Florida 33634
Mail: Post Office Box 31386 | Tampa, FL 33634
Phone: 813-206-2028 | **Fax:** 813-262-2871 | **E-mail:** Tamara.Meyer@wellcare.com

CENTENE Corporation

January 29, 2020

Re: Item 60.7 B.2.d.i (Statement of Litigation/Opinion of Counsel); RFP# 758 2000000202

To Who It May Concern:

The Vendor and its parent company, affiliates, and subsidiaries maintain sufficient insurance coverage and reserves that cover any actual or potential adverse judgment relating to the attached litigation disclosures. It is my opinion that the degree of risk presented by any pending litigation is not material. More specifically, to the best of my knowledge and belief, any pending or recent litigation will not impair our organization's performance in a Kentucky Medicaid Managed Care Contract.

Sincerely,

Keith Williamson

EVP, Secretary & General Counsel

CENTENE CORPORATION 7700 Forsyth Boulevard, St. Louis, MO 63105 | (314) 725-4477

Table B.2.d.i-1 WellCare Litigation

Table B.2.d.ii-2 WellCare Sanctions

iii. Any Securities Exchange Commission (SEC) filings discussing any pending or recent litigation. Include information for Parent Company, affiliates, and subsidiaries. The Vendor may exclude workers' compensation cases.

Below are the SEC filings discussing any pending or recent litigation for all WellCare affiliates and subsidiaries. SEC filings discussing any pending or recent litigations for our Parent company, Centene Corporation, can be found in **Attachment B.2.d.iii Centene SEC Filings**.

FROM THE WELLCARE HEALTH PLANS 2018 10 K:

Item 3. Legal Proceedings.

We are involved in legal actions in the normal course of our business, including, without limitation, protests and appeals related to Medicaid procurements, wage and hour claims and other employment claims, claims for indemnification under purchase agreements, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM THE WELLCARE HEALTH PLANS 2017 10 K:

Item 3. Legal Proceedings.

We are involved in legal actions in the normal course of our business, including, without limitation, protests and appeals related to Medicaid procurements, wage and hour claims and other employment claims, claims for indemnification under purchase agreements, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM THE WELLCARE HEALTH PLANS 2016 10 K:

Item 3. Legal Proceedings.

United States Department of Health and Human Services

In April 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of Health and Human Services ("OIG-HHS"). On January 27, 2017, we received notification from OIG-HHS that the Corporate Integrity Agreement had terminated.

Other Lawsuits and Claims

Separate and apart from the legal matter described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, protests related to

Medicaid procurements, wage and hour claims and other employment claims, vendor disputes and provider disputes regarding payment of claims. In addition, we are involved in litigation related to our pending acquisition of Universal American Corp. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM THE WELLCARE HEALTH PLANS 2015 10 K

Item 3. Legal Proceedings.

United States Department of Health and Human Services

In April 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years. The Corporate Integrity Agreement requires various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement 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, our reporting practices, and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement, we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate Integrity Agreement, OIG-HHS may exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and have a material adverse effect on our results of operations.

Other Lawsuits and Claims

Separate and apart from the legal matter described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, protests related to Medicaid procurements, wage and hour claims and other employment claims, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM WELLCARE HEALTH PLANS 2014 10 K:

Item 3. Legal Proceedings.

United States Department of Health and Human Services

In April 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years. The Corporate Integrity Agreement requires various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement 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, our reporting practices, and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate Integrity Agreement, OIG-HHS may exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and have a material adverse effect on our results of operations.

Other Lawsuits and Claims

Separate and apart from the legal matter described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, wage and hour claims and other employment claims, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM WELLCARE HEALTH PLANS 2013 10 K:

Item 3. Legal Proceedings.

United States Department of Health and Human Services

In April 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years. The Corporate Integrity Agreement requires various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement 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, our reporting practices, and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate

Integrity Agreement, OIG-HHS may exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and have a material adverse effect on our results of operations.

Other Lawsuits and Claims

Separate and apart from the legal matter described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, tax disputes, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM WELLCARE HEALTH PLANS 2012 10 K:

Item 3. Legal Proceedings.

United States Department of Health and Human Services

In April 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years. The Corporate Integrity Agreement requires various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement 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, our reporting practices and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate Integrity Agreement, OIG-HHS may exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and potentially have a material adverse effect on our results of operations.

Other Lawsuits and Claims

Separate and apart from the legal matter described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, wage and hour claims, tax disputes, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM WELLCARE HEALTH PLANS 2011 10 K:

Item 3. Legal Proceedings.

Government Investigations

Deferred Prosecution Agreement. As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the "DPA") with the United States Attorney's Office for the Middle District of Florida (the "USAO") and the Florida Attorney General's Office, resolving investigations by those offices.

Under the one count criminal information (the "Information") filed with the United States District Court for the Middle District of Florida (the "Federal Court") by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Federal Court that the prosecution be deferred for the duration of the DPA, which has a term of thirty-six months.

The DPA expires by its terms on May 5, 2012. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state, or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of $80.0 million over the course of 2008 and 2009.

Civil Division of the United States Department of Justice. In October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of its pending civil inquiry, it was investigating four qui tam complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. As previously disclosed, we 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 us and one of our subsidiaries (the "Leon County qui tam Action").

In June 2010, (i) the United States government filed its Notice of Election to Intervene in three of the qui tam matters (the "Florida Federal qui tam Actions"), and (ii) we announced that we reached a preliminary agreement with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney's Office for the District of Connecticut (the "USAO Connecticut") to settle their pending inquiries. In April 2011, we entered into certain settlement agreements, described below, which will resolve the pending inquiries of the Civil Division, the USAO and the USAO Connecticut. These settlement agreements are related to the Florida Federal qui tam Actions as well as another federal qui tam action that had been filed in the District of Connecticut (the "Connecticut Federal qui tam Action") and the Leon County qui tam Action.

The 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 and the USAO Connecticut (the "Federal Settlement Agreement") and (b) the following states (collectively, the "Settling States"): Connecticut, Florida, Georgia, Hawaii, 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 previously disclosed preliminary settlement with the Civil Division, the USAO and the USAO Connecticut. We have agreed, among other things, to pay the Civil Division $137.5 million (the “Settlement Amount”), which is to be paid in installments over a period of up to 36 months after the effective date of the Federal Settlement Agreement (the “Payment Period”) plus interest accrued from December 2010 at the rate of 3.125% per year. The settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that we are acquired or otherwise experience a change in control during the Payment Period. In addition, the settlement provides for a contingent payment of an additional $35 million in the event that we are acquired or otherwise experience a change in control within three years of the effective date of the Federal Settlement Agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Federal Settlement Agreement.

In exchange for the payment of the Settlement Amount, the United States and the Settling States agreed to release us 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 (as described below under United States Department of Health and Human Services), OIG-HHS agreed to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude us from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. This relator has objected to the Federal Settlement Agreement. Because of the objection, 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.

We can make no assurances that the objecting relator will execute the Federal Settlement Agreement or that the Federal Court will approve the settlement at a Fairness Hearing and the actual outcome of these matters may differ materially from the terms of the settlement.

United States Department of Health and Human Services. In April 2011, we entered into a Corporate Integrity Agreement (the “Corporate Integrity Agreement") with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to the Company under review by OIG-HHS. The Corporate Integrity Agreement

requires various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement 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, our reporting practices, and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate Integrity Agreement, OIG-HHS may exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and potentially have a material adverse effect on our results of operations.

Other Lawsuits and Claims

Separate and apart from the legal matters described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, wage and hour claims, and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

FROM WELLCARE HEALTH PLANS 2010 10 K:

Item 3. Legal Proceedings.

Government Investigations

Deferred Prosecution Agreement. As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the “DPA”) with the United States Attorney’s Office for the Middle District of Florida (the “USAO”) and the Florida Attorney General’s Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the “Information”) filed with the United States District Court for the Middle District of Florida (the “Federal Court”) by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Court that the prosecution be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our

continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Federal Court, a statement of facts relating to this matter. As a part of the DPA, we 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 after consultation with us and is retained at our expense. In addition, we 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 our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also has reviewed, evaluated, and, as necessary, made written recommendations concerning certain of our policies and procedures. Consistent with the DPA, the Monitor has undertaken to avoid the disruption of our ordinary business operations or the imposition of unnecessary costs or expenses.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state, or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of $80.0 million

Civil Division of the United States Department of Justice. In October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of the pending civil inquiry, it was investigating four qui tam complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases was partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the qui tam complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided with a copy of the qui tam complaints, in response to our request, which otherwise remained under seal as required by 31 U.S.C. section 3730(b)(3).

As previously disclosed, we 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 us and one of our subsidiaries (the "Leon County qui tam suit"). As part of our discussions to resolve pending qui tam and related civil investigations discussed above, we were informed that the Leon County qui tam suit was filed by one of the federal qui tam relators and contains allegations similar to those alleged in one of the recently unsealed qui tam complaints.

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) we announced that we reached a preliminary agreement (the "Preliminary Settlement") with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney's Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three qui tam complaints in which the government had intervened. Those complaints are now publicly

available. A temporary stay of discovery has been granted in the three qui tam matters until May 2, 2011.

The Preliminary Settlement is subject to completion and approval of an executed written settlement agreement and other government approvals. Following execution and government approvals, if any party objects to the settlement, the Federal Court will conduct a hearing to determine whether the proposed settlement is fair, adequate, and reasonable under all the circumstances. Under the Preliminary Settlement, we would, among other things, agree to pay the Civil Division a total of $137.5 million (the "Settlement Amount"), for which the first installment will be due after a written settlement agreement has been executed and three subsequent installments will be paid over a period of up to 36 months after the date of that executed written settlement agreement (the "Payment Period") plus interest at the rate of 3.125% per year. The Preliminary Settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that we were acquired or otherwise experienced a change in control during the Payment Period. In addition, the Preliminary Settlement provides for a contingent payment of an additional $35.0 million in the event that we are acquired or otherwise experience a change in control within three years of the execution of the settlement agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds to be specified in the settlement agreement. We expect that the final settlement agreement will provide that the Settlement Amount will account for approximately $22.9 million owed to the Florida Agency for Health Care Administration ("AHCA") as a result of overpayments received by us from AHCA during the three month period of August 2005 through October 2005. These overpayments were the result of a change implemented by AHCA in the payment methodology relating to medical benefits for newborns.

There can be no assurance that the Preliminary Settlement will be finalized and approved and the actual outcome of these matters may differ materially from the terms of the Preliminary Settlement.

United States Department of Health and Human Services. As previously disclosed, we remain engaged in resolution discussions as to matters under review with the United States Department of Health and Human Services' Office of Inspector General (the "OIG"). Those discussions are ongoing and no final resolution has been reached.

Class Action Complaints

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al., respectively, were filed in Federal Court against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The Eastwood Enterprises complaint alleged that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended ("Exchange Act"). The Hutton complaint alleged that various public statements supposedly issued by the defendants were

materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserted claims under the Exchange Act. Both complaints sought, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Federal Court appointed a group of five public pension funds from New Mexico, Louisiana, and Chicago (the "Public Pension Fund Group") as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant.

In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Federal Court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009. In April 2010, the Lead Plaintiffs filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. Discovery has been stayed through March 17, 2011.

In August 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve these matters. In December 2010, the terms of the settlement were documented in a formal settlement agreement that is subject to approval by the Federal Court following notice to all class members. On February 9, 2011, the Federal Court entered an order preliminarily approving the settlement and scheduled the final Settlement hearing for May 4, 2011. The settlement provides that we will make cash payments to the class of $52.5 million within thirty business days following the Federal Court's preliminary approval of the settlement and $35.0 million by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured subordinated bonds having an aggregate face value of $112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of $425.0 million that are senior to the bonds, the holders of the bonds have the right to accelerate payment of the bonds. We will have the right to redeem the bonds at 102% of face value during the first year and at 100% of face value thereafter. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of $30.00 or more, we will pay to the class an additional $25.0 million. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens, and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement also provides that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

There can be no assurance that the settlement will be approved by the Federal Court and the actual outcome of this matter may differ materially from the terms of the settlement

Derivative Lawsuits

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey and Christian Michalik, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, and former director and officer Todd Farha. These actions also named us as a nominal defendant. Two of these actions were filed in the Federal Court and two actions were filed in the Circuit Court for Hillsborough County, Florida (the “State Court”). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey and Christian Michalik, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contended, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants’ supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the Federal Court determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens, and Bereday.

In March 2010, a Stipulation of Partial Settlement (“Stipulation I”) was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative stockholder derivative action also agreed to dismiss their claims against Messrs. Farha, Behrens, and Bereday. In turn, we paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of $1.7 million. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our stockholders. The Federal Court also approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled WellCare v. Farha, et al. The Federal Court stayed discovery through March 17, 2011. In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"), which is pending.

In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we paid to plaintiffs' counsel in the state action attorneys' fees in the amount of $0.6 million. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a notice of appeal in this matter, which remains pending.

In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties.

Other Lawsuits and Claims

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, including, without limitation, provider disputes regarding payment of claims and disputes relating to the performance of contractual obligations with state agencies, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

Other Lawsuits and Claims

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

e. For the Vendor, Parent Company, subsidiaries and all Subcontractors list and describe any Protected Health Information (PHI) breaches (within the past five years) that have occurred and the response. Do not include items excluded per 45 CFR 164.402.

Per the Question and Answers included in Addenda 2 page 91, **Table B.2.d.ii WellCare of Kentucky PHI Breaches** includes any Protected Health Information (PHI) breaches within the past five years for the Vendor, WellCare of Kentucky. Please note, no PHI breaches occurred for WellCare of Kentucky in the years 2017, 2018, and 2019. Reportable events for 2015 and 2016 are as follows.

Breach Occurred	Number of Impacted Individuals	Type of Breach	Description of Breach	PHI Involved in Breach	Remediation
10/16/2015	19	Unauthorized Access/Disclosure	A computer coding issues caused member addresses to be incorrectly matched with member names during a mail merge and	Address/Zip Code Name Other Identifier	Provided individuals with free credit monitoring Took steps to mitigate harm

Breach Occurred	Number of Impacted Individuals	Type of Breach	Description of Breach	PHI Involved in Breach	Remediation
			were mailed to incorrect members.		Trained or retrained workforce members
03/21/2016	1	Theft	The business associate's employee had a home visit to a member, the employee is no longer working at the business associate and not all of the paperwork that the employee had was returned to the business associate.	Address/Zip Code Date of Birth Name SSN	Provided individuals with free credit monitoring Took steps to mitigate harm
08/08/2016	0	Ransomware (possible theft)	A subcontractor's servers had been compromised by ransomware. The subcontractor had no evidence that PHI was infiltrated by the threat, but that possibility could not be ruled out	Name Address/Zip Date of Birth Member ID, Group number, Diagnosis Provider name Treatment location Social Security Numbers.	Provided individuals with free credit monitoring Took steps to mitigate harm

f. Has the Vendor ever had its accreditation status (e.g., National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Accreditation Association for Ambulatory Health Care (AAAHC)) in any state for any product line adjusted down, suspended, or revoked (within the past five years)? If so, identify the state and product line and provide an explanation. Include information for the Vendor's Parent Company and subsidiaries.

WellCare of Kentucky confirms adherence to the Department's (DMS) expectations and requirements outlined in Section 19.1 National Committee for Quality Assurance (NCQA) Accreditation as well as 42 C.F.R. 438.332. WellCare of Kentucky is committed to continuous quality improvement, as evidenced by our Commendable NCQA® accreditation status in 2017 and 2018. NCQA awards a status of Commendable to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.

The following details adjustment activity for WellCare of Kentucky, our parent companies, and subsidiaries:

WellCare of Kentucky

WellCare of Kentucky's Medicaid accreditation was initially "Commendable" from 9/2/2014 – 9/2/2017. During re-calibration in 2015, we were downgraded to "Accredited" on 8/31/2015. **In 2016 we were upgraded to "Commendable" in 2016 -2019**.

WellCare (parent/affiliates)

WellCare's Florida Medicare accreditation was adjusted down from "Commendable" to "Accredited" in October of 2018 through February of 2019.

Centene (parent/affiliates)

- Centene's Florida Medicaid accreditation was "Commendable" in 2015, then downgraded to "Accredited" from 2016-2018, and then upgraded to "Commendable" in 2019. Downgrading was due to HEDIS/CAHPS scoring.
- Centene's Louisiana Medicaid was capped at "Accredited" in 2015, then received "Accredited" in 2016, then was upgraded to "Commendable" for 2017-2018, and downgraded to "Accredited" in 2019. Downgrading was due to HEDIS/CAHPS scoring.
- Centene's Mississippi Medicaid was capped at "Accredited" in 2015, then upgraded to "Commendable" in 2016, and then downgraded to "Accredited" in 2017-2019. Downgrading was due to HEDIS/CAHPS scoring.
- Centene's New Hampshire Medicaid was "Commendable" in 2015 then downgraded to "Accredited" in 2016, and the upgraded to "Commendable" in 2016-2019. Downgrading was due to HEDIS/CAHPS scoring.
- Centene's Ohio Medicaid was "Accredited" in 2015-2016, then upgraded to "Commendable" in 2017, and then downgraded to "Accredited" in 2018-2019. Downgrading was due to HEDIS/CAHPS scoring.
- Centene's Washington Medicaid was capped at "Accredited" in 2015, then received "Accredited" in 2016, then upgraded to "Commendable" in 2017, and then downgraded to "Accredited" in 2018-2019. Downgrading was due to HEDIS/CAHPS scoring.
- Centene's Wisconsin Medicaid was "Commendable" for 2015-2018 and then downgraded to "Accredited" in 2019. Downgrading was due to HEDIS/CAHPS scoring.

g. Provide a listing of Medicaid managed care contracts held in the past ten (10) years for which the Vendor, Vendor's Parent Company, and subsidiaries has:

i. Voluntarily terminated all or part of the contract under which it provided health care services as the licensed entity.

ii. Had such a contract partially or fully terminated before the contract end date (with or without cause).

iii. Had a contract not renewed.

iv. Withdrawn from a contracted service are.

v. Had a reduction of enrollment levels imposed?

WELLCARE CONTRACT TERMINATIONS AND NONRENEWALS

- WellCare of New York, Inc. ("WCNY") was party to a contract with the New York State Department of Health ("NY DOH") and the Centers for Medicare & Medicaid Services (CMS) pursuant to which WCNY operated a Fully Integrated Duals Advantage (FIDA) Plan under a CMS demonstration program. WCNY voluntarily terminated the FIDA contract as of December 31, 2016, for business reasons. The contract would otherwise have expired at the end of the demonstration.
- WCNY was party to Contract C029910 with NY DOH pursuant to which WCNY operated Qualified Health Plan on New York's Health Benefit Exchange. WCNY voluntarily terminated this contract as of December 31, 2016, for business reasons. The contract would otherwise have expired on December 31, 2018.
- In 2015 the Iowa Department of Human Services ("IA DHS") issued Iowa Department of Human Services - Request for Proposal - Iowa High Quality Healthcare Initiative - RFP MED-16-009 (the "Iowa RFP"). On August 17, 2015, IA DHS issued a Notice of Intent to Award contracts arising out of the Iowa RFP to four entities including WellCare of Iowa, Inc. ("WCIA"). Three unsuccessful bidders filed bid protests and subsequently appealed in court challenging the intended contract awards. During those proceedings, the winning bidders, including WCIA, entered into contracts with IA DHS. The proceedings concluded in December 2015, when the Iowa Department of Administrative Services Director issued a Final Order reversing the Notice of Intent to Award to WCIA and terminating WCIA's contract with IA DHS. WCIA subsequently appealed the Final Order unsuccessfully. While WellCare is not pursuing this matter further, WellCare continues to dispute the facts and law as set forth in the Final Order. WCIA has since been dissolved.
- The Centers for Medicare & Medicaid Services ("CMS") terminates Medicare Advantage plans whose enrollment falls below a certain threshold. CMS terminated a special needs plan for dual-eligibles ("DSNP") operated by WCNY due to low enrollment as of December 31, 2013. As a result, the associated Medicaid Advantage Plus contract between the New York State Department of Health and WCNY, which governed the Medicaid portion of the benefits for the members of the DSNP, automatically terminated as of the same date.
- Two subsidiaries of were each party to a Contract 2010-22-005 effective as of January 1, 2010 with the Illinois Department of Healthcare and Family Services ("Illinois DHFS"). The subsidiaries were Harmony Health Plan, Inc. ("Harmony") and WellCare Rx. These contracts were related to Illinois' state prescription insurance program ("SPAP") and were due to expire December 31, 2012. However, the Illinois General Assembly did not appropriate funds for the Illinois SPAP program for the state's 2013 fiscal year, which began July 1, 2012. As a result of the General Assembly's decision not to appropriate funds for the SPAP program, Illinois DHFS terminated all of its contracts with SPAP service providers as of July 1, 2012, including its contracts with Harmony and WellCare Rx.
- WellCare Rx was party to Contract #90009208 dated January 13, 2010, with the North Carolina Department of Health and Human Services, Office of Rural Health and Community Care ("North Carolina DHHS"). This contract related to North Carolina's SPAP and was due

to expire December 31, 2012. From 2007 to 2011, North Carolina funded its SPAP program through the North Carolina Health and Wellness Trust Fund (the "HWTF"); an entity created by the North Carolina General Assembly to administer funds received through a settlement between the state and tobacco manufacturers. The HWTF ceased funding the SPAP program as of June 30, 2011. With no funds with which to operate the SPAP program, North Carolina DHHS terminated all of its contracts with SPAP service providers as of June 30, 2011, including its contract with WellCare Rx.

- WellCare Rx was party to a Contract dated as of January 1, 2010, with the South Carolina Department of Health and Human Services ("South Carolina DHHS"). This contract related to South Carolina's SPAP and was due to expire December 31, 2010. However, South Carolina suspended funding for its SPAP program and South Carolina DHHS terminated all of its contracts with SPAP service providers as of June 30, 2010, including its contract with WellCare Rx.
- Meridian Health Plan of Iowa, Inc., received a without-cause termination notice from Iowa effective 12/31/2015, six months ahead of schedule, to facilitate transition from a voluntary to a mandatory competitive program.
- Anticipating significant growth in other markets, Meridian Health Plan of New Hampshire, Inc. d/b/a Granite Care sought and obtained a mutual, without-cause termination of its New Hampshire contract effective July 2014. Meridian worked amicably with the New Hampshire Department of Health and Human Services to complete all outstanding operational needs and ease member transition to the remaining managed care plans in the state.
- In 2016, the Medicaid Managed Care contract between the Michigan Department of Health and Human Services and Meridian Health Plan of Michigan, Inc. was replaced with re-procured contract effective 1/1/2016. There was no interruption in service.
- The Illinois Department of Healthcare and Family Services re-procured its entire managed care program in 2017. Meridian Health Plan of Illinois, Inc. was awarded a contract under the new program and its previous contracts for the Integrated Care Program, FHP/ACA population, and Managed Long-Term Services and Supports were retired.
- Meridian Health Plan of Illinois, Inc. additionally absorbed the membership and operations of Harmony Health Plan, Inc. (Harmony), following the acquisition of Meridian's parent entity by WellCare Health Plans, Inc. Harmony's HealthChoice contract was terminated effective December 31, 2018 when membership migrated to the Meridian platform. Harmony's previous managed care contracts retired into the HealthChoice contract following the 2017 reprocurement described above.
- The Centers for Medicare & Medicaid Services terminates Medicare Advantage plans whose enrollment falls below a certain threshold. CMS terminated a special needs plan for dual-eligibles ("DSNP") operated by WellCare of New York due to low enrollment as of December 31, 2013. As a result, the associated Medicaid Advantage Plus contract between the New York State Department of Health and WCNY, which governed the Medicaid portion of the benefits for the members of the DSNP, automatically terminated as of the same date.

- Windsor Health Plan, Inc., CMS, and WellCare of South Carolina, Inc. executed a novation, effective 1/1/16, transferring all rights and obligations under the existing Dual Eligible Special Needs Plan (DSNP) contract from Windsor Health Plan, Inc. to WellCare of South Carolina, Inc. upon the acquisition of Windsor by WellCare.
- WellCare of Florida, Inc. exited the Florida Nursing Home Diversion Program on August 31, 2013 due to a mutual non-renewal of its contract with the Department of Elder Affairs (DOEA). After discussions with the state, WellCare exercised the non-renewal option in its contract when the program was moved out of DOEA and into another state agency, the Agency for Health Care Administration (AHCA) under the newly organized MLTC Long-Term Care Program. This was not performance-based, and was a mutually discussed and agreed-upon non-renewal. DOEA sent a letter confirming this to WellCare of Florida, specifically noting that the non-renewal was not viewed as a termination.

CENTENE CORPORATION CONTRACT TERMINATIONS AND NONRENEWALS

Within the past ten years Centene Corporation's Medicaid managed care subsidiaries have not had a contract partially or fully terminated before the contract end date, have not had a contract not renewed, have not withdrawn from a contracted service area, or had a reduction of enrollment levels imposed. The following contract information pertains to voluntary termination.

- Kentucky Spirit Health Plan, Inc. (KSHP). In October 2012, KSHP, a Centene subsidiary, notified the Commonwealth of Kentucky (the Commonwealth) that KSHP would exercise a contractual right that it in good faith believed allowed for termination of its Medicaid managed care contract with the Commonwealth effective July 5, 2013. The Commonwealth disputed KSHP’s legal position and litigation ensued. On November 3, 2016, all parties entered into a settlement agreement with respect total pending litigation under which Kentucky Spirit received an immaterial cash payment from the Commonwealth's actuarial firm and each party dismissed all claims related to the litigation with prejudice. In addition, the Commonwealth and Kentucky Spirit agreed that neither party acted in bad faith; that the parties took reasonable positions in light of the applicable contractual language; and that the parties acted in good faith in attempting to address a difficult situation.

B.2 Corporate Information

- Attachment B.2.a.i -1 Centene Business Locations and PO Boxes
- Attachment B.2.b.ii-1 Org Chart
- Attachment B.2.b.ii-2 WHICKY-CHMI Management Service Agreement (Provided Electronically)
- Attachment B.2.b.ii-3 Amended Management Service Agreement
- Attachment B.2.b.ii-4 Income Tax Allocation Agreement
- Attachment B.2.b.ii-5 Joint Enterprise Agreement (Provided Electronically)
- Attachment B.2.b.iii-1 WHICKY Articles of Incorporation
- Attachment B.2.b.iii-2 WHICKY Bylaws (Provided Electronically)
- Attachment B.2.b.iii-3 WHP Articles
- Attachment B.2.b.iii-4 WHP Bylaws (Provided Electronically)
- Attachment B.2.b.iii-5 WCGHM Articles
- Attachment B.2.b.iii-6 WCGHM Bylaws (Provided Electronically)
- Attachment B.2.b.iii-7 TWMG Articles
- Attachment B.2.b.iii-8 TWMG Bylaws (Provided Electronically)
- Attachment B.2.b.iii-9 Centene Articles (Provided Electronically)
- Attachment B.2.b.iii-10 Centene Bylaws (Provided Electronically)
- Attachment B.2.b.iii-11 BlackRock Articles 1 (Provided Electronically)
- Attachment B.2.b.iii-12 BlackRock Articles 2
- Attachment B.2.b.iii-13 BlackRock Bylaws (Provided Electronically)
- Attachment B.2.b.iii-14 TRowePrice Articles (Provided Electronically)
- Attachment B.2.b.iii-15 TRowePrice Bylaws (Provided Electronically)
- Attachment B.2.b.iv-1 Certificate of Authority
- Attachment B.2.b.iv-2 NAIC 213 WHICKY - Q3 2019 (Provided Electronically)
- Attachment B.2.b.iv-3 NAIC 213 WHICKY - Q2 2019 (Provided Electronically)
- Attachment B.2.b.iv-4 NAIC 213 WHICKY - Q1 2019 (Provided Electronically)
- Attachment B.2.b.iv-5 NAIC 213 WHICKY - 2018 Annual Statement (Provided Electronically)
- Attachment B.2.b.iv-6 Q2 2019 Prompt Pay Report 53
- Attachment B.2.b.iv-7 Q1 2019 Prompt Pay Report 53
- Attachment B.2.b.iv-8 Q1 2019 Supplemental Report
- Attachment B.2.b.iv-9 Q4 2018 Prompt Pay 53
- Attachment B.2.b.iv-10 Q4 2018 Supplemental Report
- Attachment B.2.b.iv-11 Q3 2018 Report 53
- Attachment B.2.b.iv-12 Q3 2018 Report 53 Supplemental
- Attachment B.2.b.iv-13 Q2 2018 Prompt Pay Report
- Attachment B.2.b.iv-14 Q2 2018 Supplemental Report
- Attachment B.2.c-1 WellCare of Kentucky, Inc - Financial Stmt (Provided Electronically)
- Attachment B.2.c-2 WellCare of KY Internal Control Letter – 2018
- Attachment B.2.c Subcontractor Financial Statements (Provided Electronically)
- Attachment B.2.d.i Centene Litigation
- Attachment B.2.d.ii Centene Sanctions
- Attachment B.2.d.iii Centene SEC Filings

The table below represents Centene's business addresses and PO boxes.

CENTENE'S BUSINESS ADDRESSES

Entity Name	Address 1, Address 2, City, State, Zip Code
Health Net Federal Services	302 Cushman Street, Block 48 B Fairbanks Townsite, Fairbanks, AK, 99701
Health Net Federal Services	880 H Street, Anchorage, AK, 99501
Arkansas Health & Wellness, Arkansas Total Care	One Allied Drive, Building 1 and 2, Little Rock, AR, 72202
Arkansas Health & Wellness, Arkansas Total Care	1001 Technology Drive, Little Rock, AR, 72223
Arkansas Health & Wellness, Arkansas Total Care	19 Remington College Road, Little Rock, AR, 72204
Arkansas Health & Wellness, Arkansas Total Care	One Allied Drive, Building 5, Little Rock, AR, 72207
U.S. Medical Management	One South Church Avenue, Tucson, AZ, 85701
Centene Management Corporation	155 N. Rosemont Blvd., Tucson, AZ, 85711-3131
Centene Management Corporation	1665 West Alameda Drive, The Alameda, Tempe, AZ, 85282
Centene Management Corporation	1870 W. Rio Salado Parkway, Liberty Center at Rio Salado, Tempe, AZ, 85281
Envolve People Care	1876 E. Sabin Drive, Suite C, Casa Grande Professional Offices - Building C, Casa Grande, AZ, 85122
Envolve People Care	2285 S. 4th Ave., Peterson Office Complex, Yuma, AZ, 85364
Envolve People Care	2802 E. District Street, Tucson, AZ, 85714
Envolve People Care	333 E. Wetmore, Tucson, AZ, 85705
U.S. Medical ManagemenT	3420 E. Shea Blvd., Phoenix, AZ, 85028-3345
Centene Management Corporation	5255 E. Williams Circle, Williams Centre, Tucson, AZ, 85711
Centene Management Corporation	6221 South Palo Verde Road, Industrial Center, Tucson, AZ, 85706
U.S. Medical Management	7600 N. 15th Street, Plaza Squaw Peak, Phoenix, AZ, 85020-4327
Arizona Complete Health	956 E. Fry Blvd. Seventh Street Market, Sierra Vista, AZ, 85635
Health Net of California	101 North Brand Blvd. Glendale City Center, Glendale, CA, 91203
Health Net Federal Services	1050 Los Vallecitos Blvd., San Marcos, CA, 92069
Health Net Federal Services	10540 White Rock Road, Rancho Cordova, CA, 95670
Centene Management Corporation	10730 International Drive, Rancho Cordova, CA, 95670
Health Net Pharmaceutical Services	10734 International Drive, Rancho Cordova, CA, 95670
Centene Management Corporation	10811 International Drive, Rancho Cordova, CA, 95670
Health Net of California	11031 Sun Center Drive, Rancho Cordova, CA, 95670
Health Net of California	1111 Broadway, Oakland, CA, 94607

Entity Name	Address 1, Address 2, City, State, Zip Code
Health Net Federal Services	11299 San Pablo Ave, Del Norte Plaza Shopping Center, El Cerrito, CA, 94530-2166
Health Net	11931 Foundation Place, Gold Pointe Corporate Center, Rancho Cordova, CA, 95670-4502
Health Net	11971 Foundation Place, Gold Pointe Corporate Center, Rancho Cordova, CA, 95670-4502
Health Net	12009 Foundation Place, Rancho Cordova, CA, 95670
Health Net of California	1201 K Street, Sacramento, CA, 95814-3918
Health Net	12033 Foundation Place, Gold Pointe Office Park, Rancho Cordova, CA, 95670
MHM	155 Glen Cove Marina Road, Vallejo, CA, 94591
MHM	1576 Laurel Lane, San Luis Obispo, CA, 93401-4634
California Health & Wellness	1671 Main Street, El Centro, CA, 92243
California Health & Wellness	1699 West Main Street, El Centro, CA, 92243
California Health & Wellness	1700 Standiford Ave , Modesto, CA, 95350-6534
California Health & Wellness	1737 N. First St., First American Plaza, San Jose, CA, 95112-4510
California Health & Wellness	1740 & 1760 Creekside Oaks Drive, Sacramento, CA, 95833
Health Net Federal Services	1941 O'Farrell St., San Mateo, CA, 94403-1340
MHM	1957 Parkside Dr, Concord, CA, 94519
Health Net Federal Services	2025 Aerojet Road, Easton Place, Rancho Cordova, CA, 95742-6418
Health Net	20559 Prairie Street, Chatsworth, CA, 91311-6007
Health Net of California	2121 N Dinuba Blvd, Northside Shopping Center, Visalia, CA, 93291
Health Net	21250 Califa Street, Woodland Hills, CA, 91367
Health Net of California	21271 & 21281 Burbank Blvd, Woodland Hills, CA, 91367
Health Net Federal Services	2260 Floyd Avenue, Modesto, CA, 95355
MHM	230 Station Way, Arroyo Grande, CA, 93420
Health Net	2370 Kerner Blvd., San Rafael, CA, 94901
MHM	2380 Professional Drive, Santa Rosa, CA, 95403
MHM	2594 Anchor Ave, Port Hueneme, CA, 93041-1148
Health Net Federal Services	2600 Stanwell Drive, Concord, CA, 94520-4863
MHM	2679 11th St, Riverside, CA, 92507-5036
Health Net	2700 Mercantile Dr., Rancho Cordova, CA, 95742-7211
Health Net Federal Services	2847B Whipple Road, Whipple Business Center, Union City, CA, 94587
Health Net Federal Services	2868 Prospect Park Drive, Rancho Cordova, CA, 95670-6020
MHM	3007 Saviers Road, Oxnard, CA, 93033

Entity Name	Address 1, Address 2, City, State, Zip Code
Health Net Federal Services	3131 Camino del Rio North, Centerside II, San Diego, CA, 92108
Acaria Health	3302 Garfield Ave, Garfield Business Center, Commerce, CA, 90040
MHM	350 Brannan Street, San Francisco, CA, 94107
Health Net of California	3725 Marysville Boulevard, Sacramento, CA, 95838
MHM	4 Lobos Street, San Francisco, CA, 94112-3020
Centene Management Corporation	4201 E. Commerce Way, Sacramento, CA, 95834
Centene Management Corporation	4201 Natomas Crossing - Quad B, North Natomas, Sacramento, CA, 95834
Acaria Health	4225 Northgate Blvd., Northgate Business Park, Sacramento, CA, 95834
Health Net of California	5047 Whittier Blvd, Los Angeles, CA, 90022-3116
MHM	505 North Arrowhead Avenue, San Bernardino, CA, 92401
Health Net of California	560 N. Arrowhead Ave., San Bernardino, CA, 92401
US Script	5, 7 and 9 River Park Place East, Fresno County, River Park Corporate Center, Fresno, CA, 93710
Health Net of California	6013-1 Niles Street, Niles Center, Bakersfield, CA, 93306-4696
MHM	6041 N. First Street, Fresno, CA, 93710
MHN, a Health Net Company	6261 Katella Avenue, Cypress, CA, 90630-5249
Health Net of California	650 E Hospitality Lane, San Bernardino, CA, 92408
Health Net Federal Services	675 Hegenberger Rd, Oakland, CA, 94621
Health Net of California	678 N. Wilson Way, Eastland Plaza Shopping Center, Stockton, CA, 95205
MHM	687 Keith St, San Francisco, CA, 94124-1708
Health Net Federal Services	7375 Amador Valley Blvd, Dublin, CA, 94568-2402
Health Net of California	7625 N. Palm Ave., Fresno, CA, 93711-5787
Health Net of California	7755 Center Avenue, One Pacific Plaza, Huntington Beach, CA, 92647
MHM	812 Stella Ave, Vallejo, CA, 94589
Health Net of California	900 E. Hamilton, Campbell, CA, 95008
California Health & Wellness	901 Bruce Road, WatersEdge Office Building, Chico, CA, 95928
Interpreta	9255 Towne Centre Drive, La Jolla Center, San Diego, CA, 92121
Centene Corp.	7711 Carondelet Ave., Centene Place, Clayton, MO, 63105
Centene Corp.	7700 Forsyth Blvd., Centene Plaza, Clayton, MO, 63105
Centene Corp.	7676 Forsyth Blvd., Centene Centre, Clayton, MO, 63105
HealthSmart	10303 East Dry Creek Road, Englewood, CO, 80112
Health Net Federal Services	1125 Kelly Johnson Boulevard, Chapel Hills Atrium, Colorado Springs, CO, 80920
MHM	101 Elizabeth St, Derby, CT, 06418
MHM	135 Cherry Street, Milford, CT, 06460

Entity Name	Address 1, Address 2, City, State, Zip Code
MHM	16 River Street, Norwalk, CT, 06850
Envolve People Care	20 Batterson Park Road, Farmington, CT, 06032-4502
MHM	414 Chapel Street, New Haven, CT, 06511
MHM	69 Jefferson Street, Stamford, CT, 06902
Centene Corp.	1150 Connecticut Avenue, NW, Washington, DC, 20036
Centene Corp.	1441 L Street NW, Spaces Thomas Circle, Washington, DC, 20005
Centurion	1203 Governors Square Boulevard, Tallahassee, FL, 32301
Access Medical Group Perrine	12314-12396 Quail Roost Drive, Miami, FL, 33177
Sunshine Health	1301 International Parkway, Sunrise, FL, 33323
Community Medical Group	1415 South Collins Street, Plant City, FL, 33566
Community Medical Group	14223 SW 42 Street, Unit 27, Miami, FL, 33175
Community Medical Group	14285 SW 42 Street, Miami, FL, 33175
Community Medical Group	1490 NW 27th Ave, Miami, FL, 33125
Sunshine Health	1550 Sawgrass Corporate Parkway, 1550 Sawgrass Centre, Sunrise, FL, 33323
Sunshine Health	1560 Sawgrass Corporate Parkway, 1560 Sawgrass Centre, Sunrise, FL, 33323
Community Medical Group	1621-27, 31 & 07 SW 107th Ave, Miami, FL, 33131
Sunshine Health	1700 N. University Dr., Plantation Pointe Office Park, Plantation, FL, 33322
U.S. Medical Management	1776 North Pine Island Road, Bank of America Plaza, Plantation, FL, 33322
Community Medical Group	20001-20241 SW 127th Ave, Miami, FL, 33177
Sunshine Health	215 South Monroe Street, South Monroe Street Building, Tallahassee, FL, 32301
U.S. Medical Management	2600 Lake Lucien Drive, Maitland, FL, 32751-7233
Sunshine Health	30 & 70 S Keller Rd., Reserve at Maitland, Orlando, FL, 32810
Centurion	3200 SW 34th Ave, Paddock Park Professional Center, Building 700, Ocala, FL, 34474
Community Medical Group	321 Opa Locka Blvd, Opa Locka, FL, 33045
Community Medical Group	348 Havendale Boulevard, Havendale Square II, Auburndale, FL, 33823-4514
Community Medical Group	3805 W 20th Ave, Westland Promenade, Hialeah, FL, 33012
Community Medical Group	3978 West Hillsborough Avenue, Horizon Park Shopping Center, Tampa, FL, 33614
U.S. Medical Management	4348 Southpoint Blvd, Evergreen Building, Jacksonville, FL, 32216

Entity Name	Address 1, Address 2, City, State, Zip Code
Sunshine Health	4900 Bayou Blvd., Bayou Corporate Center, Pensacola, FL, 32503
Sunshine Health	495 N. Keller Road, Maitland, FL, 32751
Community Medical Group	5130 Sunforest Drive, Sunforest I, Tampa, FL, 33634
Sunshine Health	5210 Belfort Road, The Concourse II, Jacksonville, FL, 32256
HealthSmart	5405 Cypress Center Drive, Cypress Center III, Tampa, FL, 33609
Community Medical Group	5615 S. Florida Ave, Maryoma Plaza, Lakeland, FL, 33813-2710
Health Net Federal Services	5701 E. Hillsborough Avenue, Tampa, FL, 33610
Community Medical Group	6100 Waterford at Blue Lagoon, 6100 Blue Lagoon Drive, Miami, FL, 33126
U.S. Medical Management	6151 Lake Worth Road, Greenacres, FL, 33463-3074
Acaria Health	6923 Lee Vista Boulevard, Lee Vista Building II, Orlando, FL, 32822
Community Medical Group	7320 NW 12th Street, Miami, FL, 33126-1912
Community Medical Group	743 NE 167th St, North Miami Beach, FL, 33162
Community Medical Group	751 & 745 West Palm Drive, Florida City, FL, 33034
U.S. Medical Management	8333 N.W. 53rd Street, Doral, FL, 33166-4783
Centene Management Corporation	8427 South Park Circle, 300 Southpark Center, Orlando, FL, 32819
Centene Management Corporation	8517 South Park Circle, 200 Southpark Center, Orlando, FL, 32819
U.S. Medical Management	8600 N.W. 36th Street, Offices at Doral Square, Miami, FL, 33166
U.S. Medical Management	8600 Hidden River Parkway, Palm Court at Hidden River, Tampa, FL, 33637
U.S. Medical Management	941 West Morse Blvd., Heritage Park, Winter Park, FL, 32789
Community Medical Group	9748, 9750, 9752, 9760 & 9762 SW 24th Street, Miami, FL, 33165
Peach State Health	1100 Circle 75 Parkway, Atlanta, GA, 30339
MHM	1447 Peachtree Street, Silhouette Midtown, Atlanta, GA, 30309
MHM	1745 Phoenix Blvd, Two Crown, Atlanta, GA, 30349
Peach State Health	2810 Meredyth Drive, Albany, GA, 31707
Acaria Health	3021 Sandy Parkway, Building #2, Columbus, GA, 31909
Peach State Health	577 Mulberry Street, Macon, GA, 31201
Centene Corp.	5909 Peachtree Dunwoody Road, Palisades Office Park, Atlanta, GA, 30328
Health Net Federal Services	820 Mililani Street, Honolulu, HI, 96813
Iowa Total Care	1080 Jordan Creek Parkway, Westfield Office Building, West Des Moines, IA, 50266

Entity Name	Address 1, Address 2, City, State, Zip Code
Iowa Total Care	4900 University Avenue, Palisade Office Building, West Des Moines, IA, 50266-6775
U.S. Medical Management	1000 Burr Ridge Parkway, Burr Ridge, IL, 60527-0849
Centene Management Corporation	1175 E. Main St., University Mall, Carbondale, IL, 62901
Illinicare	1255 Bond St., Naperville, IL, 60563
U.S. Medical Management	1333 Burr Ridge Parkway, Village Center, Burr Ridge, IL, 60527
U.S. Medical Management	2 TransAm Plaza Drive, Two TransAm Plaza, Oak Brook Terrace, IL, 60181
Centene Corp.	200 East Randolph Street, Aon Center, Chicago, IL, 60601
Illinicare	345 Executive Parkway, 345 Executive, Rockford, IL, 61107
Ambetter	77 West Wacker Drive, Chicago, IL, 60601
Illinicare	999 Oakmont Plaza Drive, One Oakmont Plaza, Westmont, IL, 60559
MHS Indiana	2601 Metropolis Parkway, Plainfield, IN, 46168
MHS Indiana	3500 Coliseum Blvd. East Suite 110, Executive Center at the Woods Building #2, Fort Wayne, IN, 46805
MHS Indiana	550 N. Meridian Street, Indianapolis, IN, 46204
U.S. Medical Management	55609 Currant Road, Mishawaka, IN, 46545-4801
U.S. Medical Management	5838 West Brick Road, South Bend, IN, 46628
MHS Indiana	5920 Castleway West Drive, Indianapolis, IN, 46250
MHS Indiana	8585 Broadway, Merrillville, IN, 46410
U.S. Medical Management	9001 N Wesleyan Road, Parkstone Office Center, Indianapolis, IN, 46268
U.S. Medical Management	9100 Purdue Road, Parkstone II, Indianapolis, IN, 46268
Acaria Health	10409 W. 84th Terrace, Pine Ridge Business Park, Lenexa, KS, 66214
Sunflower Health Plan	2024 N. Woodlawn St., One Brittany Place, Wichita, KS, 67208
Sunflower Health Plan	515 S. Kansas, Topeka, KS, 66603
Centene Corp.	801 E. Douglas Avenue, Grand Hotel at Union Station, Wichita, KS, 67202
Sunflower Health Plan	8325 Lenexa Drive, Four Pine Ridge Plaza Building, Lenexa, KS, 66214
Sunflower Health Plan	900 S. Kansas Ave., Topeka, KS, 66612
U.S. Medical Management	9393 West 110th St., 51 Corporate Woods, Overland Park, KS, 66210
Centene Corp.	Akaria Plaza, North Wing, Gate D, Olaya Street, Riyadh, 1148
HealthSmart	220 Lexington Green Circle, Lexington, KY, 40503
Louisiana Healthcare Connections	144 New Camellia Blvd, Covington, LA, 70433

Entity Name	Address 1, Address 2, City, State, Zip Code
Acaria Health	1736 Gause Boulevard East, Camellia Shopping Center, Slidell, LA, 70461
Envolve People Carer	2900 Westfork Dr., Baton Rouge, LA, 70827
Louisiana Healthcare Connections	3854 American Way, Baton Rouge, LA, 70816
Louisiana Healthcare Connections	825 Kaliste Saloom Road, Brandywine I and II Office Complex, Lafayette, LA, 70508
Louisiana Healthcare Connections	8585 Archives Blvd, Twelve United Plaza, Baton Rouge, LA, 70809
Louisiana Healthcare Connections	880 W. Commerce Rd., New Orleans, LA, 70123
Acaria Health	260-E Fordham Road, Wilmington, MA, 01887
Casenet	34 Crosby Drive, Bedford, MA, 01730
Casenet	36 Crosby Drive, Crosby Corporate Center, Bedford, MA, 01730
Envolve MSO	1201 Winterson Road, Linthicum, MD, 21090
MHM	3104 Lord Baltimore Drive, Baltimore, MD, 21244
LiveHealthier Inc	7735 Old Georgetown Rd., The Fairmont Building, Bethesda, MD, 20814
Michican Complete Health	115 W. Allegan St., Suite 200, Lansing, MI, 48933
U.S. Medical Management	1315 Gratiot Blvd., Marysville, MI, 48040-1134
U.S. Medical Management	1484 Straits Drive, Mackinaw Commerce Center, Bay City, MI, 48706
U.S. Medical Management	1985 Gratiot Blvd, Marysville, MI, 48040
U.S. Medical Management	21540 W. 11 Mile Road, Southfield, MI, 48076-3843
U.S. Medical Management	2205 Jolly Road, Okemos, MI, 48864
U.S. Medical Management	2725 Airview Boulevard, Airview Center, Kalamazoo, MI, 49002
U.S. Medical Management	2755 Carpenter Road, Ann Arbor, MI, 48108
U.S. Medical Management	3081 Commerce Drive, Birchwood Office Park, Fort Gratiot, MI, 48059
U.S. Medical Management	3355 Eagle Park Drive N. E., Building F, Grand Rapids, MI, 49525
U.S. Medical Management	4444 West Bristol Rd, Bristol Office Park, Flint, MI, 48507
U.S. Medical Management	500 Kirts Blvd., Troy, MI, 48084
U.S. Medical Management	5111 East ML Avenue, Kalamazoo Commerce Park, Kalamazoo, MI, 49048
Michican Complete Health	800 Tower Drive, Troy, MI, 48098
Centurion	2277 Highway 36 West, Roseville, MN, 55113
Centene Management Corporation	1001 Highlands Plaza Drive West, St. Louis, MO, 63110
Centene Management Corporation	11720 Borman Drive, Woodlands Plaza I, St. Louis, MO, 63146

Entity Name	Address 1, Address 2, City, State, Zip Code
Crescent Condo/CC	121-187 Carondelet Plaza, The Crescent Condominium, Clayton, MO, 63105
Centene Management Corporation	1227-1243 Hanley Industrial Court, Brentwood, MO, 63144
Centene Management Corporation	12443 Olive Boulevard, Creve Coeur, MO, 63141
Centene Management Corporation	12800 Corporate Hill Drive, St. Louis, MO, 63131
Centene Corp.	1340 & 1350 Airpark Dr., Farmington East Industrial Park, Farmington, MO, 63640
Centene Management Corporation	1350 Timberlake Manor Parkway, Timberlake Corporate Center - Building III, Chesterfield, MO, 63017
Centene Management Corporation	1370 Timberlake Manor Parkway, Timberlake Corporate Center, Chesterfield, MO, 63017
Centene Management Corporation	1390 Timberlake Manor Parkway, Timberlake Corporate Center - Building I, Chesterfield, MO, 63017
Centene Corp.	16090 Swingley Ridge Road (Roosevelt Building), Chesterfield, MO, 63017
Centene Corp.	220 Madison Street, Jefferson City, MO, 65101
Centene Management Corporation	2900 Pershall Road, Ferguson, MO, 63136
Centene Management Corporation	3271 E. Battlefield Road, Springfield, MO, 65804
Centene Corp.	400 S. Woods Mill Road, Woodsmill Commons II, Chesterfield, MO, 63017
Foundation Care	4010 Wedgeway Court, Earth City, MO, 63045
U.S. Medical Management	4150 North Mulberry Drive, Briarcliff III Office Building, Kansas City, MO, 64116
Centene Management Corporation	424 S. Woods Mill Road, Woodsmill Commons I, Chesterfield, MO, 63017
Centene Management Corporation	4240 Duncan Avenue, St. Louis, MO, 63110
Centene Management Corporation	4721 S. Cliff Avenue, Cliffview Professional Building, Independence, MO, 64055-7016
Centene Management Corporation	5995 N. McDonnell Blvd., Berkeley, MO, 63134
Centene Corp.	6430 Weldon Spring Rd, O'Fallon, MO, 63368
Centene Corp.	7501 Maryland Avenue, Clayton, MO, 63105
Centene Management Corporation	7701 Forsyth Blvd., Pierre Laclede Center, St. Louis, MO, 63105
Centene Management Corporation	7733 Forsyth Boulevard, Pierre Laclede Center, Clayton, MO, 63105
Centene Management Corporation	7733 Carondelet Ave, St Louis, MO, 63105
Centene Management Corporation	7930 Clayton Road, Clayton Executive Center I, Richmond Heights, MO, 63117
U.S. Medical Management	8706 Manchester Road, Manchester Office Building, Brentwood, MO, 63144
U.S. Medical Management	8710 Manchester Road, Manchester Office Building, Brentwood, MO, 63144

Entity Name	Address 1, Address 2, City, State, Zip Code
Magnolia Health	111 East Capitol Street, Jackson, MS, 39201
Magnolia Health	2148 W. Jackson Ave., Oakwood Plaza Shopping Center, Oxford, MS, 38655
Centene Corp.	2000 26th Street South, Great Falls, MT, 59405-5116
Centene Management Corporation	10101 David Taylor Drive, David Taylor Corporate Center, Charlotte, NC, 28262
Centene Management Corporation	1118 Falls Road, Rocky Mount, NC, 27804
Centene Management Corporation	1151 Falls Road, Rocky Mount Mill, Rocky Mount, NC, 27804
Centene Management Corporation	1422 S. Tryon Street, Charlotte, NC, 28203
Centene Management Corporation	1985 Eastwood Road, Landfall Park North, Wilmington, NC, 28403
Envolve Vision	3120 Highwoods Boulevard, The Arbors, Raleigh, NC, 27604
Centene Management Corporation	4309 Emperor Blvd, Winchester Place, Durham, NC, 27703
Acaria Health	7231 ACC Boulevard, Raleigh, NC, 27617
Nebraska Total Care	233 South 13th Street, US Bank Building, Lincoln, NE, 68508
Nebraska Total Care	2525 N. 117th Ave., Omaha, NE, 68164-3679
New Hampshire Healthy Families	2 Executive Park Drive, Bedford Executive Park, Bedford, NH, 03110
Western Sky Community Care	2945 Rodeo Park Drive East, Santa Fe, NM, 87505
Western Sky Community Care	5300 Homestead NE, Albuquerque, NM, 87110
MHM	123 W Nye Ln, Carson City, NV, 89706-0899
Silversummit Health Plan	2500 North Buffalo Drive, Las Vegas, NV, 89128
Silversummit Health Plan	6100 Neil Road, Sierra Plaza (GOB), Reno, NV, 89511
Fidelis	10 British American Boulevard, Airport Park, Latham, NY, 12110
Fidelis	100-102 Post Avenue, New York, NY, 10034
Fidelis	100 Willowbrook, Fairport, NY, 14450
Fidelis	101 E Main Street, Gouverneur, NY, 13642
Fidelis	105 CrossPoint Parkway, CrossPoint Business Park, Amherst, NY, 14068-1603
CNC	110 East 55th Street, New York, NY, 10022
Fidelis	121 East Elm Street, Penn Yan, NY, 14527
Fidelis	146-01 Jamaica Avenue, Jamaica, NY, 11435
Fidelis	1656-G Fifth Avenue, Bayshore, NY, 11706

Entity Name	Address 1, Address 2, City, State, Zip Code
Fidelis	1674 Putnam Ave, Ridgewood, NY, 11385
Fidelis	1686 Forest Avenue, Staten Island, NY, 10302
Fidelis	175 Route 59, Spring Valley, NY, 10977-5231
Fidelis	180 Post Avenue, Westbury, NY, 11590
Fidelis	185 Canal Street, Manhattan, NY, 10013
Fidelis	1909 Pine Ave, Niagara Falls, NY, 14301
Fidelis	209 Elizabeth Street, Utica, NY, 13501
Fidelis	2133 86th Street, 2127-2145 86th Street, Brooklyn, NY, 11214-3205
Fidelis	232 D East Main St, Patchogue, NY, 11772
Fidelis	232 Main Street, Catholic Charities of Broome County, Binghamton, NY, 13905-2610
Fidelis	23 Chapman Avenue, Auburn, NY, 13021
Fidelis	23 Liberty St, Bath, NY, 14810
Fidelis	25 Market Street, Poughkeepsie, NY, 12601
Fidelis	25-01 Jackson Avenue, One Court Square, Long Island City, NY, 11101-5095
Fidelis	27-01 Bridge Plaza North, 27-01 Queens Plaza North, Long Island City, NY, 11101
Fidelis	2736 NY 30, The Paul Nigra Center for Performing Arts, Gloversville, NY, 12037
Fidelis	28 East Main Street, First Federal Plaza, Rochester, NY, 146014
HealthSmart	2929 Expressway Drive North, Hauppauge, NY, 11749-5306
Fidelis	31 British American Blvd, Airport Park, Latham, NY, 12110-1405
Fidelis	323 Owego St, Montour, NY, 14865-9625
Fidelis	36-36 Main Street, Flushing, NY, 11354
Fidelis	3920 Main Street, Buffalo, NY, 14226
Fidelis	4 East Third Street, Jamestown, NY, 14701
Fidelis	400 Rella Boulevard, Montebello, NY, 10901
Fidelis	402 Main Street, Dunkirk, NY, 14048

Entity Name	Address 1, Address 2, City, State, Zip Code
Fidelis	403 Main Street, Buffalo, NY, 14203
Fidelis	419-B South Broadway, 413-421 South Broadway, Yonkers, NY, 10705
Fidelis	4470 Bayview Road, Hamburg, NY, 14075
Fidelis	480 CrossPoint Parkway, CrossPoint Business Park, Getzville, NY, 14068
Fidelis	490 Crosspoint Parkway, Getzville, NY, 14068
Fidelis	5 Catherine St., Schenectady, NY, 12307
Fidelis	5010 Campuswood Drive, Pioneer Business Park, Dewitt, NY, 13057
Fidelis	5708 7th Ave., Trahall Plaza Condominium, Brooklyn, NY, 11220
Fidelis	59-17 Junction Blvd, Elmhurst, NY, 11373
Acaria Health	5 Skyline Drive, Hawthorne, NY, 10532
Fidelis	64 East Main Street, Springville, NY, 14141
Fidelis	76-02 Woodhaven Blvd, Glendale, NY, 11385-7948
Fidelis	777 Clifford Avenue, Rochester, NY, 14621-5771
Fidelis	815 E Tremont Ave, Bronx, NY, 10460
Fidelis	95-25 Queens Blvd, Queens Office Tower, Rego Park, NY, 11374
Fidelis	97-77 Queens Blvd, Rego Park, NY, 11374
Fidelis	997 Central Ave, Albany, NY, 12205
U.S. Medical Management	16600 Sprague Road, Interstate Plaza, Middleburg Heights, OH, 44130
Buckeye	1705 Indian Wood Circle, Maumee, OH, 43537
USMM	1900 Indian Wood Circle, Maumee, OH, 43537
U.S. Medical Management	1911 Indian Wood Circle, Maumee, OH, 43537
U.S. Medical Management	2024 Zettler Road, Columbus, OH, 43213
U.S. Medical Management	3033 Kettering Blvd., Point West II, Moraine, OH, 45439
U.S. Medical Management	3033 Kettering Blvd., Point West II, Moraine, OH, 45439
HealthSmart	3320 West Market Street, Summit Park Square, Building A, Fairlawn, OH, 44333
U.S. Medical Management	3515 Massillon Road, Akron/Canton Corporate Center II, Uniontown, OH, 44685
U.S. Medical Management	355 East Campus View Blvd., Crossgate Office Center, Columbus, OH, 43235

Entity Name	Address 1, Address 2, City, State, Zip Code
Buckeye Community Health Plan	3700 Embassy Parkway, Fairlawn, OH, 44333
Buckeye Community Health Plan	4249 Easton Way, Easton Way Three, Columbus, OH, 43219
Buckeye Community Health Plan	4349 Easton Way, Easton Way Two, Columbus, OH, 43219
U.S. Medical Management	4435 Aicholtz Road, Eastgate Professional Office Park, Cincinnati, OH, 45245
Buckeye Community Health Plan	4665 Cornell Dr., Fountain Pointe I, Cincinnati, OH, 45241
U.S. Medical Management	4850 Smith Road, Central Parke Business Park, Cincinnati, OH, 45212
U.S. Medical Management	7206 Market Street, Odessey Plaza, Boardman, OH, 44512
U.S. Medical Management	7314 Industrial Parkway, Mentor, OH, 44060
U.S. Medical Management	7334 Industrial Parkway, Mentor, OH, 44060
U.S. Medical Management	7350 Industrial Parkway, Mentor, OH, 44060
U.S. Medical Management	7686 St. Clair Ave., Mentor, OH, 44060
HealthSmart	81 Mill Street, Gahanna, OH, 43230
U.S. Medical Management	9799F Princeton Glendale Road, Dues Park, Cincinnati, OH, 45246-1039
HealthSmart	7725 W. Reno Avenue, 7725 Connect, Oklahoma City, OK, 73127-9711
Trillium Community Health Plan	1200 Executive Parkway, Eugene, OR, 97401
Health Net of Oregon	13221 SW 68th Parkway, Tigard, OR, 97223
Trillium Community Health Plan	1776 Millrace Drive, ORI Building, Eugene, OR, 97403
Trillium Community Health Plan	1800 Millrace Drive, University of Oregon Research Park, Eugene, OR, 97403
Trillium Community Health Plan	555 International Way, Building B, Springfield, OR, 97477
Health Net Federal Services	1 Pasquerilla Plaza, Johnstown, PA, 15901
Pennsylvania Health & Wellness	1500 Spring Garden Street, Philadelphia, PA, 19130
HealthSmart	2000 Park Place Drive, Washington, PA, 15301-2063
Pennsylvania Health & Wellness	2101 Peninsula Dr, Erie, PA, 16506
Pennsylvania Health & Wellness	300 Corporate Center Drive, Camp Hill Corporate Center, Camp Hill, PA, 17011
Pennsylvania Health & Wellness	5 Penn Center West, Building 5, Pittsburgh, PA, 15276
Pennsylvania Health & Wellness	50 Glenmaura National Blvd., Glenmaura Plaza, Moosic, PA, 18507
Pennsylvania Health & Wellness	500 Avenue of the States, Chester, PA, 19013
Centene Corp.	, Altoona, PA,
Absolute Total Care	1441 Main St., Columbia, SC, 29201
Absolute Total Care	1901 Main Street, Bank of America Plaza, Columbia, SC, 29201
Absolute Total Care	4969 Centre Point Drive, North Charleston, SC, 29418
Primerosalud	C/Serrano, 45 Planta 2a, Madrid, Spain
Centene Management Corporation	200 Prosperity Place, Cedar Bluff, Knoxville, TN, 37923
Envolve People Care	209 10th Avenue South, Cummins Station, Nashville, TN, 37203

Entity Name	Address 1, Address 2, City, State, Zip Code
Centene Management Corporation	424 Church Street, Fifth Third Center, Nashville, TN, 37219
Centurion	53 Century Blvd., ste 150, Nashville, TN, 37219
Centene Management Corporation	9005 Overlook Blvd., Brentwood Center, Brentwood, TN, 37027
U.S. Medical Management	10117 Broadway Street, San Antonio, TX, 78217-4416
Centene Management Corporation	10130 Highway 151, One51 Office Centre, San Antonio, TX, 78251
Superior Health Plan	11700 Katy Freeway, Houston, TX, 77079
Centene Corp.	12515-8 Research Boulevard, Building II, Research Park Place, Austin, TX, 78759
U.S. Medical Management	1301 West 7th Street, Fort Worth, TX, 76102
Acaria Health	1311 West Sam Houston Parkway North, Houston, TX, 77043-4010
Nurse Response	1359 Lomaland Drive, El Paso, TX, 79905
Superior Health Plan	1575 N. Resler Suite A, El Paso, TX, 79912
Health Net Federal Services	1575 N. Resler Suite C, El Paso, TX, 79912
HealthSmart	1718 Dry Creek Way, San Antonio, TX, 78259-1836
HealthSmart	2002 West Loop 289, Wayland Plaza, Lubbock, TX, 79407
HealthSmart	222 West Las Colinas Boulevard, Urban Towers - North Tower, Irving, TX, 75039
U.S. Medical Management	2707 S Cooper St, Arlington, TX, 76015
Centene Corp.	3258 Earl Campbell Parkway, Tyler, TX, 75701
Superior Health Plan	3900 N 10th Street, BBVA Premier Office Tower, McAllen, TX, 78503
Envolve People Care	4000 & 4001 McEwen Road, Dallas, TX, 75244
U.S. Medical Management	4545 Fuller Drive, O'Conner Ridge, Irving, TX, 75038
U.S. Medical Management	4800 Fredericksburg Road, San Antonio, TX, 78229
U.S. Medical Management	4917 Ravenswood Drive, San Antonio, TX, 78227
U.S. Medical Management	5340 Prudence Dr, South Post Oak Industrial Center, Houston, TX, 77045
U.S. Medical Management	5402 South Staples, Corpus Christi, TX, 78411
Health Net	5525 North MacArthur Blvd., MacArthur Plaza, Irving, TX, 75038
Superior Health Plan	5900 E. Ben White Blvd., Austin, TX, 78741
HealthSmart	6303 Commerce Dr., Gateway West II, Irving, TX, 75063
U.S. Medical Management	7000 North Mopac Expressway, Plaza 7000, Austin, TX, 78731-3027
Superior Health Plan	711 N. Carancahua, American Bank Plaza, Corpus Christi, TX, 78401
Superior Health Plan	7202 Slide Road, Lubbock, TX, 79424
U.S. Medical Management	7322 Southwest Freeway, One Arena Place, Houston, TX, 77074
U.S. Medical Management	7800 Shoal Creek Boulevard, Exchange Park, Austin, TX, 78757
Superior Health Plan	7990 IH-10 West, The Forum II, San Antonio, TX, 78230

Entity Name	Address 1, Address 2, City, State, Zip Code
U.S. Medical Management	8588 Katy Freeway, West Memorial Park, Houston, TX, 77024
U.S. Medical Management	9705 Burnet Road, Austin, TX, 78758
Regus	77 New Cavendish Street, The Harley Building, London, W1W 6XB
MHM Services	1593-1595 Spring Hill Road, Vienna, VA, 22182
HealthSmart	191 Johnson Street, KVAT Campus Office Building, Abingdon, VA, 24210
U.S. Medical Management	2106 Aluminum Ave., Hampton, VA, 23661
Health Net Federal Services	2107 Wilson Blvd., Colonial Place III, Arlington, VA, 22201-3091
U.S. Medical Management	236 Clearfield Avenue, TRC Center II, Virginia Beach, VA, 23462-1893
U.S. Medical Management	263 McLaws Circle, The Atrium Building, Williamsburg, VA, 23185
Acaria Health	2924 Telestar Court, Falls Church, VA, 22042
Envolve	3100 Clarendon Blvd., Arlington, VA, 22201
U.S. Medical Management	7229 Forest Avenue, The Highland II Building, Richmond, VA, 23226
Casenet	1 Mill Street, Chace Mill, Burlington, VT, 05401
Centurion	5430 Waterbury Stowe Road, Waterbury Center, Waterbury, VT, 05677
Coordinated Care of WA	1014 Fifth Street, Wenatchee, WA, 98801
Coordinated Care of WA	1145 Broadway Plaza, Tacoma Financial Center, Tacoma, WA, 98402
Health Net Federal Services	1145 Broadway Plaza, Tacoma Financial Center, Tacoma, WA, 98402
Health Net of Oregon	16703 SE McGillivray Boulevard, Vancouver, WA, 98683
Coordinated Care of WA	3703 River Road, Yakima, WA, 98902
Coordinated Care of WA	600 University Street, One Union Square, Seattle, WA, 98101
U.S. Medical Management	606 Oakesdale Avenue SW, Oakesdale Center, Renton, WA, 98057
MHS Wisconsin	10700 West Research Drive, Mayfair Woods, Wauwatosa, WI, 53226
MHS Wisconsin	1903 Keith Street, Eau Claire, WI, 57041
U.S. Medical Management	2514 S. 102nd Street, Lincoln Center II, West Allis, WI, 53227
MHS Wisconsin	4321 West College Avenue, Appleton, WI, 54915
Centene Management Corporation (Regus)	500 W. Silver Spring Drive, Glendale, WI, 53217
U.S. Medical Management	5315 West Wall Street, 5315 Wall Street, Madison, WI, 53718
MHS Wisconsin	801 South 60th St., Renaissance Faire Condominium, West Allis, WI, 53214
MHS Wisconsin	9000 W. Chester, Milwaukee, WI, 53214
HealthSmart	602 Virginia Street, The Woodrum Building, Charleston, WV, 25301

CENTENE'S P.O. BOXES

Department	Box Number and Address
Claims	PO Box 6123 [R] FARMINGTON, MO 63640
Claims	PO Box 25408 [R] LITTLE ROCK, AR 72221
Behavioral Health Claims	PO Box 7001 [R] FARMINGTON, MO 63640
Claims	PO Box 4040 [R] FARMINGTON, MO 63640
Claims	PO Box 92050 [R] ELK GROVE VILLAGE, IL 60009
Claims	PO Box 25255 [R] TAMPA, FL 33622
Behavioral Health Claims	PO Box 6150 [R] FARMINGTON, MO 63640
Claims	PO Box 3000 [R] FARMINGTON, MO 63640
Claims	PO Box 3001 [R] FARMINGTON, MO 63640
Claims	PO Box 3003 [R] FARMINGTON, MO 63640
Claims	PO Box 3002 [R] FARMINGTON, MO 63640
Claims	PO Box 2010 [R] FARMINGTON, MO 63640
Claims	PO Box 20262 [R] TAMPA, FL 33622
Claims	PO Box 20654 [R] TAMPA, FL 33622
Claims	PO Box 22122 [R] TAMPA, FL 33622
Claims	PO Box 22687 [R] TAMPA, FL 33622
Claims	PO Box 25857 [R] TAMPA, FL 33622
Claims	PO Box 26564 [R] TAMPA, FL 33623
Claims	PO Box 74600 [R] CHICAGO, IL 60675
Claims	PO Box 6900 [R] FARMINGTON, MO 63640
Claims	PO Box 5030 [R] FARMINGTON, MO 63640
Refunds	PO Box 50815 [R] SAINT LOUIS, MO 63105
Refunds	PO Box 50816 [R] SAINT LOUIS, MO 63105
Claims	PO Box 3050 [R] FARMINGTON, MO 63640
Claims	PO Box 4020 [R] FARMINGTON, MO 63640
Claims	PO Box 7300 [R] FARMINGTON, MO 63640
Claims	PO Box 6500 [R] FARMINGTON, MO 63640
Claims	PO Box 6700 [R] FARMINGTON, MO 63640
Claims	PO Box 7200 [R] FARMINGTON, MO 63640
Claims	PO Box 3080 [R] FARMINGTON, MO 63640
Claims	PO Box 20565 [R] TAMPA, FL 33622
Claims	PO Box 25656 [R] TAMPA, FL 33622
Claims	PO Box 5090 [R] FARMINGTON, MO 63640
Claims	PO Box 5080 [R] FARMINGTON, MO 63640
Claims	PO Box 7400 [R] FARMINGTON, MO 63640
Claims	PO Box 4030 [R] FARMINGTON, MO 63640
Claims	PO Box 4050 [R] FARMINGTON, MO 63640
Claims	PO Box 4090 [R] FARMINGTON, MO 63640
Claims	PO Box 10500 [R] FARMINGTON, MO 63640

Department	Box Number and Address
Claims	PO Box 10600 [R] FARMINGTON, MO 63640
Claims	PO Box 10700 [R] FARMINGTON, MO 63640
Claims	PO Box 3030 [R] FARMINGTON, MO 63640
Claims	PO Box 5000 [R] FARMINGTON, MO 63640
Claims	PO Box 74008545 Chicago, IL 60674-8545
Claims	PO Box 20062 [R] TAMPA, FL 33622
Claims	PO Box 20132 [R] TAMPA, FL 33622
Claims	PO Box 20144 [R] TAMPA, FL 33622
Claims	PO Box 2030 [R] FARMINGTON, MO 63640
Claims	PO Box 2020 [R] FARMINGTON, MO 63640
Claims	PO Box 40320 [R] ROCHESTER, NY 14604
Claims	PO Box 1256 [R] TROY, MI 48099
Claims	PO Box 22377 [R] TAMPA, FL 33622
Dental Claims	PO Box 20847 [R] TAMPA, FL 33622
Claims	PO Box 7100 [R] FARMINGTON, MO 63640
Claims	PO Box 4001 [R] FARMINGTON, MO 63640
Claims	PO Box 3040 [R] FARMINGTON, MO 63640
Claims	PO Box 3070 [R] FARMINGTON, MO 63640
Claims	PO Box 25438 Little Rock, AR 72221
Claims	PO Box 4080 [R] FARMINGTON, MO 63640
Claims	PO Box 22085 [R] TAMPA, FL 33622
Claims	PO Box 5070 [R] FARMINGTON, MO 63640
Claims	PO Box 9010 [R] FARMINGTON, MO 63640
Claims	PO Box 9020 [R] FARMINGTON, MO 63640
Claims	PO Box 9030 [R] FARMINGTON, MO 63640
Claims	PO Box 9040 [R] FARMINGTON, MO 63640
Claims	PO Box 10420 Van Nuys, CA 91410
Claims	PO Box 26631 [R] TAMPA, FL 33623
Claims	PO Box 26632 [R] TAMPA, FL 33623
Claims	PO Box 11756 [R] EUGENE, OR 97440
Claims	PO Box 270697 [R] SAINT LOUIS, MO 63127
Claims	PO Box 7600 [R] FARMINGTON, MO 63640
Claims	PO Box 4060 [R] FARMINGTON, MO 63640
Behavioral Health Claims	PO Box 7500 [R] FARMINGTON, MO 63640
Claims	PO Box 6300 [R] FARMINGTON, MO 63640
Claims	PO Box 748654 Los Angeles, CA 90074-8654
Behavioral Health Claims	PO Box 6000 [R] FARMINGTON, MO 63640
Claims	PO Box 6200 [R] FARMINGTON, MO 63640
Claims	PO Box 11740 [R] EUGENE, OR 97440
Claims	PO Box 3090 [R] FARMINGTON, MO 63640
Claims	PO Box 5040 [R] FARMINGTON, MO 63640

Department	Box Number and Address
Claims	PO Box 92050 [R] CHICAGO, IL 60675
Claims	PO Box 4000 [R] FARMINGTON, MO 63640
Claims	PO Box 4070 [R] FARMINGTON, MO 63640
Claims	PO Box 5060 [R] FARMINGTON, MO 63640
Claims	PO Box 6400 [R] FARMINGTON, MO 63640
Behavioral Health Claims	PO Box 6800 [R] FARMINGTON, MO 63640
Claims	PO Box 3060 [R] FARMINGTON, MO 63640
Claims	PO Box 806 Amherst NY 14226-0806
Claims	PO Box 898 Amherst NY 14226-0898
Claims	PO Box 170 Amherst NY 14226-0170
Claims	PO Box 1707 Amherst NY 14226-1707
Claims	PO Box 1206 Amherst NY 14226-1206
Claims	PO Box 1205 Amherst NY 14226-1205
Claims	PO Box 905 Amherst NY 14226-0905
Behavioral Health Claims	P.O. Box 3656 Carol Stream, IL 60132-3656
Claims	P.O. Box 3657 Carol Stream, IL
Claims	P.O. Box 419069 Rancho Cordova, CA 95741
Refunds	P.O. Box 505414 St Louis, MO 63150-5414
Health Plan Operations	PO Box 743973 Atlanta, GA 30374-3973
Health Plan Operations	PO Box 743955 Atlanta, GA 30374-3955
Health Plan Operations	PO Box 419838 Boston, MA 02241-9838
Health Plan Operations	PO Box 741302 Los Angeles, CA 90074-1302
Refunds	PO Box 505418 St Louis, MO 63150-5418
Health Plan Operations	P.O. Box 743959 Atlanta, GA 30374-3959
Health Plan Operations	P.O. Box 842760 Dallas, TX 75284-2760
Refunds	PO Box 505420 St Louis, MO 63150-5420
Claims	P.O. Box 743550 Los Angeles, CA 90074-3550
Claims	PO Box 7800 [R] FARMINGTON, MO 63640
Claims	PO Box 8010 [R] FARMINGTON, MO 63640
Claims	PO Box 8030 Farmington, MO 63640
Claims	PO Box 5010 [R] FARMINGTON, MO 63640
Health Plan Operations	P.O. Box 25010 Little Rock, Arkansas 72221
Health Plan Operations	P.O. Box 25538 Little Rock, AR 72221
Vision Claims	P.O. Box 7548 Rocky Mountain, NC 27804
Dental Claims	P O Box 1242 Milwaukee, WI 53201
Health Plan Operations	P.O. Box 9103 Van Nuys, CA 91409
Health Plan Operations	P.O. Box 441567 Indianapolis, IN 46244
Health Plan Operations	P.O. Box 2115 Tacoma, WA 98402
Claims	PO Box 952909 St. Louis, MO 63195-2909
Claims	P.O. Box 953039 St. Louis, MO 63195-3039
Health Plan Operations	P.O. Box 997413 Sacramento, CA 95899-7413

Department	Box Number and Address
Health Plan Operations	PO Box 840354 Dallas, TX 75284-0354
Refunds	PO Box 952790 St. Louis, MO 63195-2790
Dental Claims	PO Box 46 Milwaukee, WI 53201

FIRST AMENDMENT TO
AMENDED AND RESTATED
MANAGEMENT SERVICES AGREEMENT BETWEEN
COMPREHENSIVE HEALTH MANAGEMENT, INC.
AND
WELLCARE HEALTH INSURANCE COMPANY OF KENTUCKY, INC.

This **FIRST AMENDMENT TO THE AMENDED AND RESTATED MANAGEMENT SERVICES AGREEMENT** (the **"Amendment"**) is entered into and made effective January 1, 2019 (the **"Amendment Effective Date"**) by and between Comprehensive Health Management, Inc., a Florida for profit corporation (**"CHMI"**) and WellCare Health Insurance Company of Kentucky, Inc., a Kentucky for profit corporation (**"WellCare"**). CHMI and WellCare may be referred to hereinafter collectively as the "Parties," and individually, each a "Party."

WHEREAS, CHMI and WellCare are parties to that certain Amended and Restated Management Services Agreement effective January 1, 2018 (the "**Agreement**") for the provision of certain administrative and management services to WellCare;

WHEREAS, the Kentucky Department of Insurance approved the Agreement on August 27, 2018; and

WHEREAS, CHMI and WellCare wish to amend, modify, and supplement certain terms of the Agreement as stated herein.

NOW, THEREFORE, the Parties agree as follows:

1. Capitalized terms not otherwise defined herein shall have the meaning set forth in the Agreement. In the event of a conflict between this Amendment and the Agreement, this Amendment shall govern and control.

2. The Management Fee Services paragraph referred to in Exhibit A of the Agreement is deleted in its entirety and replaced with the following:

MANAGEMENT FEE SERVICES

Medicare Indirect Cost Rate:
The Indirect Cost Rate under this Agreement is 7.7% (seven and seven-tenths percent) of annual gross Medicare Advantage premium revenue.

Medicaid Indirect Cost Rate:
The Indirect Cost Rate under this Agreement is 8.0% (eight percent) of annual gross Medicaid premium revenue.

Medicare Prescription Drug Program Part D Indirect Cost Rate:
The Indirect Cost Rate under this Agreement is 8.5% (eight and five-tenths percent) of annual gross Medicare Prescription Drug Program Part D premium revenue.

3. Exhibit B entitled "Medicare Government Payor Provisions", is replaced in its entirety with the attached amended Exhibit B, "Medicare Advantage Program Requirements".

4. Except as amended and modified herein, all other terms and conditions of the Agreement shall remain unchanged and are in full force and effect.

5. This Amendment may be executed in any number of counterparts, each of which shall be an original, but all of which, together, shall constitute one agreement.

IN WITNESS WHEREOF, the undersigned authorized representatives of the Parties have executed this Amendment to be effective on the Amendment Effective Date.

WellCare Health Insurance Company of Kentucky, Inc.	**Comprehensive Health Management, Inc.**
By:	By:
Print Name: Michael W. Haber	Print Name: Michael Troy Meyer
Title: Vice President & Secretary	Title: Vice President, Corporate Controller & Assistant Treasurer

PUBLIC PROTECTION CABINET

Matthew G. Bevin
Governor

Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
1-800-595-6053
http://insurance.ky.gov

K. Gail Russell
Secretary

Nancy G. Atkins
Commissioner

July 30, 2019

WellCare Health Insurance Company of Kentucky, Inc.
Attention: Mrs. Kumarie S. Jagnarain
8735 Henderson Road
Tampa, FL 33634

RE: Form D filing received on July 25, 2019- First Amendment to Amended and Restated Management Agreement Services Agreement.

Dear Mrs. Jagnarain:

We have received the above referenced Form D filing requesting approval for an amended and restated Management Service Agreement between WellCare Health Insurance Company of Kentucky, Inc/Comprehensive Health Management Services Agreement. Pursuant to KRS 304.37-030, the Kentucky Department of Insurance approved this Form D filing. Please file the executed copies of the agreement with the Department when available.

Please feel free to contact me if you have any questions.

Sincerely,

Ms. Sandra Batts
Director
Financial Standards and Examination Division

TAX SHARING AGREEMENT

AGREEMENT dated December 31, 2002, by and among Centene Corporation ("Parent") and each of its undersigned subsidiaries.

WITNESSETH

WHEREAS, the parties hereto are members of an affiliated group ("Affiliated Group") as defined in section 1504 (a) of the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, (i) such Affiliated Group files a U.S. consolidated income tax return as permitted by section 1501 of the Code, and (ii) certain members of the Affiliated Group tax file tax returns with respect to certain state or local taxing jurisdictions on a consolidated, combined or unitary basis (collectively, "State Tax Returns");

WHEREAS, it is the intent and desire of the parties hereto that a method be established for allocating the consolidated tax liability ("Consolidated Tax") and the liabilities relating to the State Tax Returns ("State Tax") of the Affiliated Group among its members, for reimbursing Parent for payment of such tax liability, for compensating any party for use of its loses or tax credits and to provide for the allocation and payment of any refund arising from carryback of losses or tax credits from subsequent tax years.

AGREEMENTS

NOW THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties hereto agree as follows:

ARTICLE 1
Determination & Allocation of Consolidated Tax

1. A U.S. consolidated income tax return shall be filed by Parent for the tax year ended December 31, 2003 and for each subsequent taxable period in respect of which this agreement is in effect and for which the Affiliated Group is required or permitted to file a consolidated return. Each subsidiary shall execute and file such consent, elections and other documents that may be required or appropriate for the proper filing of such returns.

2. Parent and each subsidiary agree that the consolidated tax liability for each year, determined in accordance with Treasury Regulation section 1.1502-2, shall be apportioned among them in accordance with the provisions of Treasury Regulation section 1.1502-32(b)(3)(iv)(D). For purposes if this agreement, the consolidated tax liability shall not include any liability for alternative minimum tax, nor shall it be reduced by any alternative minimum tax credit. In applying that regulation, the tax liability shall be allocated to each member based on the member's contribution to consolidated taxable income. This method, called the "percentage method" allocates a tax asset (i.e., an inter-company receivable) for any benefit derived by the consolidated group for the member's losses or credits that offset consolidated taxable income. This method allocates tax liability based upon the absorption of tax attributes, without taking into account the ability of any member to subsequently absorb its own tax attributes. Under this method (also known as the "immediate payment method"), the full actual tax liability of the group is first allocated under Code section 1552(a)(1) and Treas. Reg. section 1.1552-1(a)(1)(ii).

Then, if a member's separate return tax liability exceeds the amount so allocated, an additional amount is allocated equal to a fixed percentage (not to exceed 100%) of the excess. The effect is that each profit member increases its tax liability by the entire amount of the tax saved by use of the deductions or credits of other members (Treas. Reg. section l.l502-33(d)(3)(i)). Likewise, each member whose tax attributes were absorbed, is allocated a tax benefit to reflect the absorption of such tax attributes.

3. The separate return liability of each member shall be computed in a manner consistent with the provisions of Treas. Reg. section 1.1552-1(a)(2)(ii), provided that the carryover of any tax attribute from a prior year that is not available in determining the consolidated tax liability of the group for such taxable period shall be disregarded.

4. If part or all of an unused consolidated net operating loss or tax credit is allocated to a member of the Affiliated Group pursuant to Treas. Reg. section 1.1502-79, and it is carried back or forward to a year in which such member filed a separate income tax return or a consolidated federal income tax return with another affiliated group, any refund or reduction in tax liability arising from the carryback or carryover shall be retained by such member (if such refund or reduction goes to some entity other than the member, then such entity shall pay over such amount to the member). Notwithstanding the aforementioned, the Parent shall determine whether an election shall be made not to carryback any consolidated net operating loss arising in a consolidated return year (including any portion allocated to a member under Treas. Reg. section 1.1502-79) in accordance with section 172(b)(3)(C) of the Code.

5. If the consolidated tax liability includes a liability for alternative minimum tax, the parent will be responsible for the payment of such tax. The AMT credit resulting from the payment of the alternative minimum tax shall be retained by the Parent. Any tax benefit resulting from the use of the AMT credit, shall inure to the parent and, as stated in paragraph 2 of this Article, the consolidated tax liability allocated to each member shall not be reduced by the AMT credit. In the event the AMT credit was generated by a member prior to joining the consolidated group, the tax benefit will be allocated to that member when the AMT credit is utilized in the consolidated return. If a member leaves the consolidated group, the member will reimburse the Parent for any credit allocable to the member which has been previously paid by the Parent.

ARTICLE II
Determination of State Tax Liability

1. Combined State Tax shall mean, with respect to each state or local taxing jurisdiction, any income, franchise or similar tax payable to such state or local taxing jurisdiction in which a member of the Affiliated Group files tax returns with another member and/or Parent, in a consolidated, combined or unitary basis for purposes of such income or franchise tax.

2. Combined State Tax Liability shall mean, with respect to any taxable year and any jurisdiction, an amount of Combined State Tax determined in accordance with the principles set forth in Article I, section 2; provided, however, that (i) the total amount of Combined State Tax shall also include any actual income, franchise or similar state or local tax liability (a "State Liability") owed in a jurisdiction (a "Combined Jurisdiction") in which a member of the Affiliated Group files a tax return with another member of the Affiliated Group and/or Parent, on a consolidated, combined or unitary basis, to the extent such liability exceeds the liability that would have been owed had no member of the Affiliated Group been included in such returns; and (ii) the total amount of Combined State Tax shall be reduced to the extent that, in any Combined Jurisdiction, the State Liability of the Affiliated Group and any member of the Affiliated Group, is less than

the liability that would have been owed had no member of the Affiliated Group been included in the returns of such Combined Jurisdiction.

3. If a separate tax return is required to be filed for any state or local jurisdiction by any member of the Affiliated Group, such member shall bear the responsibility for the filing of such return.

ARTICLE III
Tax Sharing

1. General. For each taxable year of the Affiliated Group during which income, loss or credit of the undersigned subsidiaries (hereinafter, the "Members") are includible in the consolidated Federal tax return of the Affiliated Group, such Members shall pay to Parent an amount equal to their respective Consolidated Tax, as set forth in Article I. Similarly, for each taxable year of the Affiliated group during which income, loss or credit of the Members are includible in any State Tax Returns, such Members shall pay to Parent an amount equal to their respective State Tax, as set forth in Article II.

2. Estimated Payments. Parent shall determine the amount of estimated tax installments of the Consolidated Tax liability, as determined under the principles of Article I of this agreement. The Members shall each, within five (5) days of receipt of such determination (but in no event earlier than five (5) days prior to the date of Parent's corresponding estimated tax payment) pay to Parent the amount so determined for the respective group. Parent shall determine under provisions of applicable law the amount of the estimated tax installment of the respective State Tax installment as determined under the principles of Article II of this agreement. The applicable Members shall each, within five (5) days of receipt of such determination (but in no event earlier than five (5) days prior to the date of Parent's corresponding estimated tax payment), pay to Parent the amount so determined.

3. Payment of Taxes at Year-End.

(i) On or before the due date (including all applicable and valid extensions) for Parent's consolidated Federal tax return, Parent shall make available to the Members of the Affiliated Group the relevant pro forma Federal tax return of the Affiliated Group, reflecting the Consolidated Tax. On or before the due date (including all applicable and valid extensions) for each of the State Tax Returns, Parent shall make available to the Members the relevant pro forma State Tax Returns (together with the Federal pro forma return, the "Pro Forma Returns") of the Affiliated Group. The Pro Forma Returns shall be prepared in good faith in a manner generally consistent with past practice.

(ii) Within 90 days of the date Parent files its consolidated Federal tax return for any year for which payments are to be made under this agreement, the Members shall each pay to Parent, or Parent shall pay to the Members, as appropriate, an amount equal to the difference, if any, between the Consolidated Tax reflected on the pro forma Federal tax return of the Affiliated Group for such year and the aggregate amount of the estimated installments of the respective Consolidated Tax for such year made pursuant to Article III, section 2. Within 90 days of the date Parent files each of the State Tax Returns for any year for which payments are to be made under this agreement, the Members shall each pay to Parent, or Parent shall pay to the Members, as appropriate, an amount equal to the difference, if any, between the State Tax reflected on the pro forma State Tax Returns of the Affiliated Group for such year and the aggregate amount of the estimated installments of the respective State Tax for such year made pursuant to Article III, section 2.

(iii) If a Pro Forma Return reflects a Tax Asset[1] that may under applicable law be used to reduce a Consolidated Tax or State Tax liability of any Member of the Affiliated Group for any taxable period, Parent shall pay to the Members, as appropriate, an amount equal to the actual tax saving (which would include refunds actually received) produced by such Tax Asset within 90 days of the time such tax saving is realized and the future Pro Forma Returns of the Affiliated Group shall be adjusted to reflect such use. The amount of any such tax saving for any taxable period shall be the amount of the reduction in taxes payable to a taxing authority with respect to such tax period as compared to the taxes that would have been payable to a taxing authority with respect to such tax period in the absence of such Tax Asset.

(iv) In the event that Parent makes a cash deposit with a taxing authority in order to stop the running of interest or makes a payment of tax and correspondingly takes action to recoup such payment (such as suing for a refund), the Members shall each pay to Parent an amount equal to the Members' respective share of the amount so deposited or paid (calculated in a manner consistent with the determinations provided in Articles I and II). Upon receipt by Parent of a refund of any amounts paid by it in respect of which the Members shall have advanced an amount hereunder, Parent shall pay to the Members the amount of such refund. If and to the extent that any claim for refund or contest based thereupon shall be unsuccessful, the payment by the Members under this section 3(iv) shall be credited toward the Members' respective obligations under this section 3(iv) and any other payment obligations of the Members under Article Ill, section 4 below.

4. Treatment of Adjustments. If any adjustment is made in a Federal return of the Affiliated Group or in a return relating to State Tax, after the filing thereof, in which income or loss of the Members is included, then within 90 days of the time of a Final Determination[2] of the adjustment, the Members shall each pay to Parent or Parent shall pay to the Members, as the case may be, the difference between all payments actually made under Article III with respect to the taxable period covered by such tax return and all payments that would have been made under Article III taking such adjustment into account, together with any penalties actually paid and interest for each day until the date of the Final Determination, calculated at the rate determined, in the case of a payment by the Members, under section 6621(a)(2) of the Code, and in the case of a payment by Parent, under section 6621(a)(l) of the Code.

5. Preparation of Returns and Contests. So long as (i) the Affiliated Group elects to file consolidated Federal tax returns as permitted by section 1501 of the Code or (ii) any State Tax Returns are filed, Parent shall prepare and file such returns and any other returns, documents or statements required to be filed with the Internal Revenue Service with respect to the determination of the Consolidated Tax of the Affiliated Group and with the appropriate taxing authorities with respect to the determination of State Tax liability. With respect to such return preparation, Parent shall act in good faith with regard to all members included in an applicable

[1] Tax Asset means any net operating loss, net capital loss, investment tax credit, foreign tax credit charitable deduction or any other deduction, credit or tax attribute which could reduce taxes (including, without limitation, deductions and credits related to alternative minimum taxes).

[2] Final Determination shall mean (i) with respect to Consolidated Tax, a "determination" as defined in section 1313(a) of the Code or execution of an Internal Revenue Service Form 870AD, and with respect to taxes other than Consolidated Tax, any final determination of liability in respect of a tax that, under applicable law, is not subject to further appeal, review or modification through proceedings or otherwise, (ii) any final disposition of a tax issue by reason of the expiration of a statute of limitations or (iii) the payment of tax by Parent with respect to any item disallowed or adjusted by any taxing authority where Parent determines in good faith that no action should be taken to recoup such payment.

return. Parent shall have right with respect any consolidated Federal tax returns or returns relating to State Tax that it has filed or will file to determine in good faith (i) the manner in which such returns, documents or statements shall be prepared and filed, including, without limitation, the manner in which any item of income, gain, loss, deduction, or credit shall be reported, (ii) whether any extensions should be requested, and (iii) the elections that will be made by any Member of the Affiliated Group. In addition, Parent shall have the right, in good faith, to (i) contest, compromise, or settle any adjustment of deficiency proposed, asserted or assessed as a result of any audit of any Federal tax return or return relating to State Tax, (ii) file, prosecute, compromise or settle any claim for refund, and (iii) determine whether any refunds shall be received by way of refund or credited against tax liabilities. In addition, Parent shall, to the extent such information is available, advise the Members of any significant applicable Member tax issue being contested by the Federal, state, local or other relevant taxing authorities, and shall keep the Members informed with respect to any contest, compromise or settlement thereof.

6. Reimbursement for Certain Services. Parent shall be responsible for services in connection with this agreement, including but not limited to, (i) those services relating to the preparation of returns (including Pro Forma Returns) described in Article III, sections 2, 3 and 5 and (ii) services relating to other activities described in Article III, section 5. The Parent will receive reimbursement for the expenses associated with performance of these services by each of the member corporations. The amount and terms of the reimbursements will be governed by the general services agreement between entities.

7. Additional Services. Parent will provide the tax services described in this Article III with respect to all of the separate state, local and foreign taxes of any of the Members that do not relate to Consolidated Tax or State Tax. Parent will provide these services in a manner consistent with the principles contained in Article III and be compensated in the same manner as described in section 6.

ARTICLE IV
Post-Deconsolidation

1. Additional Rights and Liabilities Post-Deconsolidation

(i) Deconsolidation means any event pursuant to which a Member of the Affiliated Group ceases to be a subsidiary corporation includible in a consolidated tax return of the Affiliated Group for Consolidated Tax purposes.

(ii) The Members consent that on or after a Deconsolidation they will not, nor will cause or permit any Member of the Affiliated Group to make or change any tax election, change any accounting method, amend any tax return or take any tax position on any tax return, take any other action, omit to take any action or enter into any transaction that results in any increased tax liability or reduction of any Tax Asset of the Affiliated Group or any Member thereof (immediately after the Deconsolidation) in respect of any Post-Deconsolidation Tax Period,[3] without first obtaining the written consent of any authorized representative of Parent.

(iii) In the event of a Deconsolidation, Parent may, at its option, elect and the Members shall join Parent in electing (if necessary), to ratably allocate items of the respective Members in

[3] Post-Deconsolidation Tax Period means (i) any tax period beginning and ending after the date of Deconsolidation and (ii) with respect to a tax period that begins before and ends after the date of Deconsolidation, such portion of the tax period that commences on the day after the date of Deconsolidation.

accordance with the relevant provisions of Treasury Regulation section 1.1502-76.

(iv) Parent agrees to pay to the Members, as applicable, the actual benefit received by the Affiliated Group from the use in any Pre-Deconsolidation Tax Period of a carryback of any Tax Asset of a respective Member from a Post Deconsolidation Tax Period. Such benefit shall be considered equal to the excess of (i) the amount of Consolidated Tax or State Tax, as the case may be, that would have been payable by the Affiliated Group in the absence of such carryback over (ii) the amount of Consolidated Tax or State Tax, as the case may be, actually payable by the Affiliated Group. Payment of the amount of such benefit shall be made within ninety (90) days of the filing of the applicable tax return for the taxable year in which the Tax Asset is utilized. If, subsequent to the payment by Parent to the Members of any such amount, there shall be (A) a Final Determination which results in a disallowance or a reduction of the Tax Asset so carried back or (B) a reduction in the amount of the benefit realized by the Affiliated Group as a result of any other Tax Asset that arises in a Post-Deconsolidation Tax Period, the Members shall respectively repay to Parent, within ninety (90) days of such event described in (A) or (B) (an "Event" or collectively, the "Events") any amount which would not have been payable to the Members pursuant to this section had the amount of the benefit been determined in light of the Events. The Members shall each hold Parent harmless for any penalty or interest payable by any Member of the Affiliated Group, as a result of any Event. Any such amount shall be paid separately by the Members to Parent within ninety (90) days of the payment by Parent or any member of the Affiliated Group of any such interest or penalty. Nothing in this section l(iv) shall require Parent to file a claim, amended return or refund of Consolidated Tax or State Tax which Parent, in its sole discretion, determines lacks substantial authority, as defined in the Code and the regulations thereunder. Parent agrees to file an amended Affiliated Group Consolidated Tax return or State Tax return, that does not lack substantial authority, to assist the Members obtain a tax benefit related to an Affiliated Group year.

ARTICLE V
Miscellaneous

1. Additional Members. If during a consolidated return period Parent or any Member acquires or organizes another corporation that is required to be included in the consolidated return, then such corporation shall join in and be bound by this agreement.

2. Timing. This agreement shall apply to the tax year ending December 31, 2003, and all subsequent taxable periods unless Parent and the Members agree to terminate the agreement. Notwithstanding such termination, this agreement shall continue in effect with respect to any payments or refunds due for all taxable periods prior to termination.

3. Successors. This agreement shall be binding upon and inure to the benefit of any successor, whether by statutory merger, acquisition of assets, or otherwise, to any of the parties hereto, to the same extent as if the successor had been an original party to the agreement.

4. Amendments. To the extent Internal Revenue Code sections or Treasury Regulations are adopted, amended, revised or clarified, and such adoptions, amendments, revisions, or clarifications impact the allocation of tax payments or refunds pursuant to this agreement, this agreement will be amended within ninety (90) days of the date such adoptions, amendments, revisions, or clarifications are published in the Federal Register.

IN WITNESS WHEREOF, each of the undersigned parties has caused this Tax Sharing Agreement to be executed by a duly authorized officer as of the 30th day of January, 2020, effective January 23, 2020.

WELLCARE HEALTH INSURANCE COMPANY OF KENTUCKY, INC.

By: _____
Name: Michael W. Haber
Title: Vice President and Secretary

WELLCARE HEALTH PLANS OF KENTUCKY, INC.

By: _____
Name: Michael W. Haber
Title: Vice President and Secretary

Accepted and Agreed:

CENTENE CORPORATION

By: _____
Name: Tricia Dinkelman
Title: Vice President, Tax

[Kentucky Signature Page to the Tax Sharing Agreement]

APPROVED

AUG 0 1 2013

FINANCIAL STANDING
KY DEPT. OF INSURANCE

APPROVED FOR FORM AND LEGALITY OFFICE
OF THE ATTORNEY GENERAL, FRANKFORT, KENTUCKY

BY Assistant Attorney General

31 July 2013

Restated and Amended Articles of Incorporation and Redomestication
of
WellCare Health Insurance of Illinois, Inc. d/b/a WellCare of Kentucky, Inc.

Pursuant to Section 271B.2-020 of Kentucky Business Corporation Act, the corporation hereinafter named (the "Corporation") hereby amends and restates its Articles of Incorporation in their entirety.

1. The name of the Corporation is WellCare Health Insurance of Illinois, Inc. d/b/a WellCare of Kentucky, Inc. in the Commonwealth of Kentucky.

2. The text of the Amended and Restated Articles of Incorporation and Redomestication of the Corporation, as further amended hereby, is annexed hereto and made a part hereof.

3. The Incorporators, for the limited purpose of complying with KRS 271B.2-020, are as follows:

(a) Greg E. Mitchell, 303 Stonegate Drive, Nicholasville, Kentucky 40356
(b) Alan S. Meek, 2404 Dogwood Trace Blvd., Lexington, KY 40514
(c) Jay Holley, 316 Ravenwood Place, Richmond, KY 40475

4. The annexed restatement (Second Amended and Restated Articles of Incorporation and Redomestication) contains amendments to the Amended and Restated Articles of Incorporation of the Corporation that was originally domiciled on March 27, 1962 with the State of Illinois, Division of Insurance.

5. The Corporation's Certificate of Authority was originally filed on April 28, 2011 with the Commonwealth of Kentucky, Secretary of State and assigned Kentucky number 0790513.09.

6. The Amended and Restated Articles of Incorporation of the Company are hereby amended and restated in their entirety so as henceforth to read as set forth in the Second Amended and Restated Articles of Incorporation and Redomestication annexed hereto and made a part hereof.

7. The Board of Directors duly adopted the aforesaid amendments by unanimous written consent.

8. The sole shareholder duly approved the aforesaid amendments by written consent dated as of June 27, 2013. The total number of issued and outstanding shares entitled to vote is 2,500,000 shares of Common Stock. The total number of shares voted in favor of the aforesaid amendments is 2,500,000, such vote represents 100% of the outstanding shares of Common Stock.

9. The effective time and date of these Second Amended and Restated Articles of Incorporation and Redomestication shall be August 1, 2013.

Greg E. Mitchell, Incorporator

Alan S. Meek, Incorporator

Jay Holley, Incorporator

0790513.09 dcornish AMD
Alison Lundergan Grimes
Secretary of State
Received and Filed
08/01/2013 1:40:53 PM
Fee Receipt: $6,780.00

SECOND AMENDED AND RESTATED
ARTICLES OF INCORPORATION AND REDOMESTICATION

OF

WELLCARE HEALTH INSURANCE OF ILLINOIS, INC.

d/b/a WellCare of Kentucky, Inc.

The undersigned files with the Secretary of State of the Commonwealth of Kentucky these Articles of Incorporation in accordance with Sections 14A and 271B of the Kentucky Business Corporation Act, as amended to date (the "Act") and Section 304.24-500 of the Kentucky Insurance Code.

ARTICLE I: The name of this corporation is **WellCare Health Insurance Company of Kentucky, Inc.** hereinafter referred to as the "Corporation."

ARTICLE II: The mailing address of the Corporation's corporate office is Attention: Legal and External Affairs, WellCare Health Plans, Inc., 8735 Henderson Road, Tampa, Florida 33634.

The mailing address of the Corporation's principal office in the Commonwealth of Kentucky is 13551 Triton Park Boulevard, Suite 1800, Louisville, Kentucky 40223.

ARTICLE III: The purposes for which the Corporation is formed are: (i) to engage in any and all lawful activities, businesses and enterprises for which stock life and health insurance corporations may be organized and which the Board of Directors of the Corporation may deem beneficial, profitable and in the best interest of the Corporation; (ii) to engage in the business of life and health insurance and the business incidental thereto, including without limitation, the creation, promotion, sale and servicing of health insurance products and annuity products, together with all activities incidental thereto; and (iii) to create, own, operate and manage subsidiaries as determined by the Board of Directors of the Corporation and as permitted by the Kentucky statutes. The Corporation shall be authorized to transact the following kinds of insurance, as presently defined at KRS Chapter 304.5.010 et seq. or as hereafter authorized and defined under the laws of the Commonwealth of Kentucky: "life", "health", and "annuities".

ARTICLE IV: The aggregate number, class and par value of the shares which the Corporation shall have the authority to issue is three million (3,000,000) shares of Common Stock, all of which shall have a par value of $1.00 per share. These shares shall constitute one single class with no preferences, special rights or qualifications. All preemptive rights of shareholders are hereby denied.

ARTICLE V: Participation in or conduct of any meeting of the Shareholder or Board of Directors may be in person, by proxy or by means of remote or electronic communication, including but not limited to telephone or other form of wire or wireless communication that allows for all parties to simultaneously hear each other.

ARTICLE VI: The Board of Directors shall be elected by a plurality of the votes cast by the shareholder in the manner indicated in the Bylaws. Cumulative voting is prohibited.

ARTICLE VII: The Shareholder shall have the exclusive power to alter, amend or repeal the Bylaws or adopt new Bylaws by majority vote of the Shareholder.

ARTICLE VIII: A quorum of the Board of Directors may consist of less than a majority, but shall be no fewer than one-third (⅓) of the prescribed number of Directors as determined under the Bylaws.

ARTICLE IX: No director shall be personally liable to the Corporation or its shareholders for monetary damages for breach of fiduciary duty as a director, except for (a) any breach of the director's duty of loyalty to the Corporation or its shareholders, (b) acts or omissions not in subjective good faith which involve intentional misconduct or a knowing violation of law, (c) pursuant to Section 271B.8-510(4) of the Act, as amended from time to time, or (d) any transaction from which the director derived an improper personal benefit.

ARTICLE X: The Corporation may indemnify officers, directors, employees and agents to the fullest extent permitted by law.

ARTICLE XI: The street address of the registered office of the Corporation is 306 W. Main Street, Suite 512, Frankfort Kentucky 40601 and the Registered Agent of record is CT Corporation System:

I, CT Corporation System, consent to serve as the registered agent on behalf of the Corporation.

Madonna Cuddihy — *Signature, Title*

Special Assistant Secretary — *Printed Name*

7-11-13 — *Date*

I declare under penalty of perjury under the laws of the Commonwealth of Kentucky that the foregoing is true and correct.

Dated as of 7-12-13

Lisa G. Iglesias, Secretary

Commonwealth of Kentucky
Alison Lundergan Grimes, Secretary of State

8/1/2013

Alison Lundergan Grimes
Secretary of State
P. O. Box 718
Frankfort, KY 40602-0718
(502) 564-3490
http://www.sos.ky.gov

Receipt

Payment ID	3252369
Payment type	Credit Card
Epay transaction ID	12307196
Payment date	August 1, 2013
Amount	$6,700.00

8/1/2013	$6,700.00	Corporate filing	0790513 - Organization Tax Fee (WELLCARE HEALTH INSURANCE OF ILLINOIS, INC.)

Commonwealth of Kentucky
Alison Lundergan Grimes, Secretary of State

8/1/2013

Alison Lundergan Grimes
Secretary of State
P. O. Box 718
Frankfort, KY 40602-0718
(502) 564-3490
http://www.sos.ky.gov

Receipt

Payment ID	3252392
Payment type	Credit Card
Epay transaction ID	12307226
Payment date	August 1, 2013
Amount	$80.00

8/1/2013	$80.00	Corporate filing	0790513 - Amended & Restated Art of Inc. (WELLCARE HEALTH INSURANCE COMPANY OF KENTUCKY, INC)

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF MERGER, WHICH MERGES:

"WELLCARE HEALTH PLANS, INC.", A DELAWARE CORPORATION,

WITH AND INTO "WELLINGTON MERGER SUB II, INC." UNDER THE NAME OF "WELLCARE HEALTH PLANS, INC.", A CORPORATION ORGANIZED AND EXISTING UNDER THE LAWS OF THE STATE OF DELAWARE, AS RECEIVED AND FILED IN THIS OFFICE ON THE TWENTY-THIRD DAY OF JANUARY, A.D. 2020, AT 10:29 O`CLOCK A.M.

Jeffrey W. Bullock, Secretary of State

7339110 8100M
SR# 20200489070

Authentication: 202242083
Date: 01-23-20

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF MERGER
OF
WELLCARE HEALTH PLANS, INC.
WITH AND INTO
WELLINGTON MERGER SUB II, INC.

Pursuant to Section 251 of the General
Corporation Law of the State of Delaware

Wellington Merger Sub II, Inc., a Delaware corporation, does hereby certify:

FIRST: The names and states of incorporation of the constituent corporations to this merger (the "Merger") are as follows:

WellCare Health Plans, Inc.	Delaware
Wellington Merger Sub II, Inc.	Delaware

SECOND: An Agreement and Plan of Merger, which was entered into on March 26, 2019, by and among Centene Corporation, Wellington Merger Sub I, Inc., Wellington Merger Sub II, Inc. and WellCare Health Plans, Inc. (the "Merger Agreement"), has been approved, adopted, executed and acknowledged by each of the constituent corporations in accordance with Section 251 of the General Corporation Law of the State of Delaware.

THIRD: The name of the corporation surviving the Merger is Wellington Merger Sub II, Inc., except that, at the time of the Merger, such name shall be changed to WellCare Health Plans, Inc. (the "Surviving Corporation").

FOURTH: The Certificate of Incorporation of Wellington Merger Sub II, Inc. as in effect immediately prior to the Merger shall be amended and restated to read in its entirety as set forth in Exhibit A attached hereto and, as so amended, shall be the certificate of incorporation of the Surviving Corporation.

FIFTH: The executed Merger Agreement is on file at an office of the Surviving Corporation, 7700 Forsyth Boulevard, St. Louis, Missouri 63105. A copy will be provided, upon request and without cost, to any stockholder of either constituent corporation.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, Wellington Merger Sub II, Inc. has caused this Certificate of Merger to be executed in its corporate name this 23rd day of January, 2020.

WELLINGTON MERGER SUB II, INC.

By: _____
Name: Jeffrey Schwaneke
Title: Treasurer

[SIGNATURE PAGE TO CERTIFICATE OF MERGER – SECOND MERGER]

EXHIBIT A

AMENDED AND RESTATED
CERTIFICATE OF INCORPORATION

OF

WELLCARE HEALTH PLANS, INC.

FIRST: The name of the Corporation is WellCare Health Plans, Inc. (hereinafter the "Corporation").

SECOND: The address of the registered office of the Corporation in the State of Delaware is 1209 Orange Street, Wilmington, County of New Castle, 19801. The name of its registered agent at that address is The Corporation Trust Company.

THIRD: The purpose of the Corporation is to engage in any lawful act or activity for which a corporation may be organized under the General Corporation Law of the State of Delaware as set forth in Title 8 of the Delaware Code (the "GCL").

FOURTH: The total number of shares of stock which the Corporation shall have authority to issue is one thousand (1,000) shares of Common Stock, each having a par value of $0.01.

FIFTH: The name and mailing address of the Sole Incorporator is as follows:

Name	Address
Deborah M. Reusch	P.O. Box 636 Wilmington, DE 19899

SIXTH: The following provisions are inserted for the management of the business and the conduct of the affairs of the Corporation, and for further definition, limitation and regulation of the powers of the Corporation and of its directors and stockholders:

(1) The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors.

(2) The directors shall have concurrent power with the stockholders to make, alter, amend, change, add to or repeal the By-Laws of the Corporation.

(3) The number of directors of the Corporation shall be as from time to time fixed by, or in the manner provided in, the By-Laws of the Corporation. Election of directors need not be by written ballot unless the By-Laws so provide.

(4) No director shall be personally liable to the Corporation or any of its stockholders for monetary damages for breach of fiduciary duty as a director, except for liability (i) for any breach of the director's duty of loyalty to the Corporation or its stockholders, (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, (iii) pursuant to Section 174 of the GCL or (iv) for any transaction from which the director derived an improper personal benefit. Any repeal or modification of this Article SIXTH by the stockholders of the Corporation shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification with respect to acts or omissions occurring prior to such repeal or modification.

(5) In addition to the powers and authority hereinbefore or by statute expressly conferred upon them, the directors are hereby empowered to exercise all such powers and do all such acts and things as may be exercised or done by the Corporation, subject, nevertheless, to the provisions of the GCL, this Certificate of Incorporation, and any By-Laws adopted by the stockholders; provided, however, that no By-Laws hereafter adopted by the stockholders shall invalidate any prior act of the directors which would have been valid if such By-Laws had not been adopted.

SEVENTH: Meetings of stockholders may be held within or without the State of Delaware, as the By-Laws may provide. The books of the Corporation may be kept (subject to any provision contained in the GCL) outside the State of Delaware at such place or places as may be designated from time to time by the Board of Directors or in the By-Laws of the Corporation.

EIGHTH: Each person who was or is made a party or is threatened to be made a party to or is involved (including, without limitation, as a witness) in any actual or threatened action, suit or proceeding, whether civil, criminal, administrative or investigative (hereinafter a "proceeding"), by reason of the fact that he is or was a director or officer of the Corporation or is or was serving at the request of the Corporation as a director or officer of another corporation or of a partnership, limited liability company, joint venture, trust or other entity, including service with respect to an employee benefit plan (hereinafter an "Indemnitee"), whether the basis of such proceeding is alleged action in an official capacity as a director or officer or in any other capacity while so serving, shall be indemnified and held harmless by the Corporation to the full extent authorized by the GCL, as the same exists or may hereafter be amended (but, in the case of any such amendment, only to the extent that such amendment permits

the Corporation to provide broader indemnification rights than said law permitted the Corporation to provide prior to such amendment), or by other applicable law as then in effect, against all costs, expenses, liabilities and losses (including attorneys' fees and related costs, judgments, fines, excise taxes or penalties under the Employee Retirement Income Security Act of 1974, as amended from time to time ("ERISA"), penalties and amounts paid or to be paid in settlement) actually and reasonably incurred or suffered by such Indemnitee in connection therewith, and such indemnification shall continue as to a person who has ceased to be a director, officer, partner, member or trustee and shall inure to the benefit of his or her heirs, executors and administrators. Each person who is or was serving as a director or officer of a subsidiary of the Corporation shall be deemed to be serving, or have served, at the request of the Corporation.

(1) Procedure. Any indemnification (but not advancement of expenses) under this Article EIGHTH (unless ordered by a court) shall be made by the Corporation only as authorized in the specific case upon a determination that indemnification of the director or officer is proper in the circumstances because he has met the applicable standard of conduct set forth in the GCL, as the same exists or hereafter may be amended (but, in the case of any such amendment, only to the extent that such amendment permits the Corporation to provide broader indemnification rights than said law permitted the Corporation to provide prior to such amendment). Such determination shall be made with respect to a person who is a director or officer at the time of such determination (i) by a majority vote of the directors who were not parties to such proceeding (the "Disinterested Directors"), even though less than a quorum, (ii) by a committee of Disinterested Directors designated by a majority vote of Disinterested Directors, even though less than a quorum, (iii) if there are no such Disinterested Directors, or if such Disinterested Directors so direct, by independent legal counsel in a written opinion, or (iv) by the stockholders.

(2) Advances for Expenses. Expenses (including attorneys' fees, costs and charges) incurred by a director or officer of the Corporation in defending a proceeding shall be paid by the Corporation in advance of the final disposition of such proceeding upon receipt of an undertaking by or on behalf of the director or officer to repay all amounts so advanced in the event that it shall ultimately be determined that such director or officer is not entitled to be indemnified by the Corporation as authorized in this Article EIGHTH. The majority of the Disinterested Directors may, in the manner set forth above, and upon approval of such director or officer of the Corporation, authorize the Corporation's counsel to represent such person, in any proceeding, whether or not the Corporation is a party to such proceeding.

(3) Procedure for Indemnification. Any indemnification or advance of expenses (including attorney's fees, costs and charges) under this Article

EIGHTH shall be made promptly, and in any event within 60 days upon the written request of the director or officer (and, in the case of advance of expenses, receipt of a written undertaking by or on behalf of Indemnitee to repay such amount if it shall ultimately be determined that Indemnitee is not entitled to be indemnified therefor pursuant to the terms of this Article EIGHTH). The right to indemnification or advances as granted by this Article EIGHTH shall be enforceable by the director or officer in any court of competent jurisdiction, if the Corporation denies such request, in whole or in part, or if no disposition thereof is made within 60 days. Such person's costs and expenses incurred in connection with successfully establishing his/her right to indemnification, in whole or in part, in any such action shall also be indemnified by the Corporation. It shall be a defense to any such action (other than an action brought to enforce a claim for the advance of expenses (including attorney's fees, costs and charges) under this Article EIGHTH where the required undertaking, if any, has been received by the Corporation) that the claimant has not met the standard of conduct set forth in the GCL, as the same exists or hereafter may be amended (but, in the case of any such amendment, only to the extent that such amendment permits the Corporation to provide broader indemnification rights than said law permitted the Corporation to provide prior to such amendment), but the burden of proving such defense shall be on the Corporation. Neither the failure of the Corporation (including its Board of Directors, its independent legal counsel and its stockholders) to have made a determination prior to the commencement of such action that indemnification of the claimant is proper in the circumstances because he/she has met the applicable standard of conduct set forth in the GCL, as the same exists or hereafter may be amended (but, in the case of any such amendment, only to the extent that such amendment permits the Corporation to provide broader indemnification rights than said law permitted the Corporation to provide prior to such amendment), nor the fact that there has been an actual determination by the Corporation (including its Board of Directors, its independent legal counsel and its stockholders) that the claimant has not met such applicable standard of conduct, shall be a defense to the action or create a presumption that the claimant has not met the applicable standard of conduct.

(4) Other Rights; Continuation of Right to Indemnification. The indemnification and advancement of expenses provided by this Article EIGHTH shall not be deemed exclusive of any other rights to which a person seeking indemnification or advancement of expenses may be entitled under any law (common or statutory), bylaw, agreement, vote of stockholders or disinterested directors or otherwise, both as to action in his/her official capacity and as to action in another capacity while holding office or while employed by or acting as agent for the Corporation, and shall continue as to a person who has ceased to be a director or officer,

and shall inure to the benefit of the estate, heirs, executors and administers of such person. All rights to indemnification under this Article EIGHTH shall be deemed to be a contract between the Corporation and each director or officer of the Corporation who serves or served in such capacity at any time while this Article EIGHTH is in effect. Any repeal or modification of this Article EIGHTH or any repeal or modification of relevant provisions of the GCL or any other applicable laws shall not in any way diminish any rights to indemnification of such director or officer or the obligations of the Corporation arising hereunder with respect to any proceeding arising out of, or relating to, any actions, transactions or facts occurring prior to the final adoption of such modification or repeal. For the purposes of this Article EIGHTH, references to "the Corporation" include all constituent corporations absorbed in a consolidation or merger as well as the resulting or surviving corporation, so that any person who, following such consolidation or merger, is a director or officer of such a constituent corporation or is serving at the request of such constituent corporation as a director or officer of another corporation, partnership, joint venture, trust or other entity shall stand in the same position under the provisions of this Article EIGHTH, with respect to the resulting or surviving corporation during the period following such consolidation or merger, as he would if he/she had served the resulting or surviving corporation in the same capacity.

(5) Insurance. The Corporation shall have power to purchase and maintain insurance on behalf of any person who is or was or has agreed to become a director or officer of the Corporation, or is or was serving at the request of the Corporation as a director or officer of another corporation, partnership, joint venture, trust or other entity, against any liability asserted against him and incurred by him or on his behalf in any such capacity, or arising out of his status as such, whether or not the Corporation would have the power to indemnify him against such liability under the provisions of this Article EIGHTH; provided, however, that such insurance is available on acceptable terms, which determination shall be made by a vote of a majority of the Board of Directors.

(6) Savings Clause. If this Article EIGHTH or any portion hereof shall be invalidated on any ground by any court of competent jurisdiction, then the Corporation shall nevertheless indemnify each person entitled to indemnification under the first paragraph of this Article EIGHTH as to all costs, expenses, liabilities and losses (including attorneys' fees and related costs, judgments, fines, ERISA excise taxes and penalties, penalties and amounts paid or to be paid in settlement) actually and reasonably incurred or suffered by such person and for which indemnification is available to such person pursuant to this Article EIGHTH to the full extent permitted by any applicable portion of this Article EIGHTH that shall not have been invalidated and to the full extent

permitted by applicable law.

NINTH: The Corporation reserves the right to amend, alter, change or repeal any provision contained in this Certificate of Incorporation, in the manner now or hereafter prescribed by statute, and all rights conferred upon stockholders herein are granted subject to this reservation.

State of Delaware
Secretary of State
Division of Corporations
Delivered 08:08 PM 09/14/2009
FILED 07:50 PM 09/14/2009
SRV 090854293 - 3524825 FILE

STATE OF DELAWARE
CERTIFICATE OF CHANGE
OF REGISTERED AGENT AND/OR
REGISTERED OFFICE

The Board of Directors of WCG Health Management, Inc.,
a Delaware Corporation, on this 10 day of
Sept, A.D. 09, do hereby resolve and order that the
location of the Registered Office of this Corporation within this State be, and the
same hereby is Corporation Trust Center
1209 Orange Street, in the City of Wilmington,
County of New Castle Zip Code 19801.

The name of the Registered Agent therein and in charge thereof upon whom process against this Corporation may be served, is
THE CORPORATION TRUST COMPANY.

The Corporation does hereby certify that the foregoing is a true copy of a resolution adopted by the Board of Directors at a meeting held as herein stated.

IN WITNESS WHEREOF, said Corporation has caused this certificate to be signed by an authorized officer, the Sept. SEP 10 2009 day of 10,
A.D., 2009.

By: _____
Authorized Officer

Name: Tim Light
Print or Type

Title: Vice President

DE023 - 03/26/2009 C T System Online

WellCare
Beyond Healthcare. A Better You.

Delaware

The First State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF AMENDMENT OF "WELLCARE HEALTH PLANS, INC.", CHANGING ITS NAME FROM "WELLCARE HEALTH PLANS, INC." TO "WCG HEALTH MANAGEMENT, INC.", FILED IN THIS OFFICE ON THE SIXTH DAY OF JULY, A.D. 2004, AT 12:31 O'CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

SECRETARY'S OFFICE
THE FIRST STATE
DELAWARE 1787

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

3524825 8100

040494005

AUTHENTICATION: 3214677

DATE: 07-06-04

WellCare Health Plans, Inc.
a Delaware corporation

CERTIFICATE OF AMENDMENT TO THE CERTIFICATE OF INCORPORATION

Pursuant to Section 242
of the General Corporation Law of
the State of Delaware

The undersigned Secretary of WellCare Health Plans, Inc. (the "***Corporation***"), a corporation organized and existing under and by virtue of the General Corporation Law of the State of Delaware (the "***General Corporation Law***") does hereby certify that the following amendment has been duly adopted pursuant to and in accordance with the provisions of Section 242 of the General Corporation Law, and as such, the Secretary hereby adopts the following amendment to the Certificate of Incorporation of the Corporation (the "***Certificate***").

1. Article I of the Certificate is hereby amended and restated in its entirety to read as follows:

> "The name of the corporation is WCG Health Management, Inc. (hereinafter called the "Corporation")."

IN WITNESS WHEREOF, the Secretary of the Corporation has executed this Certificate of Amendment to the Certificate of Incorporation this 6th day of July, 2004.

/s/ Thaddeus Bereday
Thaddeus Bereday, Secretary

Delaware

The First State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF AMENDMENT OF "WELLCARE ACQUISITION COMPANY", CHANGING ITS NAME FROM "WELLCARE ACQUISITION COMPANY" TO "WELLCARE HEALTH PLANS, INC.", FILED IN THIS OFFICE ON THE SEVENTH DAY OF FEBRUARY, A.D. 2003, AT 9 O'CLOCK A.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

3524825 8100

AUTHENTICATION: 2252110

030083626

DATE: 02-11-03

STATE OF DELAWARE
SECRETARY OF STATE
DIVISION OF CORPORATIONS
FILED 09:00 AM 02/07/2003
030083626 – 3524825

WellCare Acquisition Company
a Delaware corporation

CERTIFICATE OF AMENDMENT TO THE CERTIFICATE OF INCORPORATION

Pursuant to Section 242
of the General Corporation Law of
the State of Delaware

The undersigned Secretary of WellCare Acquisition Company (the "***Corporation***"), a corporation organized and existing under and by virtue of the General Corporation Law of the State of Delaware (the "***General Corporation Law***") does hereby certify that the following amendment has been duly adopted pursuant to and in accordance with the provisions of Section 242 of the General Corporation Law, and as such, the Secretary hereby adopts the following amendment to the Certificate of Incorporation of the Corporation (the "***Certificate***").

1. Article I of the Certificate is hereby amended and restated in its entirety to read as follows:

"The name of the corporation is WellCare Health Plans, Inc. (hereinafter called the "***Corporation***")."

IN WITNESS WHEREOF, the Secretary of the Corporation has executed this Certificate of Amendment to the Certificate of Incorporation this 6th day of February, 2003.

Thaddeus Bereday, Secretary

Delaware

The First State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF "WELLCARE ACQUISITION COMPANY", FILED IN THIS OFFICE ON THE THIRTEENTH DAY OF MAY, A.D. 2002, AT 9 O'CLOCK A.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

3524825 8100

020305259

AUTHENTICATION: 1775085

DATE: 05-14-02

STATE OF DELAWARE
SECRETARY OF STATE
DIVISION OF CORPORATIONS
FILED 09:00 AM 05/13/2002
020305259 – 3524825

CERTIFICATE OF INCORPORATION

OF

WELLCARE ACQUISITION COMPANY

ARTICLE ONE

The name of the corporation is WellCare Acquisition Company (hereinafter called the "Corporation").

ARTICLE TWO

The address of the Corporation's registered office in the state of Delaware is 2711 Centreville Road, Suite 400, Wilmington, New Castle County, Delaware 19808. The name of its registered agent at such address is Corporation Service Company.

ARTICLE THREE

The purpose of the Corporation is to engage in any lawful act or activity for which corporations may be organized under the General Corporation Law of Delaware.

ARTICLE FOUR

The total number of shares which the Corporation shall have the authority to issue is One Hundred (100) shares, all of which shall be shares of Common Stock, with a par value of $0.01 (One Cent) per share.

ARTICLE FIVE

The name and mailing address of the incorporator is as follows:

Name	Address
Cindy Rashed Reilly	Kirkland & Ellis 153 East 53rd Street, 39th Fl. New York, NY 10022

ARTICLE SIX

The directors shall have the power to adopt, amend or repeal By-Laws, except as may be otherwise be provided in the By-Laws.

ARTICLE SEVEN

The Corporation expressly elects not to be governed by Section 203 of the General Corporation Law of the State of Delaware.

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ARTICLE EIGHT

To the fullest extent permitted by the General Corporation Law of the State of Delaware as the same exists or may hereafter be amended, a director of this Corporation shall not be liable to the Corporation or its stockholders for monetary damages for a breach of fiduciary duty as a director. Any repeal or modification of this ARTICLE EIGHT shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification.

ARTICLE NINE

The Corporation reserves the right to amend or repeal any provisions contained in this Certificate of Incorporation from time to time and at any time in the manner now or hereafter prescribed by the laws of the State of Delaware, and all rights conferred upon stockholders and directors are granted subject to such reservation.

* * * *

I, the undersigned, being the sole incorporator hereinbefore named, for the purpose of forming a corporation in pursuance of the General Corporation Law of the State of Delaware, do make and file this Certificate, hereby declaring and certifying that the facts herein stated are true, and accordingly have hereunto set my hand this 13th day of May 2002.

Cindy Rashed Reilly
Sole Incorporator

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N. Y. S. DEPARTMENT OF STATE
DIVISION OF CORPORATIONS AND STATE RECORDS ALBANY, NY 12231-0001

FILING RECEIPT

ENTITY NAME: THE WELLCARE MANAGEMENT GROUP, INC.

DOCUMENT TYPE: CHANGE (DOM. BUSINESS) COUNTY: NEWY
PROCESS REG.AGENT

FILED:09/23/2009 DURATION:********* CASH#:090923000044 FILM #:090923000042

FILER:

REBECCA NEAL
8735 HENDERSON RD.

TAMPA, FL 33614

ADDRESS FOR PROCESS:

C/O C T CORPORATION SYSTEM
111 EIGHTH AVENUE
NEW YORK, NY 10011

REGISTERED AGENT:

C T CORPORATION SYSTEM
111 EIGHTH AVENUE
NEW YORK, NY 10011

SERVICE COMPANY: CT CORPORATION SYSTEM - 07 SERVICE CODE: 07

FEES	40.00	PAYMENTS	40.00
FILING	30.00	CASH	0.00
TAX	0.00	CHECK	40.00
CERT	0.00	CHARGE	0.00
COPIES	10.00	DRAWDOWN	0.00
HANDLING	0.00	OPAL	0.00
		REFUND	0.00

7651737MC DOS-1025 (04/2007)

STATE OF NEW YORK

DEPARTMENT OF STATE

I hereby certify that the annexed copy has been compared with the original document in the custody of the Secretary of State and that the same is a true copy of said original.

WITNESS my hand and official seal of the Department of State, at the City of Albany, on September 24, 2009.

Daniel E. Shapiro
First Deputy Secretary of State

Rev. 05/09

090923000042

CT-07

CERTIFICATE OF CHANGE
OF
The WellCare Management Group, Inc.

UNDER SECTION 805-A OF THE BUSINESS CORPORATION LAW

1. The name of the corporation is The WellCare Management Group, Inc. It was incorporated under the name Ullmann and Castellon, Inc.

2. The Certificate of Incorporation of said corporation was filed by the Department of State on the 08/25/83.

3. The following was authorized by the Board of Directors:

To change the post office address to which the Secretary of State shall mail a copy of process in any action or proceeding against the corporation which may be served on him to: c/o C T Corporation System, 111 Eighth Avenue, New York, N.Y. 10011.

To change the registered agent in New York upon whom all process against the corporation may be served to: C T CORPORATION SYSTEM, at 111 Eighth Avenue, New York, N.Y. 10011.

Name and Capacity of Signer

Tim Light Vice President

NY008 – 05/03/2005 C T System Online

090923000042

CT-07

090923000042

Certificate of Change

OF

The WellCare Management Group, Inc.

Under Section 805-A of the Business Corporation Law

1 CC

STATE OF NEW YORK
DEPARTMENT OF STATE
SEP 23 2009
FILED
TAX $
BY:

Filed by: cst ref# 7651737MC

(Name) Rebecca Neal

(Mailing address) 8735 Henderson Rd.

(City, State and ZIP code) Tampa, FL. 33614

NY102 - 03/21/07 C T System Online

044

New York State
Department of State
Division of Corporations, State Records
and Uniform Commercial Code
41 State Street
Albany, NY 12231

CERTIFICATE OF CHANGE OF

THE WELLCARE MANAGEMENT GROUP, INC.
(Insert Name of Domestic Corporation)

Under Section 805-A of the Business Corporation Law

FIRST: The name of the corporation is: THE WELLCARE MANAGEMENT GROUP, INC.

If the name of the corporation has been changed, the name under which it was formed is: _____

SECOND: The certificate of incorporation was filed by the Department of State on: August 25, 1983

THIRD: The change(s) effected hereby are: *[Check appropriate box(es)]*

☐ The county location, within this state, in which the office of the corporation is located, is changed to: _____

☑ The address to which the Secretary of State shall forward copies of process accepted on behalf of the corporation is changed to: c/o LexisNexis Document Solutions Inc. 1275 Broadway, Albany, NY 12204

☐ The corporation hereby: *[Check one]*

- ☐ Designates _____ as its registered agent upon whom process against the corporation may be served.
- ☑ Changes the designation of its registered agent to: LexisNexis Document Solutions Inc., 1275 Broadway, Albany, NY 12204
- ☐ Changes the address of its registered agent to: _____
- ☐ Revokes the authority of its registered agent.

DOS-1558 (5/01)

FOURTH: The change was authorized by the board of directors.

(Signature)

THADDEUS BERREDAY, SECRETARY
(Name and Capacity of Signer)

CERTIFICATE OF CHANGE
OF

THE WELLCARE MANAGEMENT GROUP, INC.
(Insert Name of Domestic Corporation)

Under Section 805-A of the Business Corporation Law

Filer's Name LexisNexis Document Solutions Inc. by Lyn Stiley

Address 30 Old Rudnick Lane

City, State and Zip Code Dover, DE 19901

NOTE: This form was prepared by the New York State Department of State. You are not required to use this form. You may draft your own form or use forms available at legal stationery stores. The Department of State recommends that all documents be prepared under the guidance of an attorney. The certificate must be submitted with a $30 filing fee.

For Office Use Only

F02080100063

RESTATED CERTIFICATE OF INCORPORATION

OF

THE WELLCARE MANAGEMENT GROUP, INC.

Under Section 807 of the Business Corporation Law

We, the undersigned, Todd S. Farha and David Smith, being the President and Secretary, respectively, of The WellCare Management Group, Inc., do hereby certify:

FIRST: The name of the corporation is The WellCare Management Group, Inc. (the "Corporation").

SECOND: The certificate of incorporation of the Corporation was filed with the Department of State of New York on August 25, 1983 under the original name of Ullmann and Castellon, Inc.

THIRD: The certificate of incorporation of the Corporation is hereby amended or changed to effect one or more of the amendments or changes authorized by the Business Corporation Law, as follows:

1. To change the stated purposes of the Corporation.

2. To change the location of the office of the Corporation.

3. To decrease the aggregate number of shares of all classes of capital stock of which the Corporation shall have the authority to issue (i) from an aggregate of 76,313,555 shares consisting of 75,000,000 shares of Common Stock, par value $.01 per share, of which 100 shares are currently issued and outstanding, 313,555 shares of Class A Common Stock, par value $.01 per share, of which no shares are currently issued and outstanding, and 1,000,000 shares of Preferred Stock, par value $.01 per share, of which no shares are currently issued and outstanding (ii) to an aggregate of 100 shares of Common Stock, par value $.01 per share, of which 100 shares are currently issued and outstanding.

4. To change the address to which the Secretary of State shall mail copies of any process served against the Corporation.

5. To delete a provision denying preemptive rights to the shareholders of the Corporation.

6. To delete a provision specifying the number of directors and the timing of elections and providing that directors may be removed only with cause either by action of the Board of Directors or by vote of the shareholders and to

add a provision providing that the Board of Directors is authorized to make, alter or repeal the by-laws of the Corporation.

7. To delete the provision limiting directors' and officers' liability.

8. To amend and restate the provision indemnifying directors and officers of the Corporation and to delete the provision indemnifying employees and agents of the Corporation.

FOURTH: To accomplish the foregoing amendments, Articles SECOND, THIRD, FOURTH and FIFTH of the certificate of incorporation of the Corporation, relating to (i) the purposes of the Corporation, (ii) the location of the office of the Corporation, (iii) the aggregate number of shares which the Corporation is authorized to issue, the par value thereof and the classes into which the shares are divided and (iv) the address to which copies of service of process is to be mailed, respectively, are hereby amended to read as set forth in the same numbered articles of the certificate of incorporation of the Corporation as hereinafter restated; Articles SIXTH and EIGHTH, relating to preemptive rights and limitation of directors' and officers' liability, respectively, are eliminated without substituting or adding any provisions in lieu thereof; and Articles SEVENTH and NINTH, relating to the Board of Directors and indemnification, respectively, are hereby amended and renumbered as Articles SIXTH and SEVENTH as set forth in the certificate of incorporation as hereinafter restated.

FIFTH: The restatement of the certificate of incorporation of the Corporation herein provided was approved by the Board of Directors followed by authorization by the vote of the holders of at least a majority of all of the outstanding shares of the Corporation entitled to vote thereon.

SIXTH: The text of the certificate of incorporation of the Corporation is hereby restated as further amended or changed herein to read as follows:

"FIRST: The name of the Corporation is The WellCare Management Group, Inc. (the "Corporation").

SECOND: The Corporation is formed for the following purpose or purposes:

This corporation is formed to engage in any lawful act or activity for which a corporation may be organized under the Business Corporation Law, provided that it is not formed to engage in any act or activity requiring the consent or approval of any state official, department, board, agency or other body.

THIRD: The office of the Corporation is to be located in the County of New York, State of New York.

FOURTH: The aggregate number of shares which the Corporation shall have the authority to issue is 100 shares, par value $.01 per share, all of which are to be designated as Common Stock.

2

FIFTH: The Secretary of State is designated as the agent of the Corporation upon whom process against the Corporation may be served. The post office address within the State of New York to which the Secretary of State shall mail a copy of any process against the Corporation served upon him is: c/o Corporation Service Company, 80 State Street, Albany, New York 12207-2543.

SIXTH: The Board of Directors is expressly authorized to make, alter or repeal the by-laws of the Corporation.

SEVENTH: The Corporation shall have the power to indemnify its officers and directors to the maximum extent permitted by law."

IN WITNESS WHEREOF, we have subscribed this Restated Certificate of Incorporation this 31st day of July 2002, and do hereby affirm, under the penalties of perjury, that the statements contained therein have been examined by them and are true, complete and correct.

Todd S. Farha, President

David Smith, Assistant Secretary

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State of New York }
Department of State } ss:

I hereby certify that the annexed copy has been compared with the original document filed by the Department of State and that the same is a true copy of said original.

Witness my hand and seal of the Department of State on AUG 01 2002

Secretary of State

DOS-200 (Rev. 03/02)

EX-3.1 2 d358762dex31.htm CERTIFICATE OF AMENDMENT TO THE AMENDED & RESTATED CERT. OF INCORPORATION OF BLK

Exhibit 3.1

CERTIFICATE OF AMENDMENT
TO THE
AMENDED AND RESTATED CERTIFICATE OF INCORPORATION
OF
BLACKROCK, INC.

Pursuant to Section 242 of the General
Corporation Law of the State of Delaware

BlackRock, Inc., a Delaware corporation (hereinafter called the "**Corporation**"), does hereby certify as follows:

FIRST: The third and fourth paragraphs of Article SIXTH of the Corporation's Amended and Restated Certificate of Incorporation are hereby amended to read in their entirety as set forth below:

C. **Election and Term.** A director shall be elected to hold office until the expiration of the term for which such person is elected, and until such person's successor shall be duly elected and qualified. Commencing at the annual meeting of stockholders that is held in calendar year 2013 (the "2013 Annual Meeting"), the directors of the Corporation shall be elected annually for terms of one year, except that any director in office at the 2013 Annual Meeting whose term expires at the annual meeting of stockholders in calendar year 2014 or calendar year 2015 (a "Continuing Classified Director") shall continue to hold office until the end of the term for which such director was elected and until such director's successor shall have been elected and qualified. Accordingly, at each annual meeting of stockholders after the terms of all Continuing Classified Directors have expired, all directors shall be elected for terms expiring at the next annual meeting of stockholders and until such directors' successors shall have been elected and qualified. Any vacancies created in the Board of Directors through and increase in the number of directors or otherwise may be filled in accordance with the By-Laws of the Corporation and the applicable laws of the State of Delaware.

D. **Removal of Directors.** Except as may be provided in a resolution or resolutions providing for any class or series of Preferred Stock with respect to any directors elected by the holders of such class or series, any director, or the entire Board of Directors, may be removed, with or without cause, by the holders of a majority of the votes of capital stock then entitled to vote in the election of directors at a meeting of stockholders called for that purpose, except that Continuing Classified Directors and any director appointed to fill a vacancy of any Continuing Classified Director may be removed only for cause.

SECOND: This amendment to the Corporation's Amended and Restated Certificate of Incorporation, was duly adopted in accordance with Section 242 of the General Corporation Law of the State of Delaware.

IN WITNESS WHEREOF, the Corporation has caused this Certificate to be duly executed in its corporate name this 24th day of May, 2012.

BlackRock, Inc.

By: /s/ Harris Oliner
Name: Harris Oliner
Title: Secretary

COMMONWEALTH OF KENTUCKY

STEVEN L. BESHEAR

GOVERNOR
DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

Amended

Satisfactory evidence has been furnished to me showing that **WellCare Health Insurance Company of Kentucky, Inc. DBA WellCare of Kentucky, Inc.** organized in the State of **Kentucky**, and having its principal office at **Louisville, KY**, is in sound and solvent condition, and has fully complied with all the provisions of the Insurance Laws of the Commonwealth of Kentucky that are applicable thereto. Now, therefore, on behalf of the Department of Insurance of the Commonwealth of Kentucky, I do hereby authorize the said insurance company to transact the business of

Life, Annuity, Health Insurance

in this Commonwealth for the period beginning on the date shown below and to continue in force as long as the insurer is entitled thereto.

Sharon P. Clark
Commissioner, Department of Insurance

This Certificate of Authority shall, at all times, be the property of the Commonwealth of Kentucky, and upon any expiration, suspension, revocation, or termination thereof, the insurer shall promptly deliver this Certificate to the Department of Insurance.

CERTIFICATE NO: 36-6069295 **DATE: 08/02/2013**

EFFECTIVE DATE: 08/01/2013

DESCRIPTION	VALUE
Insurer Name	Wellcare Health Plans of Kentucky, Inc.
DBA Name	WellCare of Kentucky, Inc.
Reporting quarter	619- Q2 2019
Contact Person	Rebecca Randall
Insurer's Telephone Number	502-253-5111
First Line of Mailing Address	13551 Triton Park Blvd.
Second Line of Mailing Address	
City	Louisville
State	KY
Zip Code	40223
NAIC Number	64467
NAIC Group Number	1199

DESCRIPTION	VALUE
Insurer Name	Wellcare Health Plans of Kentucky, Inc.
Federal Tax ID_Number	36-6069295
For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	95.62%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	63657	150423	2115801	0
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within the claims payment timeframe.	97.87%	98.92%	99.53%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment timeframe.	2.09%	1.05%	0.45%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty-one (31) to sixty (60) days after claims payment timeframe.	0.01%	0.01%	0.01%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to sixty (90) days after claims payment timeframe.	0.00%	0.01%	0.01%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment timeframe.	0.03%	0.00%	0.00%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	0.01%	0.00%	0.00%	0.00%
Percentage of Clean Claims received during the reporting quarter that were pa and not denied or contested within the claims payment timeframe.	89.88%	82.83%	87.89%	0.00%
Percentage of Clean Claims received during the reporting quarter that were pa and not denied or contested within one (1) to thirty (30) days from the end of th claims payment timeframe.	1.61%	0.95%	0.37%	0.00%
Percentage of Clean Claims received during the reporting quarter that were pa and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe.	0.01%	0.01%	0.01%	0.00%
Percentage of Clean Claims received during the reporting quarter that were pa and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe.	0.00%	0.01%	0.00%	0.00%
Percentage of Clean Claims received during the reporting quarter that were pa and not denied or contested more than ninety (90) days from the end of the claims payment timeframe.	0.01%	0.00%	0.00%	0.00%
Amount of interest paid.	4828.2	411.41	32053.43	0
For Clean Claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.	94.18%	97.95%	95.72%	0.00%

DESCRIPTION	VALUE
Insurer Name	Wellcare Health Plans of Kentucky, Inc.
DBA Name	WellCare of Kentucky, Inc.
Reporting quarter	319 Q12019
Contact Person	Rebecca Randall
Insurer's Telephone Number	502-253-5111
First Line of Mailing Address	13551 Triton Park Blvd.
Second Line of Mailing Address	
City	Louisville
State	KY
Zip Code	40223
NAIC Number	64467
NAIC Group Number	1199
Federal Tax ID_Number	36-6069295
For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	94.80%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	68166	161407	2151813	0
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within the claims payment timeframe.	96.75%	99.02%	99.08%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment timeframe.	3.17%	0.96%	0.85%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty-one (31) to sixty (60) days after claims payment timeframe.	0.08%	0.00%	0.04%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to sixty (90) days after claims payment timeframe.	0.01%	0.00%	0.01%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment timeframe.	0.00%	0.00%	0.01%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	0.00%	0.01%	0.01%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within the claims payment timeframe.	96.65%	99.05%	99.10%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within one (1) to thirty (30) days from the end of the claims payment timeframe.	3.04%	0.86%	0.75%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe.	0.04%	0.00%	0.03%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe.	0.00%	0.00%	0.01%	0.00%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested more than ninety (90) days from the end of the claims payment timeframe.	0.00%	0.00%	0.00%	0.00%
Amount of interest paid.	6183.23	241.7	71322.39	0
For Clean Claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.	94.00%	97.05%	94.83%	0.00%

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
3	Total claims received in the reporting quarter	89,325	$150,416,512.79	277,941	$65,685,686.78	2,151,813	$326,970,591.41	2,519,079	$543,072,790.98
4	Total clean claims received	68,166	$43,718,760.44	161,407	$10,189,677.11	2,151,813	$326,970,591.41	2,381,386	$380,879,028.96
5	Total clean claims adjudicated within claims payment timeframe	65,948	$41,096,566.63	159,840	$9,882,010.18	2,132,136	$310,065,916.71	2,357,924	$361,044,493.52
6	Total clean claims adjudicated 1 to 30 days after claims payment timeframe	2,158	$2,548,340.14	1,544	$300,041.42	18,360	$14,999,318.55	22,062	$17,847,700.11
7	Total clean claims adjudicated 31 to 60 days after claims payment timeframe	52	$71,412.07	5	$17.76	828	$1,185,618.67	885	$1,257,048.50
8	Total clean claims adjudicated 61 to 90 days after claims payment timeframe	4	$32.07	3	$6.48	243	$582,993.66	250	$583,032.21
9	Total clean claims adjudicated more than 90 days after claims payment timeframe	3	$2,409.53	8	$41.27	180	$123,492.52	191	$125,943.32
10	Total Clean Claims that have not yet been adjudicated	0	$0.00	1	$0.00	2	$0.00	3	$0.00
11	Amount of interest paid	1,973	$6,183.23	1,288	$241.70	15,246	$71,322.39	18,507	$77,747.32
12	Total Clean Claims received during reporting quarter that were paid	62,866	$43,718,731.87	145,657	$10,189,633.63	1,905,863	$326,956,710.48	2,114,386	$380,865,075.98
13	Total clean claims paid within claims payment timeframe	60,760	$41,096,538.06	144,266	$9,881,966.70	1,888,715	$310,064,610.12	2,093,741	$361,043,114.88
14	Total clean claims paid 1 to 30 days after claims payment timeframe	2,075	$2,548,340.14	1,384	$300,041.42	16,246	$14,999,041.04	19,705	$17,847,422.60

Attachment B.2.b.iv-8 Q1 2019 Supplemental Report

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
15	Total clean claims paid 31 to 60 days after claims payment timeframe	28	$71,412.07	1	$17.76	611	$1,185,618.67	640	$1,257,048.50
16	Total clean claims paid 61 to 90 days after claims payment timeframe	2	$32.07	2	$6.48	178	$582,993.66	182	$583,032.21
17	Total clean claims paid more than 90 days after claims payment timeframe	1	$2,409.53	3	$41.27	107	$123,492.52	111	$125,943.32
18	Total clean claims denied within claims payment timeframe	5,188	$28.57	15,561	$43.48	243,396	$1,192.01	264,145	$1,264.06
19	Total clean claims denied 1 to 30 days after claims payment timeframe	83	$0.00	160	$0.00	2,109	$0.00	2,352	$0.00
20	Total clean claims denied 31 to 60 days after claims payment timeframe	24	$0.00	3	$0.00	208	$0.00	235	$0.00
21	Total clean claims denied 61 to 90 days after claims payment timeframe	2	$0.00	1	$0.00	61	$0.00	64	$0.00
22	Total clean claims denied more than 90 days after claims payment timeframe	2	$0.00	3	$0.00	64	$0.00	69	$0.00
23	Total clean claims contested within claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
24	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
25	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
26	Total clean claims contested 31 to 60 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
27	Total clean claims contested more than 90 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00

Attachment B.2.b.iv-8 Q1 2019 Supplemental Report

DESCRIPTION	VALUE
Insurer Name	Wellcare Health Plans of Kentucky, Inc.
DBA Name	WellCare of Kentucky, Inc.
Reporting quarter	1218
Contact Person	Rebecca Randall
Insurer's Telephone Number	502-253-5111
First Line of Mailing Address	13551 Triton Park Blvd.
Second Line of Mailing Address	
City	Louisville
State	KY
Zip Code	40223
NAIC Number	64467
NAIC Group Number	1199
Federal Tax ID_Number	36-6069295
For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	92.98%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	66966	155641	2060659	0
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within the claims payment timeframe.	93.97%	96.81%	97.69%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment timeframe.	5.69%	3.14%	2.19%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty-one (31) to sixty (60) days after claims payment timeframe.	0.30%	0.03%	0.09%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to sixty (90) days after claims payment timeframe.	0.03%	0.00%	0.02%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment timeframe.	0.00%	0.01%	0.00%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	0.00%	0.01%	0.01%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within the claims payment timeframe.	87.09%	88.10%	87.27%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within one (1) to thirty (30) days from the end of the claims payment timeframe.	4.40%	2.27%	1.64%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe.	0.16%	0.02%	0.06%	0.00%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	66966	155641	2060659	0
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe.	0.02%	0.00%	0.01%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested more than ninety (90) days from the end of the claims payment timeframe.	0.00%	0.00%	0.00%	0.00%
Amount of interest paid.	8929.61	727.16	80582.97	0
For Clean Claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.	90.04%	94.44%	93.30%	0.00%

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
3	Total claims received in the reporting quarter	82,542	$164,144,985.22	269,051	$63,337,252.53	2,060,659	$316,305,146.76	2,412,252	$543,787,384.51
4	Total clean claims received	66,966	$39,184,997.33	155,641	$10,155,396.57	2,060,659	$316,305,146.76	2,283,266	$365,645,540.66
5	Total clean claims adjudicated within claims payment timeframe	62,928	$35,280,835.62	150,683	$9,590,487.50	2,013,033	$295,082,820.05	2,226,644	$339,954,143.17
6	Total clean claims adjudicated 1 to 30 days after claims payment timeframe	3,810	$3,694,373.29	4,886	$559,902.09	45,144	$19,065,003.54	53,840	$23,319,278.92
7	Total clean claims adjudicated 31 to 60 days after claims payment timeframe	201	$183,274.26	53	$4,545.85	1,859	$1,594,278.28	2,113	$1,782,098.39
8	Total clean claims adjudicated 61 to 90 days after claims payment timeframe	21	$26,151.33	4	$0.00	415	$500,357.16	440	$526,508.49
9	Total clean claims adjudicated more than 90 days after claims payment timeframe	2	$150.40	9	$331.71	100	$45,172.35	111	$45,654.46
10	Total Clean Claims that have not yet been adjudicated	0	$0.00	1	$0.00	2	$585.68	3	$585.68
11	Amount of interest paid	2,643	$8,929.61	2,806	$727.16	30,916	$80,582.97	36,365	$90,239.74
12	Total Clean Claims received during reporting quarter that were paid	61,396	$39,184,832.07	140,682	$10,155,267.15	1,833,613	$316,292,682.22	2,035,691	$365,632,781.44
13	Total clean claims paid within claims payment timeframe	58,324	$35,280,835.62	137,122	$9,590,487.50	1,798,347	$295,081,619.75	1,993,793	$339,952,942.87
14	Total clean claims paid 1 to 30 days after claims payment timeframe	2,944	$3,694,373.29	3,532	$559,902.09	33,816	$19,065,003.54	40,292	$23,319,278.92

Attachment B.2.b.iv-10 Q4 2018 Supplemental Report

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
15	Total clean claims paid 31 to 60 days after claims payment timeframe	110	$183,274.26	27	$4,545.85	1,223	$1,594,278.28	1,360	$1,782,098.39
16	Total clean claims paid 61 to 90 days after claims payment timeframe	15	$26,151.33	0	$0.00	190	$500,357.16	205	$526,508.49
17	Total clean claims paid more than 90 days after claims payment timeframe	2	$150.40	1	$331.71	35	$45,172.35	38	$45,654.46
18	Total clean claims denied within claims payment timeframe	4,604	$0.00	13,561	$0.00	214,677	$1,169.47	232,842	$1,169.47
19	Total clean claims denied 1 to 30 days after claims payment timeframe	866	$0.00	1,351	$0.00	11,320	$0.00	13,537	$0.00
20	Total clean claims denied 31 to 60 days after claims payment timeframe	91	$0.00	24	$0.00	635	$0.00	750	$0.00
21	Total clean claims denied 61 to 90 days after claims payment timeframe	6	$0.00	3	$0.00	222	$0.00	231	$0.00
22	Total clean claims denied more than 90 days after claims payment timeframe	0	$0.00	8	$0.00	65	$0.00	73	$0.00
23	Total clean claims contested within claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
24	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00

Attachment B.2.b.iv-10 Q4 2018 Supplemental Report

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
25	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
26	Total clean claims contested 31 to 60 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
27	Total clean claims contested more than 90 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00

Attachment B.2.b.iv-10 Q4 2018 Supplemental Report

DESCRIPTION	VALUE
Insurer Name	Wellcare Health Plans of Kentucky, Inc.
DBA Name	WellCare of Kentucky, Inc.
Reporting quarter	918
Contact Person	Rebecca Randall
Insurer's Telephone Number	502-253-5111
First Line of Mailing Address	13551 Triton Park Blvd.
Second Line of Mailing Address	
City	Louisville
State	KY
Zip Code	40223
NAIC Number	64467
NAIC Group Number	1199
Federal Tax ID_Number	36-6069295
For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	87.97%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	58231	152113	1998042	0
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within the claims payment timeframe.	86.27%	93.17%	93.92%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment timeframe.	12.65%	6.10%	5.97%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty-one (31) to sixty (60) days after claims payment timeframe.	1.03%	0.24%	0.07%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to sixty (90) days after claims payment timeframe.	0.02%	0.38%	0.03%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment timeframe.	0.01%	0.07%	0.01%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	0.01%	0.05%	0.01%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within the claims payment timeframe.	80.08%	83.51%	83.03%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within one (1) to thirty (30) days from the end of the claims payment timeframe.	9.45%	4.41%	4.45%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe.	0.80%	0.18%	0.05%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe.	0.02%	0.01%	0.00%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested more than ninety (90) days from the end of the claims payment timeframe.	0.01%	0.00%	0.00%	0.00%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	58231	152113	1998042	0
Amount of interest paid.	41026.46	5042.77	104154.41	0
For Clean Claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.	81.11%	86.82%	88.84%	0.00%

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
3	Total claims received in the reporting quarter	81,391	$158,359,458.92	308,943	$78,540,841.69	1,998,042	$318,646,511.06	2,388,376	$555,546,811.67
4	Total clean claims received	58,231	$38,518,852.91	152,113	$9,690,194.05	1,998,042	$318,646,511.06	2,208,386	$366,855,558.02
5	Total clean claims adjudicated within claims payment timeframe	50,238	$31,244,199.63	141,717	$8,412,907.83	1,876,528	$283,073,304.01	2,068,483	$322,730,411.47
6	Total clean claims adjudicated 1 to 30 days after claims payment timeframe	7,369	$5,944,427.95	9,281	$1,129,237.32	119,249	$33,927,970.33	135,899	$41,001,635.60
7	Total clean claims adjudicated 31 to 60 days after claims payment timeframe	602	$1,304,685.08	364	$146,597.61	1,401	$1,436,229.38	2,367	$2,887,512.07
8	Total clean claims adjudicated 61 to 90 days after claims payment timeframe	13	$21,417.71	579	$727.74	570	$146,977.70	1,162	$169,123.15
9	Total clean claims adjudicated more than 90 days after claims payment timeframe	4	$4,112.54	111	$90.13	183	$55,188.24	298	$59,390.91
10	Total Clean Claims that have not yet been adjudicated	0	$0.00	2	$0.00	3	$47.97	5	$47.97
11	Amount of interest paid	5,176	$41,026.46	5,962	$5,042.77	74,999	$104,154.41	86,137	$150,223.64
12	Total Clean Claims received during reporting quarter that were	52,615	$38,518,842.91	134,020	$9,689,560.63	1,749,093	$318,639,037.94	1,935,728	$366,847,441.48
13	Total clean claims paid within claims payment timeframe	46,633	$31,244,199.63	127,023	$8,412,907.83	1,659,073	$283,072,748.29	1,832,729	$322,729,855.75
14	Total clean claims paid 1 to 30 days after claims payment timeframe	5,501	$5,944,427.95	6,704	$1,129,237.32	88,848	$33,927,894.33	101,053	$41,001,559.60
15	Total clean claims paid 31 to 60 days after claims payment timeframe	467	$1,304,685.08	272	$146,597.61	1,073	$1,436,229.38	1,812	$2,887,512.07
16	Total clean claims paid 61 to 90 days after claims payment timeframe	11	$21,417.71	19	$727.74	62	$146,977.70	92	$169,123.15

Attachment B.2.b.iv-12 Q3 2018 Report 53 Supplemental

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
17	Total clean claims paid more than 90 days after claims payment timeframe	3	$4,112.54	2	$90.13	36	$55,188.24	41	$59,390.91
18	Total clean claims denied within claims payment timeframe	3,603	$0.00	14,694	$0.00	217,453	$555.72	235,750	$555.72
19	Total clean claims denied 1 to 30 days after claims payment timeframe	1,868	$0.00	2,577	$0.00	30,396	$50.00	34,841	$50.00
20	Total clean claims denied 31 to 60 days after claims payment timeframe	135	$0.00	90	$0.00	328	$0.00	553	$0.00
21	Total clean claims denied 61 to 90 days after claims payment timeframe	2	$0.00	559	$0.00	507	$0.00	1,068	$0.00
22	Total clean claims denied more than 90 days after claims payment timeframe	1	$0.00	103	$0.00	137	$0.00	241	$0.00
23	Total clean claims contested within claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
24	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
25	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
26	Total clean claims contested 31 to 60 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
27	Total clean claims contested more than 90 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00

DESCRIPTION	VALUE
Insurer Name	Wellcare Health Plans of Kentucky, Inc.
DBA Name	WellCare of Kentucky, Inc.
Reporting quarter	618
Contact Person	Rebecca Randall
Insurer's Telephone Number	502-253-5111
First Line of Mailing Address	13551 Triton Park Blvd.
Second Line of Mailing Address	
City	Louisville
State	KY
Zip Code	40223
NAIC Number	64467
NAIC Group Number	1199
Federal Tax ID_Number	36-6069295
For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment time frame for all claims (excluding pharmacy).	87.81%

Description	Hospital	Physician	All other providers excluding pharmacy	LHSBP - Dental only
Number of Clean Claims received by the insurer, its agent, or designee during the reporting quarter.	69787	156944	2096258	0
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated within the claims payment timeframe.	99.14%	99.68%	95.31%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated one (1) to thirty (30) days after claims payment timeframe.	0.75%	0.30%	4.49%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated thirty-one (31) to sixty (60) days after claims payment timeframe.	0.05%	0.01%	0.17%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated sixty-one (61) to sixty (90) days after claims payment timeframe.	0.04%	0.00%	0.02%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were adjudicated more than ninety (90) days after claims payment timeframe.	0.02%	0.00%	0.01%	0.00%
Percentage of Clean Claims received by the insurer, its agent, or designee that were not yet adjudicated.	0.00%	0.00%	0.00%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within the claims payment timeframe.	90.24%	90.11%	84.80%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within one (1) to thirty (30) days from the end of the claims payment timeframe.	0.62%	0.14%	3.30%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe.	0.03%	0.00%	0.12%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe.	0.03%	0.00%	0.02%	0.00%
Percentage of Clean Claims received during the reporting quarter that were paid and not denied or contested more than ninety (90) days from the end of the claims payment timeframe.	0.00%	0.00%	0.00%	0.00%
Amount of interest paid.	7294.01	360.59	230935.95	0
For Clean Claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.	93.21%	97.73%	86.80%	0.00%

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
3	Total claims received in the reporting quarter	88,931	$139,341,535.62	288,480	$70,061,788.37	2,096,258	$313,526,681.95	2,473,669	$522,930,005.94
4	Total clean claims received	69,787	$39,612,780.94	156,944	$10,156,963.70	2,096,258	$313,526,681.95	2,322,989	$363,296,426.59
5	Total clean claims adjudicated within claims payment timeframe	69,188	$36,924,304.18	156,450	$9,926,521.89	1,997,918	$272,118,046.36	2,223,556	$318,968,872.43
6	Total clean claims adjudicated 1 to 30 days after claims payment timeframe	521	$2,578,429.54	469	$229,496.22	94,102	$34,896,216.34	95,092	$37,704,142.10
7	Total clean claims adjudicated 31 to 60 days after claims payment timeframe	38	$50,853.29	16	$912.54	3,530	$4,657,019.46	3,584	$4,708,785.29
8	Total clean claims adjudicated 61 to 90 days after claims payment timeframe	26	$54,138.45	2	$0.00	502	$1,495,619.82	530	$1,549,758.27
9	Total clean claims adjudicated more than 90 days after claims payment timeframe	14	$5,055.48	7	$33.05	145	$337,133.06	166	$342,221.59
10	Total Clean Claims that have not yet been adjudicated	0	$0.00	0	$0.00	0	$0.00	0	$0.00
11	Amount of interest paid	412	$7,294.01	189	$360.59	58,738	$230,935.95	59,339	$238,590.55
12	Total Clean Claims received during reporting quarter that were paid	63,458	$39,612,780.94	141,650	$10,156,953.10	1,849,602	$313,491,995.70	2,054,710	$363,261,729.74
13	Total clean claims paid within claims payment timeframe	62,979	$36,924,304.18	141,429	$9,926,511.29	1,777,536	$272,116,912.93	1,981,944	$318,967,728.40
14	Total clean claims paid 1 to 30 days after claims payment timeframe	435	$2,578,429.54	212	$229,496.22	69,102	$34,889,548.31	69,749	$37,697,474.07
15	Total clean claims paid 31 to 60 days after claims payment timeframe	20	$50,853.29	7	$912.54	2,499	$4,652,691.01	2,526	$4,704,456.84
16	Total clean claims paid 61 to 90 days after claims payment timeframe	21	$54,138.45	0	$0.00	382	$1,495,619.82	403	$1,549,758.27

Attachment B.2.b.iv-14 Q2 2018 Supplemental Report

Row	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
1	DESCRIPTION	Hospital		Physician		All other excluding RX		Total	
2		Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims	Total # of Claims	Total $ of Claims
17	Total clean claims paid more than 90 days after claims payment timeframe	3	$5,055.48	2	$33.05	81	$337,133.06	86	$342,221.59
18	Total clean claims denied within claims payment timeframe	6,209	$0.00	15,020	$10.60	220,382	$1,133.43	241,611	$1,144.03
19	Total clean claims denied 1 to 30 days after claims payment timeframe	85	$0.00	253	$0.00	24,987	$1.54	25,325	$1.54
20	Total clean claims denied 31 to 60 days after claims payment timeframe	17	$0.00	8	$0.00	1,022	$0.00	1,047	$0.00
21	Total clean claims denied 61 to 90 days after claims payment timeframe	4	$0.00	2	$0.00	119	$0.00	125	$0.00
22	Total clean claims denied more than 90 days after claims payment timeframe	11	$0.00	5	$0.00	63	$0.00	79	$0.00
23	Total clean claims contested within claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
24	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
25	Total clean claims contested 1 to 30 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
26	Total clean claims contested 31 to 60 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00
27	Total clean claims contested more than 90 days after claims payment timeframe	0	$0.00	0	$0.00	0	$0.00	0	$0.00

Deloitte.

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May 8, 2019

The Audit Committee and Management of
WellCare Health Insurance Company of Kentucky, Inc.
8725 Henderson Road
Renaissance One
Tampa, FL 33634

Dear Members of the Audit Committee and Management:

In planning and performing our audit of the statutory-basis financial statements of WellCare Health Insurance Company of Kentucky, Inc. (the "Company") as of and for the year ended December 31, 2018 (on which we have issued our report dated May 8, 2019), in accordance with auditing standards generally accepted in the United States of America, we considered the Company's internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses as of December 31, 2018.

The definitions of a deficiency and a material weakness are set forth in the attached Appendix I.

A description of the responsibility of management for establishing and maintaining internal control over financial reporting and of the objectives of and inherent limitations of internal control over financial reporting is set forth in the attached Appendix II and should be read in conjunction with this report.

This report is intended solely for the information and use of the audit committee, management, others within the organization, and state insurance departments to whose jurisdiction the Company is subject and is not intended to be, and should not be, used by anyone other than these specified parties.

Yours truly,

Deloitte & Touche LLP

APPENDIX I

DEFINITIONS

The definitions of a deficiency and a material weakness are as follows:

A *deficiency* in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when (a) a properly designed control does not operate as designed, or (b) the person performing the control does not possess the necessary authority or competence to perform the control effectively.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

APPENDIX II

MANAGEMENT'S RESPONSIBILITY FOR, AND THE OBJECTIVES AND LIMITATIONS OF, INTERNAL CONTROL OVER FINANCIAL REPORTING

The following comments concerning management's responsibility for internal control over financial reporting and the objectives and inherent limitations of internal control over financial reporting are adapted from auditing standards generally accepted in the United States of America.

MANAGEMENT'S RESPONSIBILITY

The Company's management is responsible for the overall accuracy of the statutory-basis financial statements and their conformity with accounting practices prescribed or permitted by the Kentucky Department of Insurance. In this regard, management is also responsible for establishing and maintaining effective internal control over financial reporting.

OBJECTIVES OF INTERNAL CONTROL OVER FINANCIAL REPORTING

Internal control over financial reporting is a process effected by those charged with governance, management, and other personnel and designed to provide reasonable assurance about the achievement of the entity's objectives with regard to reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control over the safeguarding of assets against unauthorized acquisition, use, or disposition may include controls related to financial reporting and operations objectives. Generally, controls that are relevant to an audit of financial statements are those that pertain to the entity's objective of reliable financial reporting (i.e., the preparation of reliable statutory-basis financial statements that are fairly presented in conformity with accounting practices prescribed or permitted by the Kentucky Department of Insurance.

INHERENT LIMITATIONS OF INTERNAL CONTROL OVER FINANCIAL REPORTING

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented, or detected and corrected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

3. Staffing

B.3. STAFFING

a. Describe the Vendor's proposed approach to staffing this Contract, including the following information at a minimum

i. Description of how the organizational structure provides innovative solutions for meeting programmatic goals specific to Kentucky's Medicaid program and Enrollees and supports stakeholder groups (e.g., Enrollees, providers, partners, among others).

ii. Description of how the organizational structure will support whole-person integrated care, population health and overall improvement in health outcomes in a cost-effective manner.

iii. Description of the governing body, how members are selected, and envisioned role specific to the Vendor's support of the Kentucky Medicaid managed care program.

iv. A listing of Key Personnel identified in Section 9.2 of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," and as otherwise defined by the Vendor, including:

   a. Individual names, titles, brief job descriptions, qualifications and fulltime equivalents (FTEs) dedicated to this Contract, as well as their office locations for this Contract. An FTE is defined as the ratio of the total number of paid hours divided by the total number of working hours in the period. Annually, an FTE is considered to be two thousand eighty (2,080) hours.

   b. Whether each Key Personnel position will be filled by a Vendor's employee or a Subcontractor.

   c. Resumes, including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Include as an Appendix or Attachment to the Proposal.

v. Summary of recruitment timelines and activities for Key Personnel positions for which individuals have not been identified at the time of the proposal. Describe contingency plans should those positions continue to remain open after Contract Award.

vi. Overview of the Vendor's proposed training of staff to fulfill all requirements and responsibilities of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," for all operational areas.

vii. Overview of Vendor's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

viii. Retention approach for key personnel.

b. Provide a detailed description of the Vendor's organizational structure for this Contract, including an organizational chart that clearly displays the following:

i. Management structure, lines of responsibility, and authority for all operational areas of this Contract.

ii. How the RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices" fits into the overall organizational structure of the Parent Company.

iii. Where subcontractors will be incorporated.

iv. A summary of how each Subcontractor will be integrated into the Offeror's proposal performance of their obligations under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," to ensure a streamlined experience for the Members, providers and the Department.

v. Number of proposed FTEs dedicated to RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," by position type and operational area and how the Vendor determined the appropriateness of these ratios.

B.3. STAFFING

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 9.2 Administration/Staffing of the Draft Medicaid Managed Care Contract (MMC) and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. WellCare of Kentucky is already fully staffed to support the Kentucky MMC program and we will submit a detailed staffing plan within the timeframes defined by DMS.

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc. (WellCare). On January 23, 2020 WellCare was acquired by Centene Corporation (Centene). WellCare is now a wholly owned subsidiary of Centene. **WellCare of Kentucky's leadership, staff, branding, and model for delivering services to the Commonwealth is not changing and we remain committed to partnering with DMS to ensure Kentucky's Enrollees, communities, providers and other stakeholders receive the integrated, whole-person care and services necessary to address all of their physical, behavioral, and social needs.** With the acquisition, WellCare of Kentucky is now also able to leverage the combined experience and best practices of our Centene affiliate health plans, which is now managing the care of more than 12.9 million Medicaid Enrollees across 30 states.

a. Describe the Vendor's proposed approach to staffing this Contract, including the following information at a minimum

PROPOSED APPROACH TO STAFFING THIS CONTRACT

As an experienced managed care partner with over three decades serving Medicaid beneficiaries across more than a dozen states, we share DMS' view and vision for how managed care can be a mechanism for change and transformation in the lives of Medicaid Enrollees. As described below, our approach, which has been built and refined through our exclusive focus on government sponsored health programs, is grounded on putting the Enrollee first, providing whole-person, fully integrated care, delivering services locally, positively impacting unmet social needs, and ensuring access through and aligning with our provider partners. This focus and approach has resulted in WellCare growing to become the largest Medicaid health plan in half of our 12 states. Further, we have garnered the trust and support of our state customers as evidenced by the fact that in the last 5 years, WellCare is the only national Medicaid managed care plan to be re-awarded 100% of rebid contracts and, in multiple states, have been awarded contracts to serve additional populations and geographies, many being new to managed care.

WellCare of Kentucky is first and foremost a local company. In 2011, when developing our initial staffing plan for the Kentucky Medicaid Managed Care (MMC) program, we understood the

criticality of offering a locally staff plan in Kentucky, employing a local workforce that lives and operates within the Commonwealth. As such, we developed a face-to-face, high-touch staffing model where our local Executive Team and associates are out in the field, engaging with our Enrollees, providers, community partners, and DMS to ensure their needs are being met. **Since that time, WellCare of Kentucky has become the most hands-on Managed Care Organization (MCO) within the Commonwealth and we have the most experienced and stable leadership team out of any MCO operating Kentucky's MMC program.**

Led by our Chief Executive Officer, Bill Jones, and Chief Operating Officer, Ben Orris, WellCare of Kentucky currently has in place a stable, skilled group of health plan executives that serve as our Executive Team and are responsible for oversight of all WellCare of Kentucky operations. This Executive Team has over eight years of experience operating Kentucky's MMC program and a combined tenure of more than 75 years serving Kentucky. Every member of WellCare of Kentucky's Executive Team is located in Kentucky and is dedicated full-time to this Contract. All Executive Team members are available to meet at DMS' requested location within 24 hours' notice from DMS. Each has a deep understanding of the challenges specific to the Commonwealth's health care landscape as well as institutional knowledge of our collaborative programs, network providers, and community partners in all eight regions across the Commonwealth.

Along with our executive leaders, WellCare of Kentucky employs more than 300 associates, all of which are dedicated to serving people in Kentucky and receive best-in-class training, which allows them to better support the MMC program and serve our Enrollees. Of these associates, 55 have been with WellCare of Kentucky since 2011, which shows the passion our associates have for serving our Enrollees as well as the stability of our organization supporting the MMC program. This approach to staffing this Contract is critical to our success as these locally-based employees perform a variety of key functions including, but not limited to, population health, utilization management, grievances and appeals, quality improvement, provider service (including provider relations, network development, and enrollment), pharmacy enrollee services, compliance, finance, and enrollee and provider complaints.

Additionally, a stable and established workforce of more than 800 associates working at our corporate headquarters in Tampa, support our associates within the Commonwealth. All told, WellCare has over 1,100 associates supporting the Kentucky MMC program.

i. Description of how the organizational structure provides innovative solutions for meeting programmatic goals specific to Kentucky's Medicaid program and Enrollees and supports stakeholder groups (e.g., Enrollees, providers, partners, among others).

AN ORGANIZATIONAL STRUCTURE THAT PROVIDES INNOVATIVE SOLUTIONS

WellCare of Kentucky is a thought leader within the Commonwealth and our drive for developing and providing innovative solutions permeates all aspects of our organization from executive leadership to every WellCare associate. WellCare of Kentucky is the only MCO in the state with a completely integrated team and service capabilities. Under the umbrella of our health plan leadership, and

leveraging the support and resources of WellCare Health Plans, Inc., our operational structure and processes fully support the integrated delivery of services, including WellCare staff, contractors, systems, and call centers. Building on WellCare of Kentucky's achievements and experience operating within the Commonwealth, we support DMS' goal of enhancing its current Medicaid managed care system with a focus on quality goals and improving health outcomes.

WellCare at Home Care Management Team – Supporting our Enrollees through a Whole-Person Approach

Our clinical organization structure has always supported the programmatic goals of ensuring high-needs Enrollees get access to the services and supports they need. WellCare of Kentucky has utilized a local high-touch, high-engagement care management model since we began providing services within the Commonwealth in 2011. WellCare of Kentucky believes in leveraging one integrated care team covering all care needs including physical, behavioral, pharmacy and unmet social needs. Within this model, we have built on our innovative organizational structure in which WellCare provides and oversees local care management, which includes local, in-person, care coordination resources from WellCare and from our partners. These staff live and work in the communities they serve, reaching Enrollees in remote, rural areas, and in urban centers.

Shannon Maggard, our Population Health Management Director leads WellCare of Kentucky's Care Management Team. Shannon grew up in Eastern Kentucky and began her career in 1996 at McDowell ARH after graduating from nursing school. During this time, she gained experience while working in several areas including ICU/CCU and home health nurse. She then transferred to Hazard ARH in 2000 and worked as a care a manger in the outcomes management department, supervising teams at both the Medical and Psychiatric unit. Shannon's extensive experience as a Registered Nurse with over 22 years of managed care experience including an extensive background in case management programs and utilization management allows her to guide our Care Management Team. Our Care Management Team is comprised of more than 95 associates including over 33 Field Care Managers, 16 Field Outreach Coordinators, 20 Behavioral Health Care Managers, 11 Inpatient Care Nurses, 10 Clinical Social Workers, 3 Enrollee Outreach Coordinators, and a Behavioral Health Advocate.

WellCare at Home, supported by our advanced CareCentral care management system, ensures the administration of a seamless continuum of care management from initial screening through follow-up and monitoring at a point of care closest to the Enrollee. WellCare at Home delivers all aspects of our care model right in the communities and offer in-person and telephonic outreach to Enrollee with assessment and screenings to identify Enrollee need; care planning; interventions and engagement; monitoring etc. **After moving to this high-touch, in-person model, those Enrollees engaged experienced a 26% reduction in inpatient admission and an 8% decline in preventable ED visits.**

Unable to Contact 'REACH' Program Team - Engaging Our Most Hard-to-Reach Enrollees

WellCare of Kentucky developed an Unable to Contact program, REACH, in order to address the ongoing problem of locating and engaging high-risk Enrollees in care coordination. This program

is staffed by Member Outreach Coordinators whose focus is to research, locate, and build stronger connections with our most hard-to-reach Enrollees. Our REACH program focuses on developing innovative ways to reach and engage with our Enrollees. **In a 3-month timespan, our REACH team successfully connected with nearly 6,000 UTC Enrollees**, providing important services such as education, coordinating Enrollees with primary care providers, bridging Enrollees to our community connections resources, and helping complete the health risk assessment to better identify Enrollee needs. We deployed our REACH program Eastern Region of Kentucky and it resulted in a **19.6% reduction in Emergency Department care and a 21.4% reduction in overall medical expenses** for engaged Kentucky Enrollees.

Hazard Care center - Helping our Enrollees Take a More Active Role in their Health

Understanding the importance of helping our Enrollees engage and take a more active role in their health, we have created our Kentucky CARE Center. The CARE Center conducts telephonic outreach to Enrollees who are experiencing difficulties with eligibility or accessing the care they need for covered services or community services. We took a proactive customer service approach and developed a Kentucky CARE Center that would perform outbound calls to Enrollees at risk of a suspension for failure to meet one of the many requirements, or were potentially eligible for an exemption that would allow them to maintain their benefits. We worked collaboratively with the Economic Development Cabinet, Kentucky Community and Technical College System, One Kentucky East, the Hazard/Perry County Chamber of Commerce and the Hazard Community and Technical College (HCTC) in selecting our final location of Hazard, Kentucky. Our decision was in part due to the significantly higher unemployment rate in Perry County compared to the statewide average, as well as the expansive workforce catchment area that spanned to 13 neighboring counties. In a test of the labor market performed in conjunction with HCTC, we received over 200 interested candidates. We have since learned that Hazard and neighboring communities offer a rich and motivated work force as evidenced by the 4% turnover of the new associates that were hired in August of 2018; one associate out of 23 new hires in that location over the last 16 months. That is very atypical in an industry that typically has a 30% to 50% annual turnover rate.

Despite the cancellation of the Kentucky HEALTH program, we have maintained our workforce development commitments made to the Hazard area and repurposed the functions of that team. Half of the team supports our quality team by making outbound calls to address care gaps and assisting Enrollees that may lose eligibility in the coming months. The other half supports our Community Connections Help Line (CCHL) (described below) and it has become WellCare‘s fastest growing CCHL site in the country in continuation of our efforts to impact social determinants of health. As a result of these successes and recognition of the expansive and talented workforce, we have recently completed the expanded our Hazard facility through the lease and build-out of the adjoining 3,200 square feet to facilitate future operations from this location.

Community Connections Team – Supporting our Enrollees by Addressing Their Unmet Social Needs

We began Community Connections as a pilot in the Commonwealth in 2011 as we realized how impactful unmet social needs could be on health and wellness outcomes. As a key part of our organizational structure, WellCare has made a significant investment in a team wholly dedicated to helping Enrollees address social determinants of health and helping our communities meet the diverse social service resource needs of their residents. **Since launching the Community Connections Program in Kentucky, we have connected more than 35,000 people to over 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program including a 26% reduction in Emergency Department visits, a 53% decrease in inpatient spending (Robert Wood Johnson study of our Community Connections Model (formerly CommUnity Impact), 2016).**

Elizabeth Starr, our Enrollee Services Manager, has been with WellCare since 2013 and she leads our Community Connections Team. James Baker our Manager, Community Help Line, who oversees our Community Connections Help Line and a team of Peer Coaches, supports Elizabeth. Elizabeth also oversees our Community Engagement Team comprised of Community Engagement Partners, Community Relations Specialists, and Member Engagement and Outreach Specialists. We designed our Community Connections Model to increase Enrollee access to health care by removing social barriers, driving health care cost savings by aligning social service support with health care delivery, and reinvesting the resulting savings into community supports to improve the overall system.

Our Community Connections Model features a Community Connections Help Line (CCHL) linking Enrollees and others to a comprehensive database of community social supports through peer-supported social service case management. The Community Connections Help Line (CCHL) is a resource and referral source for all callers with social service needs. Not only does CCHL assist WellCare Enrollees, they are also open to the family members and caregivers and anyone in the community who has social service needs. CCHL refers Enrollees to organizations and partners in the community who can provide housing, healthy food, utility assistance, employment and training, legal help, peer support services, and non-benefitted transportation options, as well as resources for social development.

James Baker, Manager, Community Help Line, oversees our CCHL. The CCHL is staffed by a team of Peer Coaches hired through our workforce innovation program. This team provides individuals in need with support from empathetic listeners with first-hand experience in navigating social services. Our Peer Coaches assess the needs of an individual, collect information to better understand their situation and eligibility, and connect them to local resources. Follow-up calls are completed to ensure needs are met, and connect the individual with any additional resources needed.

Dedicated Provider Engagement Team – Supporting Provider Satisfaction

WellCare of Kentucky is focused on creating the highest level of provider satisfaction with our health plan and eliminating problems for providers who serve our Enrollees. As such, in 2016,

we evolved our innovative provider engagement organizational structure to include a dedicated Commonwealth-based provider engagement team, employing local representatives who live and work in the communities they support and are better equipped to assist our providers in moving along the value-based continuum.

Anthony Piagentini, WellCare of Kentucky's Provider Services Manager, leads our provider engagement team. Anthony has been with WellCare since 2015 and is responsible for managing our provider relations team for WellCare of Kentucky including all institutional, professional, and behavioral health providers. Our Provider Engagement Team also includes Patricia Russell, our Director, Provider Operations, who has been with WellCare of Kentucky since 2011 and provides additional stability to the team. Currently, WellCare of Kentucky has the largest and most active field-based provider relations team amongst our competitors, comprised of over 30 associates to conduct provider relations and engagement in full support of DMS' goals.

With this dedicated provider engagement team, WellCare of Kentucky is able to provide the highest frequency of face-to-face and overall interactions from provider support staff among our competitors. **WellCare of Kentucky averages 736 contacts with providers each month from the Provider Relations Team. Of these interactions, on average that includes 476 face-to-face meetings in provider's offices per month.** This is supported by four Hospital Specialists calling on institutions, and 15 Provider Relations Representatives who call on primary care and behavioral health providers across the state. These interactions focus on multiple objectives including resolving existing issues, educating providers on current programs like pay-for-quality, and executing Joint Operating Committee meetings with a variety of participants including quality and pharmacy as an example.

Dedicated Quality Improvement Team – Improving the Quality of Care and Health care Outcomes for MMC Enrollees

During the last eight years serving the Commonwealth, we have developed a comprehensive Quality Management program, executed by a dedicated Quality Improvement Team. **WellCare of Kentucky leads the Commonwealth in 24 HEDIS® measures for 2019** (including all three Well-Child Visit measures, Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits), has maintained a two-year commendable NCQA accreditation status, and **has the highest member satisfaction as measured by the CAHPS® survey**. This best-in-class Quality Management program is a result of our matrixed Quality Infrastructure and local, hands-on approach. WellCare of Kentucky's Quality infrastructure is connected across all departments and functional areas of the organization including, Pharmacy, Behavioral Health, Population Health and Network Management to ensure we provide the highest quality of care for our Enrollees. By having our Quality infrastructure touch every aspect of our organization, we are able to quickly address trends in a multi-disciplinary way. Our Quality department is structured to provide a comprehensive and holistic approach to meeting DMS' goals of improving health outcomes and reducing and eliminating health disparities with the Commonwealth while empowering MMC Enrollees to improve their health and engage in their health care.

Our dedicated Quality Improvement Team's top priority is to coordinate with providers to improve health outcomes for Kentucky Medicaid Enrollees. This team consists of local experts, from leaders to support staff, who live and work in the communities they serve. Since 2015, we have added over 33 associates to our Quality Improvement Team. Our Quality leadership includes Medical Director, Dr. Howard Shaps, and Quality Improvement Director, Laura Betten. Reporting to Laura are a Senior QI manager and six QI managers with a combined 81 years of experience as Quality Practice Advisors (QPAs), Behavioral Health (BH) specialists and HEDIS experts. These managers lead dedicated QI teams consisting of more than 50 clinical experts, some of whom hold advanced degrees in epidemiology, health care administration, and social work. These experts includes QI project managers, QI specialists, QI coordinators, Health Coaches, Care Needs Coordinators, Quality Practice Advisors, Patient Care Advocate Supervisor, Patient Care Advocates, and Business Technical Analysts.

Quality Practice Advisors

As the needs of the Commonwealth have evolved, so has our dedicated Quality Improvement Team. In 2014, after meeting extensively with our providers, we realized the need to assist our providers in closing care gap needs as well as educating them on HEDIS and HPR measures, the importance of completing Appointment Agendas and capturing all chronic conditions a patient has annually. As such, we added regionally based Quality Practice Advisor (QPA) Teams to our Quality Improvement Structure. These QPAs are also responsible for coordinating with care managers and assisting provider groups in practice transformation in order to develop coordination of care for patients. In addition, QPAs are responsible for EPSDT and AMRR audits, reviewing results with providers directly and developing corrective action plans as needed.

Health Coaches

Currently, our Quality Improvement team includes Health Coaches that conduct telephonic outreach to Enrollees and have outreached to nearly 5,000 Enrollees with more than 2,000 being successfully education on recommended critical screenings and preventive services, helping to transform Enrollee lives. We will expand our program to include two additional Health Coach Teams comprised of local experts responsible for supporting DMS in improving health outcomes and addressing disparities surrounding the topics of smoking cessation, obesity and prediabetes/diabetes. These teams will strive to develop relationships with Enrollees through focused outreach, education, and support to enrollees including resources and programs relevant to each individual's needs to improve health outcomes.

Practice Transformation Specialist

We view our active participation in the KHIE community as an opportunity to significantly improve our existing strategies and to form collaborative efforts with Department. As a part of our collaboration strategy, we are creating a new position within our organization, Practice Transformation Specialist, to assist providers in adoption to EHR and connecting to KHIE. They will work in conjunction with our Quality team, monitoring the provider adoption to EHR and working with them in developing corrective action plans as needed.

ii. Description of how the organizational structure will support whole-person integrated care, population health and overall improvement in health outcomes in a cost-effective manner.

Since 2011, WellCare of Kentucky has provided an organizational structure that improves the quality of life and health outcomes for the Kentucky MMC Program Enrollees by meeting their complex physical, social, pharmacy, and behavioral health needs in a cost effective manner.

'ONE TEAM' APPROACH

WellCare of Kentucky's infrastructure provides integrated accountability with behavioral, social, pharmacy and physical health staff aligned through our clinical, administrative, and operational structure. This ensures that integration of services begins at the top of WellCare of Kentucky's management structure and flows down into our regional and local service delivery at the Enrollee level. Our governance and decision making model ensures that these local leaders engage in daily, weekly, and monthly interactions with our local staff to address Kentucky specific issues, to ensure challenges are being addressed, to ensure adherence to escalation protocols, and to guarantee our associates are making timely, accurate, and proactive decisions. Examples of these interactions include weekly meetings with leadership, weekly interdepartmental meetings, weekly and monthly report reviews, and monthly town halls.

Figure B.3-1 Integrated Care Team

WellCare of Kentucky's organizational structure and practices support integrated delivery of services across our staff, systems, call centers, and all available resources to provide a unified, streamlined managed care experience for our Enrollees, physicians, and DMS. WellCare does not subcontract behavioral health and our integrated clinical, behavioral, pharmacy and social work teams are co-located to optimize teamwork and collaboration to the benefit of the Enrollee. We believe in leveraging one integrated care team, illustrated in **Figure B.3-1**, covering all care needs including physical, behavioral, pharmacy and unmet social needs. With this organizational structure, our Enrollees have one point of contact, one card to carry, one phone number to call, which simplifies their understanding, access and coordination of all available services. For DMS, this provides a clear and transparent view into the clinical approach that WellCare delivers and for which WellCare is singularly accountable. In addition, for our provider and care management partners, it serves to deliver a comprehensive set of Enrollee data through a single on-line platform that the provider can use to access and maintain a complete health record for the people they serve, allowing providers to better meet and coordinate their needs.

Our approach to integrated service delivery begins with our 'One Team' philosophy—which has been the cornerstone of our organizational culture and the culmination of WellCare's 30 years' experience building toward a fully integrated, holistic approach to Enrollee care. One Team

means that our philosophy applies to every aspect of our organization, from the executive leadership staff led by our CEO, William Jones, to the fully integrated care management team, and across all entities that support our Enrollees, including our local subcontractors and the Enrollee call center staff trained to support the Commonwealth through the Enrollee Call Center, Nurse Advice Line (NAL), and our Behavioral Health Crisis Line.

Because of our streamlined operational structure, processes, and staff, our health plan can focus on providing comprehensive, holistic care management that focuses on proactively leveraging services that treat the whole-person. As a fully integrated health plan, we implement person-centered goal setting and care planning, address social determinants of health (SDOH), and ensure that Enrollees have reliable access to services that treat more than a specific diagnosis or condition, such as physical health, behavioral health, and pharmacy. Our whole-person care approach includes guidance assisting Enrollees with access to carved-out services when necessary, or to our suite of valued-added services that address non-medical needs and serve to improve health outcomes.

Organizational Structure Focused on Providing Whole-Person Integrated Care

Our eight years of experience in providing Medicaid services in Kentucky has taught us that the best way to ensure whole-person integrated care is to employ culturally diverse individuals who live in the communities we serve, have a deep understanding of challenges specific to the Kentucky health care landscape, and who have real life experience that reflects the experience of the Enrollees we serve. We are proud to have an Executive Team in place with expertise in the Kentucky MMC program and experience providing whole-person integrated care.

WellCare of Kentucky's CEO, Bill Jones, is fully accountable for overseeing all operations, strategic direction and administration of our Kentucky MMC Program plan. Working closely with our CEO is our Commonwealth-based Executive Team, comprised of key leaders, each of whom are responsible for overseeing specific functional areas within WellCare of Kentucky's organization. Together, our Commonwealth-level leadership team and support staff anchor each regional staff team located in one of our six regional offices. Our dynamic team of local leaders are responsible for making decisions for WellCare of Kentucky. This decision-making responsibility extends downward to the teams deployed throughout the Commonwealth to ensure that associates closest to our Enrollees, providers and stakeholders are empowered to make decisions with support and feedback from our Commonwealth leadership team. For example, the scope of decision-making authority of our local team in Kentucky includes, but is not limited to, how staff and resources are deployed throughout the local market to support our Enrollees and providers, the authority to administer the execution and management of our provider network, the ability to make decisions about Value-Based Purchasing with our providers, and the capability to make local decisions regarding claims adjudication and prior authorization issues.

An Organizational Structure Focused on Population Health and Improving Health Outcomes

Population health permeates every aspect of our organization and every single associate employed by WellCare of Kentucky is focused on improving the health of our Enrollees. Our population health strategy is grounded in an eight-year history in Kentucky, collaborating with

providers, community partners, and DMS. Our programs promote wellness and prevention, improve chronic condition management and self-management, and partnering with communities to improve population health through intervention channels at the Enrollee, provider, and system levels to deliver the highest impact to our most vulnerable populations.

Our Medical Director, Dr. Howard Shaps, and our in-house clinical management team direct our Population Health Management programs, supported by our national advisory groups and framework, to deliver improved outcomes at a lower cost. A key element of our population health strategy is **aligning clinical outcomes and performance metrics for each domain.** Through our population health domains, we align all parts of the organization to manage the health of all of our Enrollees. This alignment creates a synergy of effort across the organization in working to achieve Enrollee-centric objectives and exceeding regulatory contract requirements.

Because of our Population Health Management (PHM) Program, WellCare of Kentucky has seen a **64% reduction in Admissions for Children with Asthma and a 51.8% reduction in Admission for Adults with Asthma from 2016 to 2018**. Further evidence of our PHM Program success in Kentucky is our Comprehensive Diabetic Care, with **87% of Enrollees receiving HbA1c testing (4% above the national average)** and 92% receiving appropriate kidney monitoring. **Nearly 60% had an annual diabetic eye exam – a 22.2% increase between 2016 and 2018**.

iii. Description of the governing body, how members are selected, and envisioned role specific to the Vendor's support of the Kentucky Medicaid managed care program.

GOVERNING BODY

As shown in **Figure B.3-2**, WellCare of Kentucky, Inc. is an indirect wholly owned subsidiary of WellCare Health Plans, Inc. WellCare of Kentucky has its own Board of Directors (the "Board"), which is fully responsible for the operations and oversight of WellCare of Kentucky.

The Board has adopted bylaws and a Code of Conduct and Business Ethics Program ("Code of Conduct"), all of which are reviewed and approved by WellCare of Kentucky's Board. Authority is delegated through the management hierarchy, the Governance Overview structure, the Code of Conduct structure, and the Quality Improvement Program Descriptions of WellCare of Kentucky. In addition, the organizational charts (including those in section B.03.b) and job descriptions (including those in section B.03.iv.a) define the WellCare organizational structures and functional relationships. Associates report to management staff, who in turn report to senior management and officers, who in turn report to their respective company's Board. The Quality Improvement Program Description, which is reviewed annually and approved by WellCare of Kentucky's Board, defines individual and committee roles for each of the licensed health plans.

WellCare of Kentucky has established organizational policies and procedures to ensure all aspects of the business are conducted in an orderly manner to meet mission requirements and performance standards, such as the UMAC and the QIC, which work in conjunction with the Code of Conduct. The goal of the Code of Conduct is to establish a culture of integrity and trust within the organization and to promote the prevention, detection, and resolution of conduct that does not conform to applicable federal or state laws or the organization's high standards of

business ethics. The Code of Conduct provides guidance and oversight and helps ensure that work is performed in an ethical and legal manner. The Code of Conduct applies to WellCare of Kentucky's Board, its associates and, as applicable, its business partners.

Additional information regarding our governing body is located in section B.2 Corporate Information of our response.

HOW BOARD MEMBERS ARE SELECTED

The sole stockholder of WellCare of Kentucky, The WellCare Management Group, Inc., appoints the members of the Board. Each board director is an employee of Comprehensive Health Management, Inc., part of the WellCare Group of Companies. The members of the Board of Directors of WellCare of Kentucky, Inc. are Bill Jones, Andrew L. Asher, and Michael Troy Meyer. The Board of Directors of WellCare of Kentucky, Inc. has ultimate supervisory authority over the activities of WellCare of Kentucky. The Board meets quarterly to review the operations of WellCare of Kentucky and as needed.

Figure B.3-2 Governing Body and Ownership Structure

William Jones

William Jones is a senior leader with over 25 years of experience in health care. He is an accomplished executive with experience in working with Boards of Directors, State and Federal Legislators, and Regulators in order to deliver results. Bill is a high-energy, organizational leader with demonstrated success in developing sound strategies that are balanced between financial performance, quality, stakeholder satisfaction, and growth. He is a team player that conveys a value proposition and gains buy-in from cross-functional groups for the development and execution of strategies and the implementation of process improvements utilizing Six Sigma, Lean, and other process improvement methodologies. Bill is a change agent that brings a sense of urgency to drive positive organizational change, with experience in building, turning around/optimizing a company's fundamental infrastructure, technologies, processes, and measurement systems to increase profitability and performance.

Drew Asher

Mr. Asher serves as WellCare's executive vice president and chief financial officer. He leads WellCare's financial activities, including financial and performance management, capital strategy and planning, actuarial, medical economics, internal controls, investment management, corporate development and investor relations. Mr. Asher is also is also a member of the Audit Committee of the Company. He joined WellCare in August 2014 as senior vice president. Prior to joining WellCare, Mr. Asher was the CFO of Aetna's local and regional

businesses, a position he held since May 2013 when his former employer, Coventry Health Care, was acquired by Aetna. Mr. Asher was with Coventry for 15 years, most recently as senior vice president, corporate finance. During his tenure with Coventry, he had responsibility for financial planning and analysis, investor relations, mergers and acquisitions, capital markets, treasury, real estate and procurement. He started his career with Deloitte & Touche LLP where he spent five years as an auditor and accountant serving clients including managed care. Mr. Asher holds a bachelor's degree in accounting from the University of Florida and a master's in taxation from the University of Central Florida.

Troy Meyer

Mr. Meyer serves as WellCare's Chief Accounting Officer. He oversees WellCare's accounting operations; SEC, statutory and regulatory reporting functions; financial systems; merger and acquisition projects; revenue reconciliation functions; cash applications; and tax department. Mr. Meyer is also a member of the Audit Committee of the Company. He joined WellCare as Vice President of Financial Reporting and Analysis in May 2015. Prior to joining WellCare, Mr. Meyer dedicated 15 years of his managed care experience to Aetna, Inc. and Coventry Health Care, Inc. as their Executive Director of Regulatory and Financial Reporting, Senior Director of Financial Reporting and Analysis, and Director of Corporate Accounting and Internal Control. Mr. Meyer holds a Bachelor of Science in Business and Management from Purdue University.

ROLE SPECIFIC TO THE VENDOR'S SUPPORT OF THE KENTUCKY MMC PROGRAM

As mentioned above, the Board of Directors of WellCare Health Insurance Company of Kentucky, Inc. has ultimate supervisory authority over the activities of WellCare of Kentucky. Annually, the governing body authorizes, empowers, and directs the officers of the WellCare Group to implement all actions necessary and appropriate to enable WellCare of Kentucky to attain their mission, goals and objectives.

The Governance Overview structure (see **Figure B.3-3** Governance Overview Structure) provides a diagram of the structure of committees reporting up to the WellCare Board, as well as the downward flow of information from the WellCare Board, whereby the WellCare Board's directives may be performed and enacted at the WellCare of Kentucky plan level. Additional committees are formed to meet specific functional and regulatory needs, as defined by the Quality Improvement Program Descriptions of the licensed health plans. Typically, committees are multi-disciplinary and cross-functional, serving a variety of purposes including, but not limited to, quality improvement, credentialing, pharmacy, behavioral health, delegation, etc.

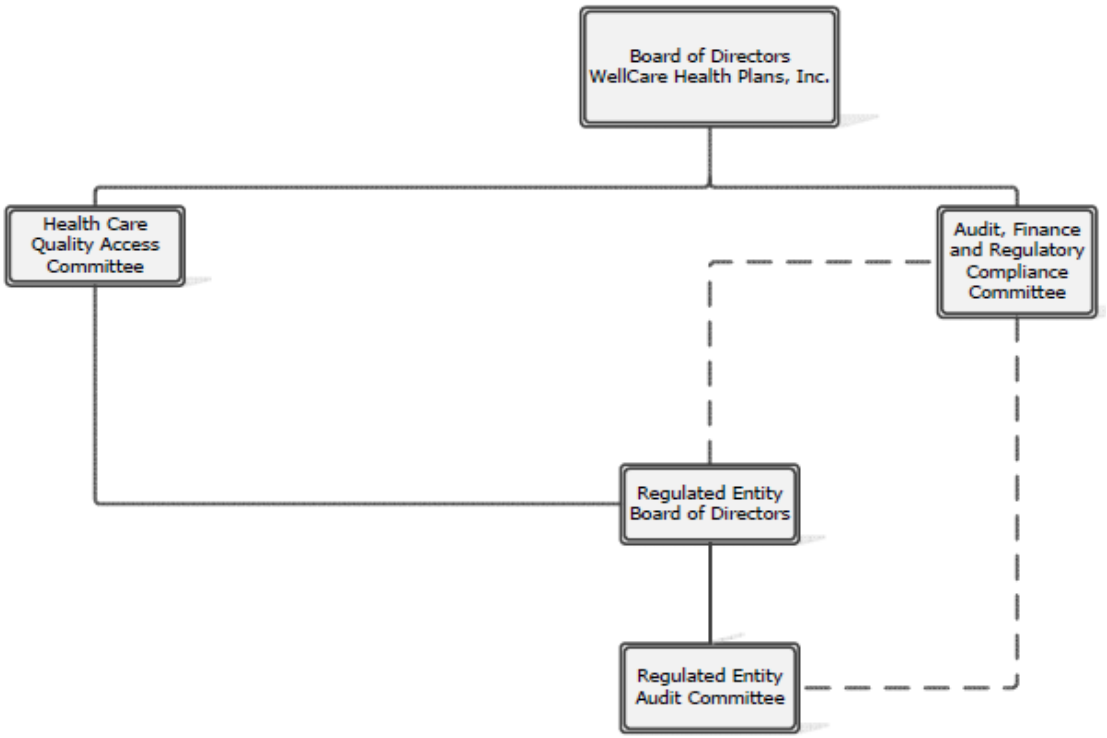


Figure B.3-3 Governance Overview Structure

iv. A listing of Key Personnel identified in Section 9.2 of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," and as otherwise defined by the Vendor, including:

a. Individual names, titles, brief job descriptions, qualifications and fulltime equivalents (FTEs) dedicated to this Contract, as well as their office locations for this Contract. An FTE is defined as the ratio of the total number of paid hours divided by the total number of working hours in the period. Annually, an FTE is considered to be two thousand eighty (2,080) hours.

WELLCARE OF KENTUCKY KEY PERSONNEL

We are pleased and fortunate to have a team of executive leaders in place with expertise in the Kentucky MMC Program, our providers, our community partners, and the unique health care aspects of the Commonwealth. All told, WellCare of Kentucky's Executive Team has over 75 years of service with WellCare. These leaders have a depth of experience providing services and supports in a variety of settings including community based settings, nursing facilities, behavioral health treatment facilities, and acute care settings. This experience has informed our evidence-based, innovative care delivery models to positively affect Kentucky's MMC Program. **Table B.3-1** below includes the names, titles, office locations, and fulltime equivalents (FTEs) dedicated to this Contract.

Table B.3-1 WellCare of Kentucky Executive Team Members

Title	Name	Office Location	Employee or Subcontractor	FTEs 100% Dedicated to KY Medicaid
Chief Executive Officer	William Jones, MBA	Louisville	Employee	1.0
Chief Financial Officer	Laurie Holden, MBA	Louisville	Employee	1.0
Chief Compliance Officer	Rebecca Randall, MPA	Louisville	Employee	1.0
Medical Director	Howard Shaps, MD, MBA	Louisville	Employee	1.0
Pharmacy Director	Thea Rogers, Pharm.D	Louisville	Employee	1.0
Dental Director	Jerry Caudill, DMD	Campbellsburg	Subcontractor	0.25
Behavioral Health Director	Marketa Wills, MD, MBA	Louisville	Employee	1.0
Provider Network Director	Bonnell Gustafson Irvin, MPA	Lexington	Employee	1.0
Quality Improvement Director	Laura Betten, MBA, RN	Lexington	Employee	1.0
Population Health Management Director	Shannon Maggard, RN	Louisville	Employee	1.0

ADDITIONAL KEY PERSONNEL

In addition to the required Executive Team members listed above, WellCare of Kentucky has the appropriate, qualified staff in place to fulfill the additional roles identified in Section 9.2 “Administration/Staffing” in Attachment C – Draft Medicaid Managed Care Contract and Appendices. **Table B.3-2** below includes the names, titles, and fulltime equivalents (FTEs) dedicated to this Contract, as well as office locations for these additional key leadership positions.

Table B.3-2 Additional WellCare of Kentucky Qualified Key Staff

Title	Name	Office Location	Employee or Subcontractor	FTEs
Management Information System Director	Mark Shelton	Louisville	Employee	1.0
Enrollee Services Manager	Elizabeth Starr,	Louisville	Employee	1.0

Title	Name	Office Location	Employee or Subcontractor	FTEs
	LCSW, MSSW			
Provider Services Manager	Anthony Piagentini, MBA	Louisville	Employee	1.0
Claims Processing Manager	Julie Crousore	Bowling Green	Employee	1.0
Utilization Management Director	Deborah Lemke, RN, BSN, MHA, CCM	Louisville	Employee	1.0
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator	Kevin Fow, RN, BSN	Louisville	Employee	1.0
Guardianship Liaison	James Conway	Louisville	Employee	1.0
Program Integrity Coordinator	David Blackford	Louisville	Employee	1.0

WELLCARE OF KENTUCKY'S INCOMING MEDICAL DIRECTOR - PENDING LEADERSHIP CHANGE

WellCare of Kentucky recently hired Thomas James III, M.D. who will begin serving as our Medical Director in February of 2020. Dr. James has extensive leadership experience with government programs, population health, health policy, and quality measurement. Dr. James also has over 25 years of experience in Kentucky within the managed care industry as well as extensive direct patient care specifically in the areas of internal medicine and pediatrics. Prior to joining WellCare of Kentucky, Dr. James held the position of Senior Medical Director, Medical Management, and Quality with Highmark, Inc. Within this role, Dr. James was responsible for clinical oversight of quality, clinical quality in care transition of Highmark members from UPMC, and provided support for wellness and preventive services initiatives. Dr. James has also served as Chief Medical Officer with Baptist Health. Within this role, Dr. James was responsible for Population Health for Baptist Health, an integrated delivery network (IDN) in Kentucky. He coordinated the analytics units of Baptist Health, Evolent Health, and other partners while achieving NCQA interim accreditation for the first time for this health plan. In addition to his time spent with Highmark and Baptist Health, Dr. James has held Medical Director positions with other various MCOs including, AmeriHealth Caritas, Humana, and Anthem Health Plans of Kentucky. Dr. James has an active medical license in the state of Kentucky as well as certifications from the American Board of Internal Medicine, the American Board of Pediatrics, and the American Board of Medical Management.

WELLCARE OF KENTUCKY KEY PERSONNEL JOB DESCRIPTIONS AND QUALIFICATIONS

WellCare of Kentucky will submit job descriptions and required qualifications, and a description of the qualifications of each individual with key management responsibility for any mandatory

function to DMS for approval within 30 days of signing the Contract, annually, prior to material revisions and upon request by DMS.

Job descriptions and qualifications for the key personnel and qualified staff identified in **Table B.3-1** and **Table B.3-2** begin on the following page.

b. Whether each Key Personnel position will be filled by a Vendor's employee or a Subcontractor.

As denoted in **Table B.3-1** and **Table B.3-2**, all of WellCare of Kentucky key personnel and qualified staff positions are filled by a WellCare of Kentucky employee except our Dental Director, which is filled by a subcontractor.

c. Resumes, including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Include as an Appendix or Attachment to the Proposal.

Please refer to **Attachment B.03.a.iv Key Personnel Resumes** for resumes including information such as degrees, credentials, clinical licensure as applicable, years of experience and type of experience for each of the key personnel and qualified staff listed in **Table B.3-1** and **Table B.3-2**.

CHIEF EXECUTIVE OFFICER (CEO)

WellCare of Kentucky's CEO has ultimate accountability for the general administration and implementation of the requirements detailed within the Model contract. Responsible for the overall operations of the Kentucky MMC Program plan, including strategic direction, administration for all existing programs, and the development of new programs to ensure we meet or exceed the goals and objectives of the program. Leads and directs overall operations including: provider contracting and relations, sales and marketing, medical management, regulatory compliance, government relations and finance, as well as interfacing with corporate office operations. Has clear authority to make operational decisions quickly and locally over the general administration and day-to-day business activities of this Contract.

Primary Responsibilities:

- Provides leadership to ensure the organization's strategic plan is translated into tactical goals and objectives that guarantee performance objectives are met or exceeded
- Directs and manages the organization's financial performance. Takes appropriate actions to increase revenue, leverage resources, manages and/or minimizes expenses and ensure compliance with all business and administrative regulations.
- Assist and leads where appropriate, with aspects of state and federal government relationships, including dealing with regulators, as necessary, to establish and continue effective working relationships. Ensures that all state and federal regulations are met
- Ensures WellCare of Kentucky compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance
- Receiving and responding to all inquiries and requests made by Department related to the Agreement, in the time frames and formats specified by Department
- Attending and participating in regular meetings or conference calls with Department
- Making best efforts to promptly resolve any issues identified either by the WellCare of New Kentucky or DMS that may arise and are related to the Agreement
- Meeting with Department at the time and place requested by Department, if Department determines that WellCare of New Kentucky is not in compliance with the requirements of the Contract

Education:

- A Bachelor's Degree in Business Administration, Finance or a related field is required
- A Master's Degree in a related field is preferred

Work Experience:

- 10+ years of experience in overall Managed Care, Network Management and/or Business Operations
- 5+ years of experience in Senior management with P&L accountability for an MCO
- Successful track record in: Provider Relations, ownership of top and bottom line P&L responsibility with a successful HMO (government program experience preferred), growing membership and revenue, and improving the MLR)
- Extensive experience in Provider Contracting
- Broad knowledge of the Managed Care industry and proven experience leading governmental programs

CHIEF FINANCIAL OFFICER (CFO)

WellCare of Kentucky's Chief Financial Officer is responsible for overseeing the budget and accounting systems implemented by WellCare of Kentucky. Directs, coordinates, and administers all financial aspects of the Kentucky MMC Program plan. Drives the development and implementation of long-range plans, goals, and objectives that align with DMS. Directs and coordinates a broad range of activities and functions to ensure effective operations and the achievement of organizational objectives. As a key member of the Executive Team, helps to define corporate strategy and is a key representative of the Contractor with outside organizations including the Department Plans, provides resources and directs activities for Provider financial analysis. Provides analytics for strategic and operating decisions. Manages and leads in the development of complex adhoc reports to enable process and trend analysis. Provides recommendations on the implementation of new/revised operational and/or reporting processes.

Primary Responsibilities:

- Builds, develops and directs management staff capable of carrying out company initiatives
- Manages all health plan financial functions including general accounting, internal reporting and controls, planning, budgeting, forecasting, variance analysis, actuarial determinations and investor relations
- Directs the preparation of annual operating and capital budgets and cash flow projections
- Monitors and analyzes the organization's financial condition and performance
- Manages the financial analysis of medical cost
- Leads the contract modeling process
- Manages companywide capitation calculation and payment
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources
- Prepares and distributes financial reports to management, investors, and the Advisory Board. Makes financial presentations at quarterly meetings of the Board of Advisors
- Manages relations with the company's outside auditors, bankers, and financial advisors
- Reviews and implements financial information systems
- Establishes reporting systems and controls to ensure compliance with company requirements

Education:

- A Bachelor's Degree in a financial discipline is required
- A Master's Degree in a related field is preferred

Work Experience:

- 15+ years of experience in a broad range of functional areas, including Financial Planning and Analysis, Forecasting, Modeling and Budgeting, Financial Reporting, Accounting and Controls, Capital Management and Risk Management

Licenses and Certifications:

- Certified Public Accountant (CPA) is preferred

CHIEF COMPLIANCE OFFICER

WellCare of Kentucky's Chief Compliance Officer is responsible for maintaining current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to WellCare of Kentucky, and oversee WellCare of Kentucky's compliance with the laws and requirements of DMS. The Compliance Director serves as the primary contact for and facilitate communications between WellCare of Kentucky leadership and DMS relating to WellCare of Kentucky compliance issues. The Compliance Director also oversees WellCare of Kentucky's implementation of and evaluates any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by DMS. Implements policies, procedures, and practices designed to ensure compliance with applicable federal and Kentucky MMC Program contracts, laws, regulations, health care program requirements, and fraud, waste, and abuse monitoring and prevention. Responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract.

Primary Responsibilities:

- Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of FWA and erroneous payment compliance program
- Developing/overseeing methods to prevent and detect potential FWA and erroneous payments. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans
- Reviewing records and referring suspected Enrollee FWA to DMS and other duly authorized enforcement agencies
- Establish and lead the Market Compliance Committee. Manages WellCare of Kentucky Program plan's SIU to communicate with WellCare of Kentucky's Fraud Control Unit.
- Complete Market Compliance Assessment – Quarterly Performance Report Work plan and compile Quarterly Performance Report
- Partner with WellCare's Internal Audit Department on Market-based assessments.
- Guide the escalation path within New Hampshire for compliance related and ethical issues and involve the appropriate resources and support from Corporate Compliance as needed.
- Conduct and track on-site compliance trainings
- Serve as Commonwealth subject matter expert for HIPAA, assess compliance with HIPAA requirements, perform periodic HIPAA audits of office location, and guide remediation plans.

Education:

- A Bachelor's Degree in a related field or 5 years of relevant work experience is required
- A Master's Degree in Business Administration, Public Health, or Healthcare Administration is preferred

Work Experience:

- 5+ years of experience in a business setting
- Experience in health care and/or risk management
- Experience in Corporate Compliance, Regulatory Affairs or State Government preferred

MEDICAL DIRECTOR

WellCare of Kentucky's Medical Director is responsible for overseeing all clinical functions. The medical director is actively involved in all major WellCare of Kentucky health programs. All clinical directors, including those employed by Subcontractors, report to the Medical Director for all responsibilities of this Contract. The Medical Director is also responsible for treatment policies, protocols, Quality Improvement activities, Population Health Management activities, and Utilization Management decisions and devote sufficient time to ensuring timely medical decisions. The Medical Director is also available for after-hours consultation, if needed. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization / service coordination / disease management activities, quality improvement activities, and Provider relations functions. Will meet with DMS and the DBHDID no less than quarterly to discuss the State Mental Health Authority and Single State Agency protocols, rules and regulations.

Primary Responsibilities:

- Manages day-to-day quality improvement and medical management activities of the Kentucky MMC Program plan
- Oversees and is responsible for all clinical activities, including but not limited to the proper provision of Covered Services to Enrollees, developing clinical practice standards and clinical policies and procedures. Substantial involvement in QAPI Program activities.
- Oversight of all utilization review techniques and methods and their administration and implementation.
- Collaborates with the organization's senior leadership to ensure medical compliance with all customer, regulatory, and accreditation requirements for clinical services
- Establishes professional working relationships with providers and provider organizations to support the development of the highest possible Provider partnerships
- Works with other Kentucky MMC Program Medical Directors/clinical services staff to maintain compliance with customer, accreditation and regulatory requirements
- Provides clinical expertise needed to effectively and efficiency resolve complex, controversial and/or unique administrative circumstances
- Provides medical leadership for development and attainment of the organization's goals.

Education:

- A Doctor in Medicine (MD) or D.O. from an accredited school of medicine recognized by national medical regulatory bodies in the United States

Work Experience:

- 5 years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).
- 5+ years of experience in Direct Patient Care
- Substantial experience/expertise in the development of medical policies, procedures and programs
- Demonstrated success implementing Utilization and Quality Improvement strategies / techniques and experience with physician behavior modification

Licenses and Certifications:

- The Medical Director must be a physician licensed to practice in Kentucky

PHARMACY DIRECTOR

Pharmacy Director is responsible for coordinating, managing, and overseeing the provision of pharmacy services to Enrollees. Provides clinical pharmacy direction for the Kentucky MMC Program including, but not limited to Medical Economics, Disease Management, Pharmacy, Utilization, and Quality Management. Assists in development of goals and objectives for the clinical pharmacy programs within the Kentucky MMC Program plan. Implements the requirements of the Agreement as it pertains to prescribed drug services and other pharmacy related items for the Medicaid line of business. Assists with the development, presentation, and implementation of policies and procedures consistent with the regulatory requirements of the contract.

Primary Responsibilities:

- Oversees pharmacy utilization and produces informative reports to the Kentucky MMC Program plan market
- Works directly with the respective Medical Director of the Kentucky MMC Program plan with the Medical Economics department to ensure cost effective management of both medical and pharmacy utilization as part of the Network Improvement Program (NIP)
- Assists in educating clinical pharmacist managers for the Kentucky MMC Program plan providing information on clinical and trend issues. Provides drug utilization review
- Implements and maintains the NIP program specific to pharmacy utilization
- Reviews prescribing practices on high utilizing physicians and intervenes as needed providing drug information on pharmacy expenses
- Collaborates with pharmacy clinical programs department to support and represent WellCare quality initiatives to providers with the market / region
- Recommends changes in prescribing practices to improve quality and lower costs.
- Provides detailed claim analysis for over and under utilization
- Reviews pharmacy data to look for savings opportunities
- Provides clinical pharmacy support for Pharmacy, Disease Management programs, Quality and Utilization Management with an emphasis on Diabetes and asthma
- Provides in service education to staff

Education:

- A Bachelor's Degree in Pharmacy is required
- A Doctor of Pharmacy (PharmD) is preferred

Work Experience:

- 7+ years of experience in a licensed Pharmacist role
- 5+ years of pharmacy experience as a practicing pharmacist.
- 3+ years of management experience
- Experience in Managed Care

Licenses and Certifications:

- Pharmacist licensed by the KY Board of Pharmacy

DENTAL DIRECTOR

WellCare of Kentucky's Dental Director is actively involved in all WellCare of Kentucky oral health programs and devotes sufficient time to ensuring timely oral health decisions. Our Dental Director works in conjunction with the dental vendor to identify provider network needs and develops strategies to fill identified gaps and ensure an appropriate training process is in place for all providers. The Dental Director has responsibility for the coordination and monitoring of dental continuous quality improvement activities. The Dental Director is responsible for the administration and delivery of all dental services provided by the health plan, including the development, implementation, and interpretation of dental policies and procedures to guide and support the provision of dental care. The Dental Director monitors vendor performance and provides direction to the dental vendor to ensure that decisions are made in a clinically appropriate and timely manner. Dental Director is also be available for after-hours consultation, if needed.

Primary Responsibilities:

- Works in conjunction with the dental vendor to identify provider network needs and develop strategies to fill identified gaps
- Shared oversight with the dental vendor for dental provider orientation, education, and in-service training
- Continuous assessment and improvement of the quality of dental care provided to Enrollees
- Serves as a liaison with the local market regulatory agencies and dental community
- Collaborates with the organization's senior leadership to provide current dental expertise and direction for the dental program
- Provides dental advice to health committees and attends required meetings or functions
- Chairs the dental advisory committee
- Ensures that dental vendor utilization review activities conform to company protocols, customer requirements, and professional standards
- Provides dental clinical expertise needed to effectively and efficiently resolve complex and/or unique administrative circumstances
- Provides expert dental education and consultation for the clinical staff as needed
- Works with care management and quality management to identify trends in dental utilization by interpreting various data sources
- Works with the dental vendor as needed to review provider and Enrollee complaints, assist in resolution, and make recommendations

Education:

- DDS or DMD from an accredited School of Dentistry

Work Experience:

- 5+ years of experience in dentistry
- 3+ years of experience in NCQA accreditation
- 3+ years of experience in government sponsored health care programs

Licenses and Certifications:

- Must be licensed to practice dentistry, without restrictions, in Kentucky.

BEHAVIORAL HEALTH DIRECTOR

WellCare of Kentucky's Behavioral Health Director is actively involved in all programs or initiatives relating to behavioral health. The Behavioral Health Director coordinates efforts to provide Behavioral Health Services by WellCare of Kentucky and any behavioral health Subcontractors. Oversees the day-to-day operations of behavioral health service coordination as it relates to the psychosocial, socioeconomic needs and services of select Enrollee populations across the continuum of care.

Primary Responsibilities:

- Works directly with staff and Enrollees to assess, plan, implement, coordinate, monitor, and evaluate services and outcomes to maximize the health of the Enrollee. Implements utilization and/or case management workflows, and policies and procedures for integrated behavioral health programs. Proactively monitors appropriate metrics to drive efficiency
- Provides leadership and support to front-line staff and supervisors of behavioral health services in Kentucky. Function as SME for BH processes, mental health services and psychosocial programs
- Serves as an instrumental partner in monitoring and tracking key performance indicators to include identification of over/under utilization and/or case management patterns and/or deviation from expected results for Kentucky
- Assists with development of clinically-focused training associated with behavioral health assessment, care plan development and behavioral health services in Kentucky
- Performs audits of assessments, case plans and service notes to verify cases are properly established and that coordination activates are occurring/appropriately documented
- Provides training and guidance to new and current behavioral health associates regarding policy and procedure, systemic tools, workload and care plan development
- Ensures regulatory requirements / accreditation standards are applied to all activity / reporting. Ensures compliance with all state and federal regulations as well as corporate guidelines in day-to-day activities.

Education:

- A Master's Degree in Social Work, Psychology, Counseling, Rehabilitation, or other relevant field that provides a foundation to receive a license as required of the position

Work Experience:

- 5+ years of experience in BH management and/or acute behavioral health care setting focusing on outpatient/inpatient utilization, case management and discharge planning
- 3+ years of experience in a managed care environment
- Experience working with the needs of vulnerable populations who have chronic or complex bio-psychosocial needs

Licenses and Certifications:

- Behavioral health practitioner licensed in Kentucky
- One of the following is required: Licensed Clinical Social Worker, Licensed Clinical Mental Health Counselor, Licensed Clinical Marriage & Family Therapist, Licensed Clinical Professional Counselor, Licensed Clinical Psychologist

PROVIDER NETWORK DIRECTOR

WellCare of Kentucky's Provider Network Director is responsible for oversight of Provider Services and Provider Network Development. The Provider Network Director provides oversight of required coordination with DMS' contracted Credentialing Verification Organization(s) (CVOs). The Provider Network Director also coordinates workforce development initiatives conducted by WellCare of Kentucky and collaboratively with DMS and other contracted MCOs. The Provider Network Director directs a team in managing physician contracting, network development, and Provider operations for the Kentucky MMC program. Develops, executes and maintains a Provider network strategy and is responsible for development and maintenance of our Participating Provider network. Manages tools and reports related to the performance of WellCare's networks. Oversees the strategy and implementation of the Provider Master Data Management software. Provides data and subject matter expertise to specified capital projects such as the Enrollee Identification and Stratification program. Identifies and cultivates strategic alliances and builds new network models with significant Provider organizations.

Primary Responsibilities:

- Constructs and operationalizes the implementation of network contracting and expansion strategies (including HCBS and LTC) specific to New Hampshire. Identifies and cultivates strategic alliances and builds new network models with significant Provider organizations to ensure that the health care needs of the Kentucky MMC Program Enrollees are met
- Work with the IDNs to coordinate any network contracting and engagement activities
- Achieves company targets through aggressive IPA primary care, specialty and ancillary Provider contracting as well as risk contract management
- Leads a team of managers in developing and executing strategic departmental initiatives.
- Manages required Hospital Contracting as appropriate
- Leads the development and operation of the local plan's value based purchasing strategies. Partners with market leadership to improve the efficiency and quality of the cost structure through innovative value based purchasing strategies, restructuring of Provider contracts and care management approaches
- Monitors primary care and specialty risk arrangements for Medicaid product lines
- Identifies areas to improve Provider service levels. Educates/enhances relationships within the Provider community

Education:

- A Bachelor's Degree in Business, Health Care or related field or equivalent work experience with directly related Hospital and/or Network Contracting experience beyond the 5-7 years is required
- A Master's Degree in a related field is preferred

Work Experience:

- 7+ years of experience in Health Care sector (preferably at HMO or PPO)
- 5+ years of experience in HMO Provider/Hospital/Ancillary Contracting and Network Development
- 4+ years of management experience

QUALITY IMPROVEMENT DIRECTOR

WellCare's Quality Improvement Director is responsible for the operation of the WellCare of Kentucky's Quality Improvement Program. Our Quality Improvement Director provides leadership necessary to achieve national best practice performance levels in quality improvement while implementing evidence based medicine / practices. Ensures that the quality of health care services rendered meets or exceeds professionally recognized community standards. Interfaces with a diverse range of clinical and administrative professionals, resolves sometimes-complex policy and service issues within the group, and directs data analytic and reporting activities that are prescribed by customers and regulators in a complex environment. Ensures compliance with state, federal and accreditation requirements. Shall participate in regular Quality Improvement meetings with DMS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

Primary Responsibilities:

- Develops and implements our Kentucky MMC Program's quality improvement plan in accordance with the mission and strategic goals of the organization, federal and state laws and regulations, and accreditation standards. Ensures systemic and individual quality of care.
- Identifies / implements process improvements. Integrates quality throughout the organization. Ensures a network of credentialed providers
- Establishes professional relationships with Kentucky, stakeholders and community agencies to facilitate quality process internally and externally
- Develops / implements systems, policies, and procedures for identification, collection, and analysis of performance measurement data
- Assists in strategizing and facilitating various committee structures and functions to best address the QI process and oversees Quality Committees. Serves as a member of the our QAPI Committee and Enrollee/ad hoc Enrollee of other quality related committees
- Oversight/interface internally/externally with pay for performance programs and initiatives

Education:

- A Bachelor's Degree in Health Care, Nursing, Public Health, Health Administration or directly related field or equivalent work experience is required
- A Master's Degree in a related field is preferred

Work Experience:

- 7+ years of experience in Directly related Quality Improvement job functions
- 5+ years of experience in Managed Care and 4+ years of management experience
- Excellent knowledge of JCAHO, URAC, AAAHC, and NCQA standards
- Relevant experience in quality management for physical and/or behavioral health care

Licenses and Certifications:

- State License as a Registered Nurse (RN), physician, or physician's assistant
- Certified Professional in Healthcare Quality (CPHQ), Certified by the National Association for Health Care Quality, or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review providers is preferred.

POPULATION HEALTH MANAGEMENT DIRECTOR

WellCare of Kentucky's Population Health Management Director is responsible for coordination and oversight of the Population Health Management (PHM) Program and services. Responsible for all aspects of the planning, delivery and monitoring of strategic programs within PHS organization. Manages initiatives through advanced skills in project management and strong organizational relationships. Provides leadership and direction to matrixed teams to ensure the successful completion of complex enterprise programs.

Primary Responsibilities:

- Independently oversees the creation and implementation for programs relevant to the organization's strategic initiatives involving PHS clinical, administrative, and operational input.
- Responsible for creating comprehensive project timelines including sign-off from all work streams. Ensures the project teams create and maintain appropriate deliverables while following WellCare standards and best practices.
- Serves as the first escalation point for project issues and risks. Works directly with the project teams to resolve issues and create risk mitigation plans. Responsible for escalating well-formulated issues and risks to leadership.
- Drives program-level reporting to increase visibility and proactive monitoring of the program performance. Responsible for reporting program progress to senior leaders
- Responsible for proactive management in areas such as risks, budget/forecast, dependencies, etc. Prepares strategic analysis of potential business and/or operational opportunities as needed.
- Responsible for leading cross-functional teams, internal and external, through all phases of the project lifecycle to achieve project objectives. Encourages collaboration and ensures that all viewpoints are represented and explored.
- Oversee and collaborate on and various projects as assigned that are cross-functional in nature.
- Oversee the activities of one or more project managers, analysts, and/or administrator. Coaches other team members on the project management process and best practices.

Education:

- A Bachelor's Degree in Public Health, Health Administration or related field
- A Master's Degree in Public Health, Health Administration or related field is preferred

Work Experience:

- 5+ years of experience in Health Care or Health Insurance Industry
- 3+ years of experience in Direct project management managing projects from start to finish as primary responsibility
- 1+ year of experience in people leadership
- Thorough understanding of current trends and strategies in health care

Licenses and Certifications:

- Project Management Professional (PMP)

MANAGEMENT INFORMATION SYSTEM DIRECTOR

WellCare of Kentucky's Management Information System Director oversees, manages, and maintains WellCare of Kentucky's Management Information System (MIS). The MIS Director ensures the highest degree of user satisfaction by ensuring high-quality, high-availability Information Technology and Services on a round the clock basis for our Kentucky MMC program. Responsible for all information systems supporting the Kentucky MMC contract, including but not limited to continuity and integrity of operations, continuity flow of records with DMS' information systems and providing necessary and timely reports to DMS. Leads team in the development of strategies, implementation, administration, troubleshooting, repair, monitoring, and reporting of the company's IT hardware, networks, servers, and applications. Creates new procedures and reviews existing procedures to conform to these standards.

Primary Responsibilities:

- Manages and leads a team of dedicated IT professionals by coaching, mentoring, disciplining and leading by example
- Directs work assignments, measures results and initiates personnel actions as required
- Provides technical leadership for the design/deployment/operation of IT hardware / software
- Management of IT Systems and devices including, but not limited to EMC, Sun, IBM and Microsoft, Veritas, Oracle, Cisco networking equipment, IBM software and various other mission critical software packages. Serves as the technical lead for the IT department
- Applies experience / skills to advise and shape the IT direction of processes and procedures
- Documents processes and procedures. Changing or refining processes when necessary
- Plans and coordinates technical architecture, design and development for local, regional, and national use
- Working in conjunction with other IT Management to create, test and refine a companywide Disaster Recovery / Business Continuity plan
- Investigates, initiates, and manages process and cost saving improvement initiatives.
- Manages IT systems production and change management

Education:

- A Bachelor's Degree in Business Administration, Finance or a related field is required
- A Master's Degree in a related field is preferred

Work Experience:

- 10+ years of experience in overall Information Systems (IS)
- 8 + years IT management experience
- Experience with negotiating software and hardware contracts and licenses
- Prior experience "starting up" and delivering against an Information Systems initiative
- Effective analyst in reviewing current practices, identifying improved approaches, and proposing the same.
- Experience with managing re-engineering and implementation projects

Licenses and Certifications:

- Professional certification in IT security or network / systems administration is desirable (CISSP, GIAC, MCSE, CCNA, CCIE, others)

ENROLLEE SERVICES MANAGER

WellCare of Kentucky's Enrollee Services Manager plans, provides resources and directs long term and short term planning for the department including manpower, facility, training, and systems requirements within the WellCare of Kentucky's Medicaid Enrollee Services program. This includes ensuring that there are sufficient Enrollee services staff, including sufficient culturally and linguistically appropriate services, to enable Enrollees to receive prompt resolution of their problems or questions and appropriate education about participation in the Kentucky's Medicaid Program. The position will serve as the leader of our plan's communication between the plan and all Enrollees.

Primary Responsibilities:

- Develops and directs the implementation of strategies to substantially improve efficiencies and service provided while reducing costs
- Directs the allocation of resources to ensure goals are met
- Develops and directs the implementation of goals and performance standards for Customer Service and its associates
- Develops hiring and performance management strategies that enhance employee retention and morale
- Works closely with the appropriate parties to implement state of the art initial training and quality assurance programs
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors
- Plans, conducts and directs work on complex Kentucky MMC Program projects/programs necessitating the origination and application of new and unique approaches
- Sets operational priorities and manages resources to operational goals and budgets
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources
- Ensures corporate initiatives are implemented to achieve optimum results
- Advises management in long-range planning for areas of specialization
- Provides technical direction to functional managers, other directors and management

Education:

- A Bachelor's Degree in a related field or equivalent work experience is required
- MBA or directly related or equivalent work experience is preferred

Work Experience:

- 10+ years of experience in progressively responsible management
- Strong experience in the areas of customer service and Call Center management at the leadership level, and a deep understanding of the interrelationships between Call Center, Health Services, and Claims and their impact on the success of the health plan as a whole

PROVIDER SERVICES MANAGER

WellCare of Kentucky's Provider Services Manager is responsible for coordinating network development and all communications with Contractor providers, Out of Network providers as applicable, and Subcontractors who are involved in clinical services. Plans, provides resources, and directs activities in provider operations, provider contracting/negotiation and Provider service functions for the Kentucky MMC Program. Responsible for provision of all Provider services activities. The manager shall have Strategizes for optimal business practices and efficiencies with an emphasis on producing revenue for the corporation. Plans, provides resources, and oversees Provider relations representatives and Provider operations coordinators, Provider claims issues and Provider service functions. Acts as a mentor to Provider Relations Representatives. Manage relationships with key Provider groups, facilities, or large IPAs. Uses extensive Provider Relations experience to provide an account management experience as the "Go To" person for those providers. Services include Provider education, claims research and resolution, confirmation of proper system load and any other services needed by these key external partners.

Primary Responsibilities:

- Oversees the management physician network by developing and maintaining relationships to drive business results within a specific geographic area
- Oversees service and education to network physicians/providers
- Achieves company targets through implementation of Network Improvement plans
- Sets goals for their area and works closely with Managers/Representatives to drive performance and to ensure Provider satisfaction metrics are met or exceeded
- Conducts field rides with Provider Relations Representatives to gauge their performance and provide coaching and development in order to improve the business results
- Plans, conducts and directs Provider contracting/negotiations and Provider servicing
- Develops practices to assist risk partners in managing financial risk
- Performs data analysis and develops specific actions to manage medical cost trends
- Plans, provides resources and directs activities, network development, Provider contracting/negotiation and Provider service functions
- Develops Provider contracting and service strategies and ensures maximum efficiencies in the utilization of human and financial resources
- Strategizes for membership growth, retention, and to affect sophisticated or complex Provider relationships
- Maintains compliance for State and CMS audits
- Special projects as assigned or directed

Education:

- A Bachelor's Degree in a related field or equivalent work experience directly related to the level and duties of the job is required

Work Experience:

- 7+ years of experience in Provider relations or similar background
- 4+ years of management experience
- Prior experience with individual physicians, Provider groups, and facilities.

CLAIMS PROCESSING MANAGER

WellCare of Kentucky's Claims Processing Manager is responsible for ensuring the timely and accurate processing of Claims, including original Claims, corrected Claims, and re-submissions, and the overall adjudication of Claims, including the timely and accurate submission of Encounter data. Responsible for directing WellCare of Kentucky's Claims department's processing activities in support of established production and quality standards. Responsible for and qualified by training and experience to oversee claims processing and to ensure the accuracy, timeliness, and completeness of processing payment and reporting. Responsible for leading a team responsible for processing Provider claims, as well as oversee the strategic direction of the Claims Department.

Primary Responsibilities:

- Develop, implement and administer a comprehensive Kentucky-specific Medicaid Managed Care claims processing system capable of paying claims in accordance with State, Federal and contractual requirements
- Direct and oversee claims processing activities with the objective of meeting production, timeliness, and quality standards. Direct and oversee claims activities to ensure that services comply with governmental and accrediting agency regulations
- Recruit, select, train, and retain highly qualified professionals. Provide the senior leadership necessary to maintain a motivated, productive and competent team through open communication and delegation of responsibilities and authority
- Identifies, defines and executes on opportunities for strategic improvement, including opportunities for increased auto adjudication of claims
- Develop and implement a cost avoidance processes
- Direct and oversee claims activities to ensure that services comply with governmental and accrediting agency regulations including reporting requirements
- Partners effectively with business partners (Configuration, Training, IT, etc.) to execute on critical business objectives and priorities
- Ensure the delivery of superior customer services by providing timely and accurate claims payment and responding timely to Enrollee and Provider inquiries and complaints regarding claims processing including ensuring the minimization of claims recoupments
- Manages/develops direct reports who include other management or supervisory personnel and/or exempt individual contributors. Directs work assignments, measures results and initiates personnel actions as required for assigned claims unit

Education:

- A Bachelor's Degree in a related field or equivalent work experience is required

Work Experience:

- 10+ years of management experience in a Managed Care Claims Processing environment
- Extensive experience and leading edge knowledge of best practice Claim Processes, Measurements, Rewards and Systems
- Experience in the selection and implementation of Systems, and taking an active risk-taking role while implementing and achieving the savings/results
- Medicaid risk and/or Medicare risk experience

UTILIZATION MANAGEMENT DIRECTOR

WellCare of Kentucky's Utilization Management Director is responsible for the operation of our Utilization Management Program and any Subcontractors performing services relevant to UM. Accountable for providing vision and strategy for inpatient utilization and prior authorization management activities designed to achieve quality and service-driven objectives. Oversees all phases of development, organization, planning, and implementation of projects / initiatives / workflows / processes to enhance quality-driven outcomes. Ensures that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

Primary Responsibilities:

- Provides direction and oversight to ensure effective management of inpatient care, discharge planning, and prior authorizations. Responsible for all UM activities
- Optimizes processes and workflows to achieve successful quality outcomes and benefit maximization within the scope of responsibility
- Serves as a partner in development of KPIs. Monitors and tracks KPIs to independently identify over/under utilization patterns and/or deviation from expected results
- Develops processes and procedures to ensure department-wide compliance with contractual, regulatory (Federal/State) and accreditation entities
- Provides leadership and support to front-line staff, supervisors and managers
- Leads talent management activities to develop and cultivate future leaders
- Promotes and improves environment of Provider and Health Plan partnership
- Ensures monitoring and tracking tools are in place to adequately link and assess production and quality driven work products and outcomes to individual performers
- Serves as the subject matter expert for inpatient and prior authorization management for future expansion and growth efforts
- Develops formal policies, procedures and workflows that effectively guide work activity
- Develops formal department-specific new employee orientation and training programs

Education:

- A Bachelor's Degree in Nursing (BSN), Health Administration, Nutrition or business related field is required
- A Master's Degree in Business, Public Health or Healthcare administration is preferred

Work Experience:

- 7+ years of experience in acute clinical/surgical experience and/or behavioral health clinical setting is required.
- 3+ years of management experience in a managed health care setting is required
- Current experience in utilization management to include pre-authorization, utilization review, concurrent review, discharge planning, and/or skilled nursing facility reviews is required

Licenses and Certifications:

- Licensed Registered Nurse (RN) is required
- Utilization review/management certification, or equivalent professional certification is preferred

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) COORDINATOR

WellCare of Kentucky's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator is responsible for coordinating and arranging for the provision of EPSDT services and EPSDT special services for Enrollees. Ensures the case management process of assessing, planning, implementation, coordination, monitoring, and evaluating services and outcomes is pursued to maximize the health of the Enrollee. Designs programs to ensure that all Enrollees who are children receive necessary EPSDT services. Oversees the socio economic needs and services of selected Enrollee populations across the continuum of illness

Primary Responsibilities:

- Promotes appropriate health care initiatives including family planning and preventative care health strategies.
- Proactively monitors appropriate metrics to drive up efficiency.
- Providing advice when necessary of complex, and identifying and coordinating assistance for identified Enrollee needs, specific to maternal/child health and EPSDT.
- Establish, maintain, and foster professional working relationships with all providers and community stakeholders.
- Partners and collaborates with other departments cross functionally regarding care and case management and/or Health Service initiatives.
- Manages and resolves e-mails and escalated phone issues in response to provider, staff, and other department requests.
- Directs work assignments, measures results and initiates personnel actions as required.
- Participates in continuous quality improvement projects that involve case and social service components.
- Ensure timely and complete delivery of required regulatory reports.

Education:

- A Bachelor's Degree in Health Services, public health, or health care administration

Work Experience:

- 10+ years of experience in Current case management
- 5+ years of management experience
- 5+ years of experience in Managed care

Licenses and Certifications:

- State Licensed Registered Nurse (RN), Physician, or Physician's Assistant is required
- Certified Professional in Health Care Quality (CPHQ), certified by the National Association for Health Care Quality, or certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review providers is preferred
- Certified Case Manager (CCM) is preferred

GUARDIANSHIP LIAISON

WellCare of Kentucky's Guardianship Liaison serves as our primary liaison for meeting the needs of Enrollees who are adult guardianship clients.

Primary Responsibilities:

- Performs outreach to the adult guardian's state worker to obtain service plan in order to identify Enrollee needs.
- Acts as a liaison and advocate between the adult guardian, physician, and facilities/agencies.
- Partners with providers, community resources, Enrollee and Department of Aged and Independent Living to ensure that elements of the care plan are executed.
- Track, analyze, and report data back to the state to show care plans are being met and identify continued opportunities for support.
- Completes assessment and creates a plan of care focused on identifying needs of the Enrollee.
- Engages the individual care team to meet, review, and adjust Enrollee's care plan goals and objectives.
- Assists in obtaining benefits for Enrollees through community resources when benefits are exhausted or not available.

Education:

- A Bachelor's Degree in Social Work (BSW), Psychology, Counseling, Rehabilitation, or other relevant field or equivalent work experience in managed care directly related to assisting Enrollees to change behaviors and to locate and gain access to needed social, community, medical and behavioral health services is required

Work Experience:

- 4+ years of experience in a health care environment with client care coordination responsibilities via assisting clients to change behaviors and to locate and gain access to needed social, community, medical and behavioral health services
- 2+ years of experience in a managed care environment

Licenses and Certifications:

- State Licensed Registered Nurse (RN), Physician, or Physician's Assistant
- Certified Professional in Health Care Quality (CPHQ), certified by the National Association for Health Care Quality, or certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers.
- Certified Case Manager (CCM)

PROGRAM INTEGRITY COORDINATOR

WellCare of Kentucky's Program Integrity Coordinator serves as the single point of contact with DMS whose job duties are dedicated exclusively to the coordination, management, and oversight of the WellCare of Kentucky's Program Integrity unit to reduce Fraud, Waste and Abuse of Medicaid services within Kentucky. Responsible for facilitating timely response to Department requests for information. Implements policies, procedures, and practices designed to ensure compliance with applicable federal and Kentucky MMC contracts, laws, regulations, health care program requirements, and fraud, waste, and abuse monitoring and prevention. Functions as the local contact for the Corporate Compliance Department's functional units and serve as a Kentucky resource for identifying, tracking, mitigating and reporting on operational compliance risks.

Primary Responsibilities:

- Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse, (FWA) and erroneous payment compliance program
- Developing/overseeing methods to prevent and detect potential FWA and erroneous payments. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans
- Reviewing records and referring suspected Enrollee FWA to DMS and other duly authorized enforcement agencies
- Establish and lead the Market Compliance Committee. Manages the Kentucky MMC Program plan's Special Investigations Unit to communicate with Kentucky's Medicaid Fraud Control Unit.
- Complete Market Compliance Assessment – Quarterly Performance Report Work plan and compile Quarterly Performance Report for submission to Market leader and Chief Compliance Officer
- Partner with WellCare's Internal Audit Department on Market-based assessments.
- Guide the escalation path within Kentucky for compliance related and ethical issues and involve the appropriate resources and support from Corporate Compliance as needed.
- Conduct and track on-site compliance trainings
- Serve as Kentucky subject matter expert for HIPAA, assess compliance with HIPAA requirements, perform periodic HIPAA audits of office locations, and guide remediation plans.

Education:

- A Bachelor's Degree in a related field or 5 years of relevant work experience is required
- A Master's Degree in Business Administration, Public Health, or Healthcare Administration is preferred

Work Experience:

- 5+ years of experience in a business setting
- Experience in health care and/or risk management
- Experience in Corporate Compliance, Regulatory Affairs or State Government preferred

v. Summary of recruitment timelines and activities for Key Personnel positions for which individuals have not been identified at the time of the proposal. Describe contingency plans should those positions continue to remain open after Contract Award.

RECRUITMENT TIMELINES AND ACTIVITIES

Although WellCare of Kentucky currently has a well-established Executive Team in place, we have a multi-faceted recruiting strategy that is planned and executed by our Talent Acquisition Team. Our Talent Acquisition Team, comprised of specialized recruiters well positioned to leverage our ongoing pipelines, is responsible for executing our staffing plan. **Our Talent Acquisition Team includes 11 Talent Acquisition leaders at varying levels, one College Recruiting Program Manager, 56 recruiters (five specialized executive recruiters, 26 FTEs, 25 temporary positions), six Sourcing Specialists, and 12 Staffing Assistants.** This team continuously and proactively recruits top-level candidates for WellCare of Kentucky's executive management positions to develop bench strength in the event of an expected or unexpected position vacancy. This continuous recruitment ensures we are always developing a best-in-class team to serve our Enrollees, providers and DMS. We have consistently demonstrated a strong commitment to offering a locally staffed plan within the Commonwealth. During our time serving people in Kentucky we have shown a unique ability to recruit local, high-performing executive leaders that understand the diverse needs and cultural nuances of our Enrollees.

WellCare of Kentucky carefully selects associates through written application, personal interview, reference checks, and skills testing. Both the recruiting team and the hiring manager utilize behavioral based interview guides that assess candidates in a fair and unbiased manner. Recruiters have access to HireVue video interviewing technology for live, recorded, or panel interviews. Applicants complete a predictive index survey upon applying to WellCare that identifies a candidate's behaviors and personality traits relative to their desired role. Prior to award, we will screen all potential candidates to ensure they have the required licensure and experience to fulfill the role for which they are applying. Criminal and general employment background checks and drug screens are required following a conditional offer of employment. Our screening protocol also ensures these have not been excluded from participation in Federal health care programs. Within 14 days of award, we will be prepared to interview and extend offers to key personnel should any of the current filled positions become open. Once hired, we will onboard the new associate utilizing our newly developed key personnel onboarding program.

In the event of an expected or unexpected vacancy of a key position, our Chief Executive Officer will work with Commonwealth leadership to appoint a qualified interim leader within 30 calendar days of departure. Drawing from our leadership at the national, state and market level we will quickly identify the necessary key leader and transition them into the role as expeditiously as possible. This key individual will remain in this position until we find a permanent replacement. This individual immediately begins shadowing the departing key leader to get a better understanding of their day-to-day responsibilities and to ensure a seamless transition. The interim associate is responsible for familiarizing himself or herself with this document to understand what they are accountable for within this role. Once we identify a long-term associate, it is the responsibility of the interim associate to bring them up to speed.

WellCare of Kentucky's Chief Compliance Officer, Rebecca Randall, will notify DMS and FAC in writing of any change in our Executive Management key personnel, department managers, and point of contact for this Contract within three Business Days of WellCare of Kentucky learning of a change, including a change in duties or time commitments, resignation, or of WellCare of Kentucky notifying an individual of planned changes for the key position (e.g., promotion, termination). Simultaneously, our Chief Executive Officer will engage with our Talent Acquisitions team to identify both external and internal candidates for the vacated position using a combination of internal and external sourcing strategies. Our Talent Acquisition Team will prioritize the recruiting of the vacated position in order to fill the role within 30 calendar days of departure, unless a different timeframe is approved by the Commonwealth.

CONTINGENCY PLANS

We will not have any key personnel positions opened after Contract Award as we already have a well-established Executive Team in place. Even so, WellCare of Kentucky is always prepared to serve our Enrollees and be responsive to Department regardless of any turnover in executive staff. We are always prepared for the unexpected, and we will have associates in place to assume abruptly vacated roles as needed as outlined below.

To ensure we continue to provide an optimized level of care to our Enrollees, we have a pipeline of internal candidates within the Commonwealth who have expertise in serving Enrollees within the Kentucky MMC program. Our organizational and talent development team continuously works with our Commonwealth leaders to craft thorough and actionable succession plans for key positions within WellCare of Kentucky to ensure we have a "bench" of key leaders that we can deploy at any time. These succession plans include a proactive internal 'candidate search' for positions instrumental to the successful operation of WellCare of Kentucky. WellCare's Executive Leadership Team, including Ken Burdick, WellCare's CEO, the Board of Directors, and WellCare of Kentucky leaders regularly reviews our succession plans.

Coupled with WellCare of Kentucky's internal succession planning strategy is a Training and Development component which aligns our key and developing leaders with a suite of carefully developed curricula targeted at closing development gaps and grooming a team of 'ready now' key leaders. We have a series of sequential learning roadmaps that are tailored for each level of management that ensures that we are continuously developing a body of outstanding leaders. WellCare of Kentucky has an internal training organization that continually and proactively provides best-in-class learning and development to existing staff in core areas. Our philosophy around continuous learning fosters an environment where all associates are provided with the training they need to effectively perform not only their current roles, but also growth roles. We are committed to providing all associates with effective learning in the necessary business and development skills to expand the skills and knowledge essential to their roles and ensure we have a stable of associates that are prepared to assume vacated roles should the need arise.

Leveraging Associates from Corporate and Other Markets

WellCare of Kentucky has associates at the executive level in our corporate functions as well as locally in our affiliate markets that can be leveraged in the event of an unexpected staffing gap. As needs arise, WellCare of Kentucky affiliates are prepared to re-allocate targeted individuals

and functional groups from other state offices or from our corporate office in Florida to support critical functions. We draw on a corporate workforce of more than 13,000 associates that we are able to readily leverage in the event of an unexpected vacancy, minimizing abrasion to Enrollees, DMS, and providers.

vi. Overview of the Vendor's proposed training of staff to fulfill all requirements and responsibilities of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," for all operational areas.

WellCare of Kentucky has over eight years of experience in providing training to our Kentucky MMC associates. To ensure we are meeting DMS' expectations regarding training, we have designed training programs that are aligned with the requirements of the updated Contract. Through a rigorous training and oversight program, WellCare of Kentucky ensures that all staff, providers, and Subcontractors have appropriate training, education, credentials, experience, liability coverage, and orientation to fulfill the requirements of their positions. All persons assigned to perform work under this Contract shall have the necessary credentials to perform the work herein. We ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice in the Commonwealth of Kentucky. On at least an annual basis, WellCare of Kentucky and our Subcontractors will verify that applicable staff have all necessary current licenses that are in good standing and will provide a list to DMS of licensed staff and current licensure status. Additionally, WellCare of Kentucky will submit to DMS an educational and training plan within 120 Calendar Days of the Contract Execution Date. We shall update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

DESIGNING MARKET SPECIFIC TRAINING FOR STAFF WITH VARYING BACKGROUNDS AND EDUCATIONAL LEVELS

WellCare's Learning and Development department, made up of more than 40 full-time training professionals, is responsible for developing, facilitating, and evaluating our training curriculum. Led by Anne Read, M.A., Senior Director of Enterprise Learning and Development, in 2019, we have provided more than 900 hours of market-specific training year-to-date to our associates within the Commonwealth. Since WellCare of Kentucky's focus is to develop a workforce reflective of our diverse membership, our staff represent different backgrounds and educational levels. Accordingly, we have a depth of experience in designing Commonwealth-specific training for our diverse staff to successfully acquire the knowledge and skills to be successful within the Commonwealth and further their professional careers.

Our training development methodology follows the time-tested **ADDIE** principles, an instructional design development program developed in the 1970s for the U.S. Army. These principles are the gold standard for training course development and have five components:

Analysis – We have conducted a thorough analysis of the Contract to align training with the Commonwealth's needs.

- *Contract Review:* Our learning and development team and regulatory affairs leaders conduct a line-by-line analysis of the MMC Contract identifying training needs based on

requirements, policies, and procedures. Content development is parsed out by functional areas such as Enrollee services, provider relations, care management, and claims/encounters to subject matter experts. For example, training content for care management would include the care needs screening requirements, such as sharing the screening results with the Enrollee's assigned PCPs within seven calendar days. For changes to the MMC program, we follow the same process ensuring ongoing compliance with the Contract.

- *Enrollees:* Our analysis identifies any changes in eligibility categories and populations included in Kentucky's MMC Program, demographic attributes, geographic distribution within the Commonwealth, health morbidities, health disparities, as well as any circumstances affecting Enrollees.
- *Providers:* We generate training content for our provider-facing staff by assessing the provider environment in terms of the number of Medicaid providers who are independent practices, large groups, FQHC penetration, health systems, payment models, and familiarity with managed care. Given the wide range of managed care knowledge and experience among the Kentucky MMC providers, our Commonwealth-specific training would prepare our provider-facing staff to assist providers regardless of their size or sophistication whether that means an in-service on the provider portal or a strategic meeting to discuss payment models.

Design and delivery of the curriculum for staff of all educational levels – Our training methodology consists of a blend of instructor-led and web-based learning through WellCare University, which meets the diverse learning styles of our staff. We tailor training to include operational scenarios for roles requiring less formal education yet more operational experience and supplement further with additional modules, reading, practice guidelines, and critical thinking scenarios for roles requiring more formal education. Regardless of our staff's educational levels or role, our Commonwealth-specific training program design helps them complete the training and be successful in their roles.

Development of training materials for staff of varying backgrounds – Just as we practice cultural competency when interacting with our Enrollees, we abide by the same principles with the staff we train. We honor their individualities, we seek to understand their perspective, respect their religious and cultural beliefs, sexual orientation, and other means of self-identification. We accommodate our staff's language needs and provide American Sign Language (ASL) interpreters if requested, provide materials in large print, include captioning on training videos, and ensure adequate space in our training rooms for wheelchair users to maneuver. Depictions of people in our videos and written materials reflect diversity in race, ethnicity, gender, and disability. Our training model leverages the diversity of our staff to contribute their lived experiences to the success of the market-specific training. We engage our associates to draw from their own culture and heritage and contribute to group discussions about cultural beliefs and health care. Some of our staff were former Medicaid beneficiaries who are now transforming their lives through a career. We tap into their experience and have them provide a first-hand perspective to better understand, engage, and serve our Enrollees.

Implementation of the training – Includes tracking associate enrollment through WellCare University, periodic knowledge assessments, completion of the training curriculum, and any

additional end-of-training knowledge assessments. The system documents all scored assessments, tabulates, and generates a training report. For required training, our system tracks status and completion sending reminder notices to the associate and successive escalation notices to their manager(s) if the training is coming due. Through online training, our field employees can access remotely at a time amenable to their work demands allowing them to continue learning while they integrate into communities in Kentucky.

Evaluation of the training in meeting its objectives. Staff are provided with course evaluations to rate the content, the delivery, materials, assessments, and other components of the training program. Our Learning and Development team reviews the results and recommend changes to the training program as needed. For example, as part of that review, we have begun to add additional formats and features to our training with positive feedback such as video, avatars, animation, and gamification. The end result of this evaluation loop is that market specific training tailored to Kentucky evolves based on feedback from local associates who best know the Commonwealth, Enrollees, and providers.

PROVIDING KENTUCKY MMC TRAINING TO OUR STAFF FOR ALL OPERATIONAL AREAS

WellCare's Enterprise Learning and Development department offers a comprehensive onboarding and ongoing training program for Commonwealth associates and contractors. Tonya Farris, our Commonwealth-based Learning and Development Specialist, is responsible for executing our Commonwealth training program. Initial training is delivered in a three phase approach including:

- WellCare New Hire
- Market Specific Training
- Role Specific Training

Our WellCare new hire curriculum orients associates to the company and programs; the Commonwealth-specific curriculum enables staff and contractors to become subject matter experts regarding Kentucky's MMC program; and the role-specific training focuses on the job-specific skillsets needed to be successful. Following the **ADDIE** process described above, we develop the curriculum to the Commonwealth's specifications. Training delivery is a combination of instructor-led training, both in the classroom and by WebEx, and computer-based training through WellCare University. Training materials consists of written materials, such as PowerPoint slides, multi-media, such as videos, and written or online assessments. Associates enroll in WellCare University which tracks completion of the training and successful performance on the assessments. We will submit to DMS the training program and evaluation within 15 days of Contract award and begin training within five days of approval. We will train our staff within seven days of their start date and can provide completion reports for DMS if requested.

The training outlined in **Table B.3-3** below provides a breakdown of the training phases, course topics, and training frequency. The top sections list the New Hire and Market-Specific courses required for all staff followed by the role-specific courses for each individual training group. Our role-specific training takes four to eight weeks to complete. Instructor-led training is made available through location of training staff within the Commonwealth as needed.

Table B.3-3 Training Phases, Learning Topics and Frequency

Training Phase	Learning Topics	Frequency
New Hire All Associates	▪ Overview of WellCare Health Plans ▪ WellCare's purpose, vision, mission and core values; ▪ WellCare Policies/Procedures ▪ WellCare systems ▪ Mandatory Compliance Training ▪ Sexual Harassment Awareness Training ▪ Emergency Preparedness ▪ Code of Conduct and Business Ethics ▪ Cultural Competency and Cultural Sensitivity ▪ Economic Disadvantage ▪ HIPAA Privacy and Information Security Awareness ▪ Insider Trading ▪ Fraud, Waste, and Abuse ▪ First Aid (all non-clinical Enrollee-facing associates)	▪ Within 7 days of hire ▪ Annual mandatory compliance training ▪ Updated policies and procedures as needed
Kentucky Specific-Contract Requirements All WellCare of Kentucky Associates	▪ Overview of Kentucky MMC (partial list) ▪ Contract requirements ▪ Program eligibility, benefits, covered services, utilization management, cost sharing, transitioning Enrollees, EPSDT ▪ Commonwealth partners including DMS ▪ Unique populations served under Kentucky MMC ▪ Fee for Service programs ▪ Provider Networks ▪ Sensitivity training on age, low income, disability, language, culture, reading comprehension and literacy ▪ Understanding unmet health-related resource needs ▪ First Aid (all non-clinical Enrollee-facing associates) ▪ WellCare Works ▪ SUD Waiver Training	▪ Within 7 days of hire ▪ Updated policies and procedures as needed
Role Specific Care Management Associates	▪ Role of the CM ▪ Cultural Competency for the general population ▪ HIPAA Privacy and Security and Information Governance Training ▪ Disease Management ▪ Execution of Comprehensive Assessments of Enrollees ▪ EPSDT ▪ Motivational interviewing, including understanding	▪ 4-8 week curriculum depending on role ▪ Updated policies and procedures as needed ▪ Upskill

Training Phase	Learning Topics	Frequency
	literacy, and cultural awareness. ▪ Self-management to evidenced based care; medication adherence strategies ▪ Person-centered screening, needs assessments, and all elements of care planning ▪ Understanding and addressing unmet health-related resource needs; using available social supports ▪ Transitional care management including medication reconciliation ▪ BH crisis response (for CMs with assigned Enrollees with BH needs) ▪ Understanding and addressing ACEs, trauma, and trauma-Informed care	training annually
Role Specific Pharmacy and Clinical Services Staff Responsible for UM	▪ Pharmacy protocols ▪ Training on application of varying clinical guidelines, ▪ Benefit coverage ▪ Modules on care management resources and processes, ▪ Grievance and administrative review training ▪ HEDIS care gap education, ▪ Management information systems ▪ Authorization process - both expedited and standard. ▪ We include InterQual Training Modules in our training curriculum. ▪ Preceptor training for up to 80 days depending on previous work experience, performance in training, and demonstrated proficiency.	▪ 4-8 week curriculum depending on role ▪ Updated policies and procedures as needed ▪ Upskill training annually
Role Specific Enrollee Services Representatives	▪ Customer Service principles and Quality Governance ▪ Communication Skills and Call Listening ▪ Enrollee self-service ▪ Overview of WellCare Systems and how to navigate WellCare's public website and intranet for information; ▪ Enrollee Experience ▪ Enrollee rights and responsibilities ▪ Enrollee Handbook ▪ Enrollee Advanced Directives ▪ Overcoming barriers to accessing care ▪ Healthy Rewards program ▪ Enrollee grievance and appeals process ▪ Documenting grievances and grievance quality	▪ 4-8 week curriculum depending on role ▪ Updated policies and procedures as needed ▪ Upskill training annually

Training Phase	Learning Topics	Frequency
	▪ Appeals and Commonwealth fair hearing process ▪ Top call drivers ▪ Provider directory and changing PCPs ▪ Pharmacy basics, PDL, and internal systems ▪ Activating language line and ASL calls, engaging nurse line and BH crisis lines ▪ De-escalation Skills; Safety and Violence Protection for Field Associates ▪ Behavioral Health Overview ▪ Claims Essentials ▪ Step Actions ▪ Kentucky Medicaid eligibility requirements ▪ DAIL clients; SKY program ▪ covered and carved-out services ▪ VABs ▪ Kentucky place names and surnames (cultural competency)	
Role Specific Quality Improvement Associates	▪ HEDIS Boot Camp ▪ External Quality Review (EQR) Protocol ▪ Medical Record Review ▪ NCQA Accreditation and Guidelines Summit ▪ Cultural Competency and Awareness ▪ PIP Validation ▪ Ongoing Quality Status Updates to Kentucky Associates ▪ Quality Line ▪ Behavioral Health ▪ Medically Frail ▪ Health Literacy	▪ 4-8 week curriculum depending on role ▪ Updated policies and procedures as needed ▪ Upskill training annually
Role Specific Provider Relations Representatives	▪ Overview of WellCare Systems and how to navigate WellCare's public website and intranet for information ▪ High Performance Network Strategy ▪ Value-Based Care ▪ Educating providers on WellCare Policies and Procedures including Plan Benefits and Services, Claims, Authorizations, Reporting and on Balance Billing ▪ Quality/HEDIS Overview ▪ Activating language line and ASL calls ▪ AMH Tiering	▪ 4-8 week curriculum depending on role ▪ Updated policies and procedures as needed ▪ Upskill training annually

Training Phase	Learning Topics	Frequency
	▪ Provider groups ▪ Provider Experience ▪ Provider rights and responsibilities ▪ Quality and efficiency drivers	
Role Specific Associates working with DMS	▪ Overview of WellCare Systems and how to navigate WellCare's public website and intranet for information ▪ Eligibility process including rules and regulations; ▪ Eligibility categories ▪ WellCare of Kentucky Enrollee journey ▪ 834 files and enrollment flags ▪ Community Connections and the Community CCHL	▪ 4-8 week curriculum depending on role ▪ Updated policies and procedures as needed ▪ Upskill training annually

vii. Overview of Vendor's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

SUBCONTRACT STAFF RECRUITING

Prior to delegating any functions to a third party, we perform due diligence including a comprehensive assessment to prospectively evaluate the Subcontractor's ability to perform the activities to be delegated. The comprehensive vetting and due diligence process is a requirement in our delegated subcontracts, and compliance must be demonstrated prior to a delegated Subcontractor becoming active with WellCare of Kentucky. We perform oversight and monitoring of the delegation activities through scorecards, data analysis, focused reviews, and annual audits. We develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and the Contract. All pre-delegation audits for new Subcontractors are based on the National Committee for Quality Assurance (NCQA), and state and federal requirements.

We will not delegate to an entity unless it achieves a successful passing score on its pre-delegation audit. Our pre-delegation audit process confirms the Subcontractor has the structural elements, i.e. policies, procedures, staff, licensure, etc., in place to comply with all of the contractual requirements for the functions assigned to them. The pre-delegation audit includes a review of the Subcontractor's recruitment policies so that standard adherence to WellCare policies and procedures are applied during the recruitment of staff. Additionally, for all new requests for delegation, one of the first steps we take is to screen them against the state and federal exclusion lists. On a monthly basis, Delegation Oversight confirms the screening of our subcontractors against the Department of Health and Human Services Office of

Inspector General's List of Excluded Individuals/Entities and the General Service Administration's System for Award Management exclusion lists and similar state exclusion lists. WellCare will not knowingly hire, retain or otherwise conduct business with subcontractors that:

- Have been excluded, debarred or suspended from participating in state and federal programs; or
- Have been convicted of a criminal offense within the scope of exclusion laws, but has not yet been excluded, debarred, suspended, or otherwise declared ineligible by a governmental authority.

Subcontractors have to comply with the expectations of the company on an ongoing basis. After delegation, the team continues to monitor performance. In addition to the confirmation, we require the submission of supporting documentation to demonstrate compliance. Examples of documentation may include codes of conduct, compliance policies, copies of training materials, training rosters, etc. WellCare's extensive oversight of Subcontractor performance reflects our commitment to deliver high quality services and our understanding that Subcontractors' performance is a reflection of WellCare's focus on quality.

SUBCONTRACTOR STAFF TRAINING

WellCare places the highest value on the importance of effective associate and Subcontractor onboarding and training. While associate and subcontractor satisfaction and retention are important byproducts, the most important results of our training investment are reflected in the service received by our Enrollees and Providers.

WellCare's corporate training team is skilled at building and delivering specialized training content. For Kentucky, WellCare developed training modules, which provide staff and subcontractors an in-depth understanding of the populations, service coordination needs and regulatory requirements specific to our membership in Kentucky. All WellCare associates and Subcontractors who will bear responsibility in the execution of commitments made in this Contract will be required to complete a detailed training program specific to Kentucky Medicaid. Content for the training modules will be developed in accordance with the regulations, eligible populations, and characteristics of Kentucky Medicaid. All training content is stored, deployed, assessed, and tracked through our Learning Management Platform. This includes aligning all market specific training to the appropriate associate by role or function. **Table B.3-4** includes examples of some of the curriculum WellCare of Kentucky subcontractors are required to complete.

Table B.3-4 Subcontractor Training Curriculum

Training Curriculum	
▪ Overview of WellCare Health Plans	▪ Enrollee Privacy and Data Protection
▪ WellCare's purpose, vision, mission and core values	▪ Disaster, Emergency Events, and Service Disruptions

Training Curriculum	
▪ WellCare Policies/Procedures	▪ Critical and adverse incident reporting
▪ WellCare systems	▪ Emergent or High Priority Concerns
▪ Plan/Program Overview	▪ Oversight and Reporting
▪ Contract Overview	▪ Subcontractor Arrangements
▪ Understanding of delegated functions and expectations of subcontractors	▪ Specific training for depending on subcontractor function
▪ Understanding WellCare of Kentucky's membership, eligibility and benefits	▪ Protecting against, Identifying, and reporting suspected or confirmed fraud, waste, and abuse
▪ Continuity of Care Requirements	▪ Code of Conduct and Business Ethics

Subcontractors must re-administer all trainings:

- As necessary to ensure staff compliance
- At least annually
- Upon a significant change in training materials as directed by WellCare of Kentucky

Additionally, WellCare expects delegated entities to provide training reports and attestations that demonstrate their staff have been trained to meet the standards of WellCare and our state partners.

viii. Retention approach for key personnel.

WellCare of Kentucky is the employer of choice within the health care industry in Kentucky and we spend considerable effort recruiting and retaining best-in-class employees. With our extensive experience, we have built an organization that has become an attractive place to work for experienced health care executives, people leaders, and individual contributors. Since our inception in 2011, WellCare of Kentucky has established the most experienced and stable leadership team out of any MCO operating Kentucky's MMC program. **For the last two years, WellCare of Kentucky has made the list of Best Places to Work in Kentucky. We placed 10th in the Large Company category in 2018 and 8th in the Large Company category in 2019.** The Society of Human Resource Management and the Kentucky Chamber of Commerce sponsor best Places to Work in Kentucky and the rankings are based on an Employer Benefits and Policies Questionnaire (25% weighting) and an Employee Engagement and Satisfaction Survey (75% weighting).

In 2019, WellCare reflected a significantly better reputation than our competitors do (**see Figure B.3-4**) as an employer of choice within the managed care industry based on reviews from Glassdoor, which is one of the fastest growing jobs and recruiting sites, and holds a growing database of millions of company reviews. We attract and retain top level talent through our comprehensive benefits package, promoting work life balance with flexible schedules, opportunities for working remotely (15% of our workforce work from home full time and a large percentage telecommute anywhere between 1 to 4 days per week), and tuition reimbursement. Additional benefits include:

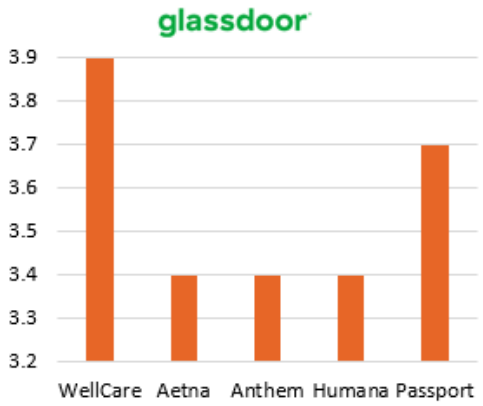


Figure B.3-4 2019 Glassdoor Rating

- Competitive compensation
- Paid time off
- Health/dental/vision insurance
- Telemedicine
- Employee assistance plans
- 401(k) retirement plan
- Company-paid life and disability insurance
- Flexible spending accounts
- Casual Dress Code
- Tuition Reimbursement
- Volunteer Time Off Program

In addition, we are committed to diversity and inclusion, and create an environment in which associates bring their authentic selves to the work place. In addition to the benefits listed above, we use a variety of strategies for retaining key personnel and associates to ensure we always have talented team Enrollees in place to perform the functions of the Contract. Strategies include leadership goals and training, measures and action plans, career development to engage and empower associates, and targeted retention programs. **In 2018, WellCare of Kentucky's overall undesirable turnover was 8.4%, well below the health care industry average.**

RETAINING KEY PERSONNEL THROUGH MEASURES AND ACTION PLANS

The WellCare of Kentucky leadership team is committed to ensuring that we have a highly motivated and engaged team of associates in our regional offices, on-site at hospitals, and remotely to provide exceptional support to our Enrollees and providers. We measure the satisfaction and engagement of our associates by soliciting feedback from all employees through a confidential annual Associate Opinion Survey (AOS) and a New Hire Experience Survey (NHES). **In our most recent AOS conducted in 2018, WellCare of Kentucky's average**

score for 14 of the 15 AOS categories in the survey was 11% to 31% higher than the U.S. high performing norm comparator, which includes Fortune 100 companies. WellCare of Kentucky has led the organization in AOS engagement scores for the last two years. In addition, Kentucky had a 100% employee participation rate on the 2018 survey. WellCare's NHES goes out 90 days after a new associate starts. In 2018, WellCare surveyed 2,160 associates with an 87% favorable result. WellCare of Kentucky surveyed 31 associates in 2018 with a 93% favorable result. We review AOS and NHES results with each functional area and partner, creating action plans to address areas of opportunity identified by the surveys and capitalize on successes, leveraging best practices and ensuring strong future results. We hold executives accountable for achieving successful outcomes and addressing opportunities these surveys identify.

RETAINING KEY PERSONNEL THROUGH CAREER DEVELOPMENT

One of our most important strategies for enhancing retention and minimizing staff turnover is to create an environment that supports professional achievement by providing all associates with the tools and resources they need to ensure success. WellCare of Kentucky is committed to providing all associates with effective learning in the necessary business and professional development skills to ensure their success. In 2018, 82% of WellCare of Kentucky's associates said that they receive the training they need to perform their current job effectively and that they are given a real opportunity to improve their skills (based on WellCare of Kentucky's 2018 AOS Survey Results). We support all of our employees in their development and individual growth at the company and are proud of our ability to recruit and promote employees from within the organization. **In 2018, 15 of WellCare of Kentucky's associates received promotions and WellCare filled more than 33% of open positions with internal associates.**

LinkedIn Learning

As our industry and our business grow more complex, our associates must adapt and innovate, faster and better than ever before. WellCare is excited to provide all associates with access to LinkedIn Learning – an award-winning, industry leader in online training – with a digital library of over 11,000+ micro-learning courses covering a wide range of technical, business, software and creative topics. Launching LinkedIn Learning is a strong commitment to providing professional development opportunities for our associates, allowing them to take charge of their learning and planning for their career growth.

RETAINING KEY PERSONNEL THROUGH TARGETED RETENTION PROGRAMS

Each functional area leader partners with their respective human resources business partner to create retention programs that address retention risks. This ensures we retain our top talent and that our associates are engaged and developed to serve our Enrollees and providers. For example, if we identify an attrition opportunity among a particular functional role, we implement a series of proactive measures to address it. Examples of retention plan action items include 'stay' and 'skip' level interviews with high performing associates, stretch assignments, mentoring, and engagement programs and activities. **These targeted retention programs have proved to be very successful. In 2019, WellCare of Kentucky's overall undesirable turnover was 8.4%, well below the health care industry average.**

b. Provide a detailed description of the Vendor's organizational structure for this Contract, including an organizational chart that clearly displays the following:

WellCare of Kentucky will submit a current organizational chart depicting all functions including mandatory functions, number of employees in each functional department and key managers responsible for the functions to DMS for approval within 30 days of signing the Contract, annually, prior to material revisions and upon request by DMS.

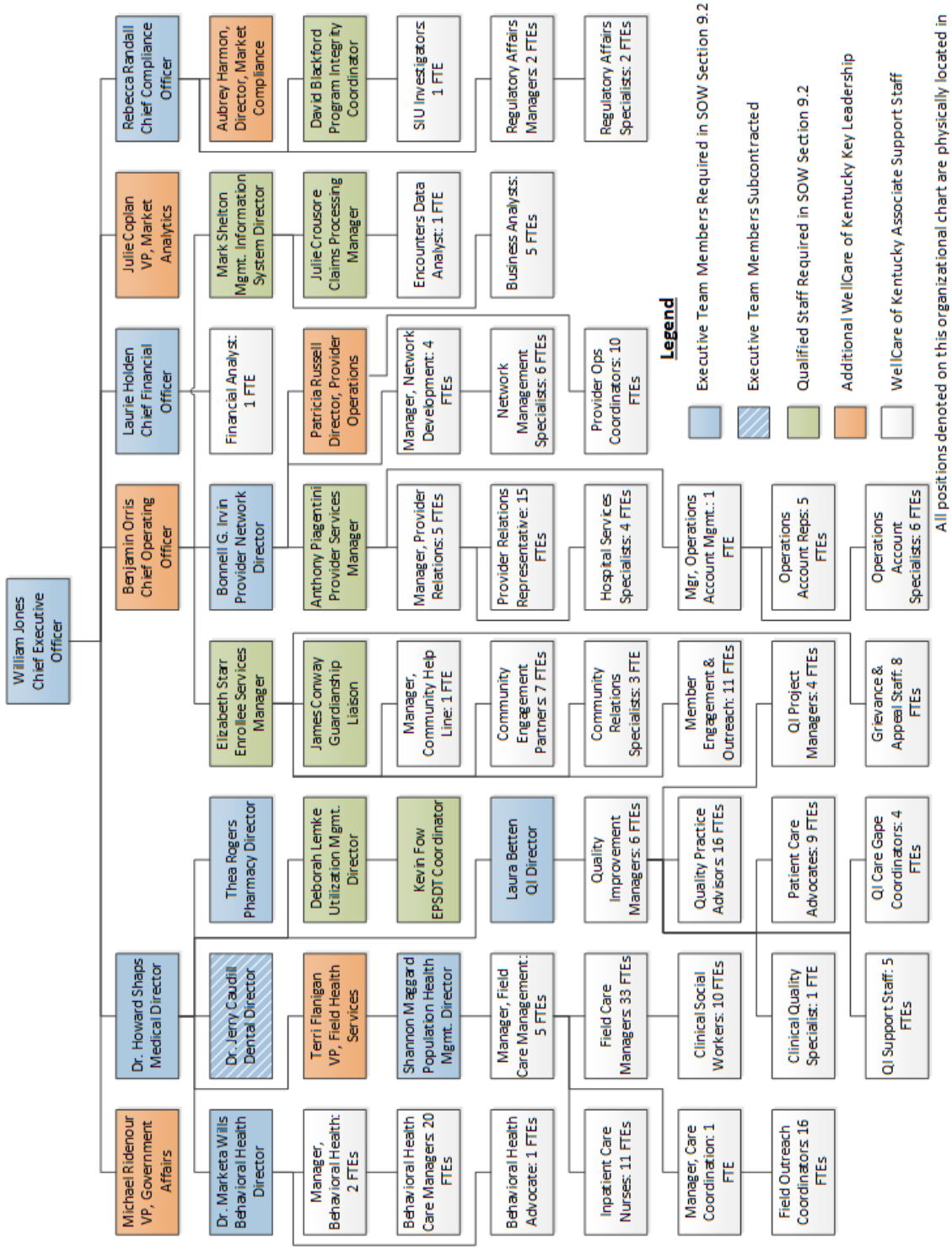
i. Management structure, lines of responsibility, and authority for all operational areas of this Contract.

WellCare of Kentucky's Chief Executive Officer, Bill Jones, has full accountability for overseeing all operations, strategic direction and administration of our Kentucky MMC Program plan. Working closely with our CEO is our Kentucky-based Executive Team, comprised of key leaders, each of whom are responsible for overseeing specific functional areas within WellCare of Kentucky's organization. Together, our Commonwealth-level leadership team and support staff will anchor each regional staff team located in one of our six regional offices. Our dynamic team of local leaders are responsible for making decisions for WellCare of Kentucky. This decision-making responsibility extends downward to the teams deployed throughout the Commonwealth to ensure that associates closest to our Enrollees, providers and stakeholders are empowered to make decisions with support and feedback from our Commonwealth leadership team. For example, the scope of decision-making authority of our local team in Kentucky includes, but is not limited to, how staff and resources are deployed throughout the local market to support our Enrollees and providers, the authority to administer the execution and management of our Provider network, the ability to make decisions about Value-Based Purchasing with our providers, and the capability to make local decisions regarding claims adjudication and prior authorization issues.

WellCare of Kentucky's infrastructure provides integrated accountability with behavioral, social, pharmacy and physical health staff aligned through our clinical, administrative, and operational structure. This ensures that integration of services begins at the top of our management structure and flows down into our regional and local service delivery at the Enrollee level. Our governance and decision making model ensures that these local leaders engage in daily, weekly, and monthly interactions with our local staff to address Kentucky specific issues, to ensure challenges are being addressed, to ensure adherence to escalation protocols, and to guarantee our associates are making timely, accurate, and proactive decisions.

The organizational chart below, **Chart B.3-1** WellCare of Kentucky Organizational Structure, shows the management structure, lines of responsibility, and authority for all operational areas of WellCare of Kentucky for this Contract.

CHART B.3-1: WELLCARE OF KENTUCKY ORGANIZATIONAL STRUCTURE



ii. How the RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices" fits into the overall organizational structure of the Parent Company.

WellCare of Kentucky is an indirect wholly owned subsidiary of Centene Corporation, Inc. (Centene).

CENTENE

Centene Corporation (Centene), which includes WellCare Health Plans, provides managed care services to more than 12.9 million Medicaid Enrollees across 30 states. Centene's focus and expertise is in serving beneficiaries through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), Modified Adjusted Gross Income (MAGI), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Foster Care, Medicaid Expansion Populations, LTSS, and Medicare-Medicaid Plans (MMPs). Centene serves 1 million Medicare members across 28 states.

WELLCARE HEALTH PLANS

WellCare Health Plans, Inc. ("WellCare") provided managed care to over 4.1 million Medicaid Enrollees in 12 states (as of yearend 2019) including serving Aged, Blind and Disabled (ABD), Children's Health Insurance Plan (CHIP), Dual-Eligible Populations (Medicare & Medicaid), Intellectual Developmental Disabilities (IDD), Managed Long-Term Services and Supports (MLTSS), Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF) populations. WellCare also offers Medicare Advantage plans in 21 states serving 506,000 Enrollees including approximately 125,000 dual-eligibles. WellCare also offers Medicare Part D prescription drug plans in all 50 states with approximately 1.05 million Enrollees. WellCare does not split time or our infrastructure in commercial insurance or other types of health coverage, which allows us to ensure that we tailor everything we do for Medicaid and Medicare Enrollees. As of January 23, 2020, WellCare is a wholly owned subsidiary of Centene.

WELLCARE OF KENTUCKY, INC.

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc., and an indirect wholly owned subsidiary of Centene. WellCare of Kentucky currently serves more than 430,000 Medicaid Enrollees across the Commonwealth, which includes (as of Q3 of 2019) approximately 229,000 Temporary Assistance for Needy Families (TANF)/Kentucky Children's Health Insurance Program (KCHIP), 141,000 Medicaid Expansion, 43,000 Supplemental Security Income (SSI), 24,000 Dual Eligible, and 8,100 foster care, juvenile justice system, adoption assistance, and former foster care Enrollees. Additionally, WellCare of Kentucky services approximately 47,000 Medicare Enrollees across Kentucky, including 14,000 Medicare Advantage Enrollees and 33,000 Medicare PDP Enrollees. We currently employ over 300 people throughout the Commonwealth serving our Medicaid and Medicare Enrollees. Our experience teaches us that a local presence is the key to both successful implementation and ongoing operations. More importantly, local service to our Enrollees and providers has a positive impact on quality and availability of Enrollee care.

The ownership path is as follows:

The organizational chart below, **Chart B.3-2** Management Structure Organizational Chart, shows how Attachment C “Draft Medicaid Managed Care Contract and Appendices” fits into the overall organizational structure of the WellCare of Kentucky's Parent Company and ultimate parent company (Centene). Parts 12 through 17 provide the specific details of WellCare of Kentucky and our affiliates and direct parent (WellCare).

iii. Where subcontractors will be incorporated.

INCORPORATION OF SUBCONTRACTORS

We choose highly qualified subcontractors to complement and enhance the services we provide to our Enrollees and providers. We thoughtfully integrated these subcontractors into WellCare of Kentucky's organizational structure to ensure a streamlined experience for our Enrollees, providers and DMS. Reporting to our Chief Executive Officer, our Chief Operating Officer, Ben Orris, is responsible for overseeing the day-to-day functions and services supplied by operational subcontractors. Several additional key personnel are responsible for overseeing services performed by our subcontractors.

- Ben Orris, Chief Operating Officer – Responsible for overseeing subcontractors providing Operations Support services
- Dr. Howard Shaps, Medical Director – Responsible for overseeing subcontractors providing Clinical services
- Deborah Lemke, RN, BSN, MHA, CCM, Utilization Management Director – Responsible for overseeing subcontractors providing Utilization Management services.
- Thea Rogers, Pharm.D., Pharmacy Director – Responsible for overseeing subcontractors providing Pharmacy Benefits Management services
- Bonnell Irvin, MPA, Provider Network Director – Responsible for overseeing subcontractors providing Provider Network services
- Julie Crousore, Claims Processing Manager – Responsible for overseeing subcontractors providing Claims Processing services
- Elizabeth Starr, Enrollee Services Manager – Responsible for overseeing subcontractors providing Enrollee Services

Table B.3-5 below shows the Subcontractors WellCare of Kentucky utilizes to support our Kentucky MMC Program plan.

Table B.3-5 Subcontractors, Functions, and Reporting Structure

Subcontractor	Function
Enrollee Services – Elizabeth Starr	
All Asian Group	Translation services
C3/CustomercontactChannels Inc.	Call Center
CareerArc	Career service & employment and training support for our Enrollees
Cobalt Therapeutics, LLC	Behavioral health website training for Enrollees
Concentrix Corp. (f/k/a IBM Daksh Business Process Services PVT Ltd)	Enrollment services
CSI Southeast, Inc., d/b/a Interpretek	Sign language interpretation
Eliza Corporation	Interactive voice recognition – Enrollee risk

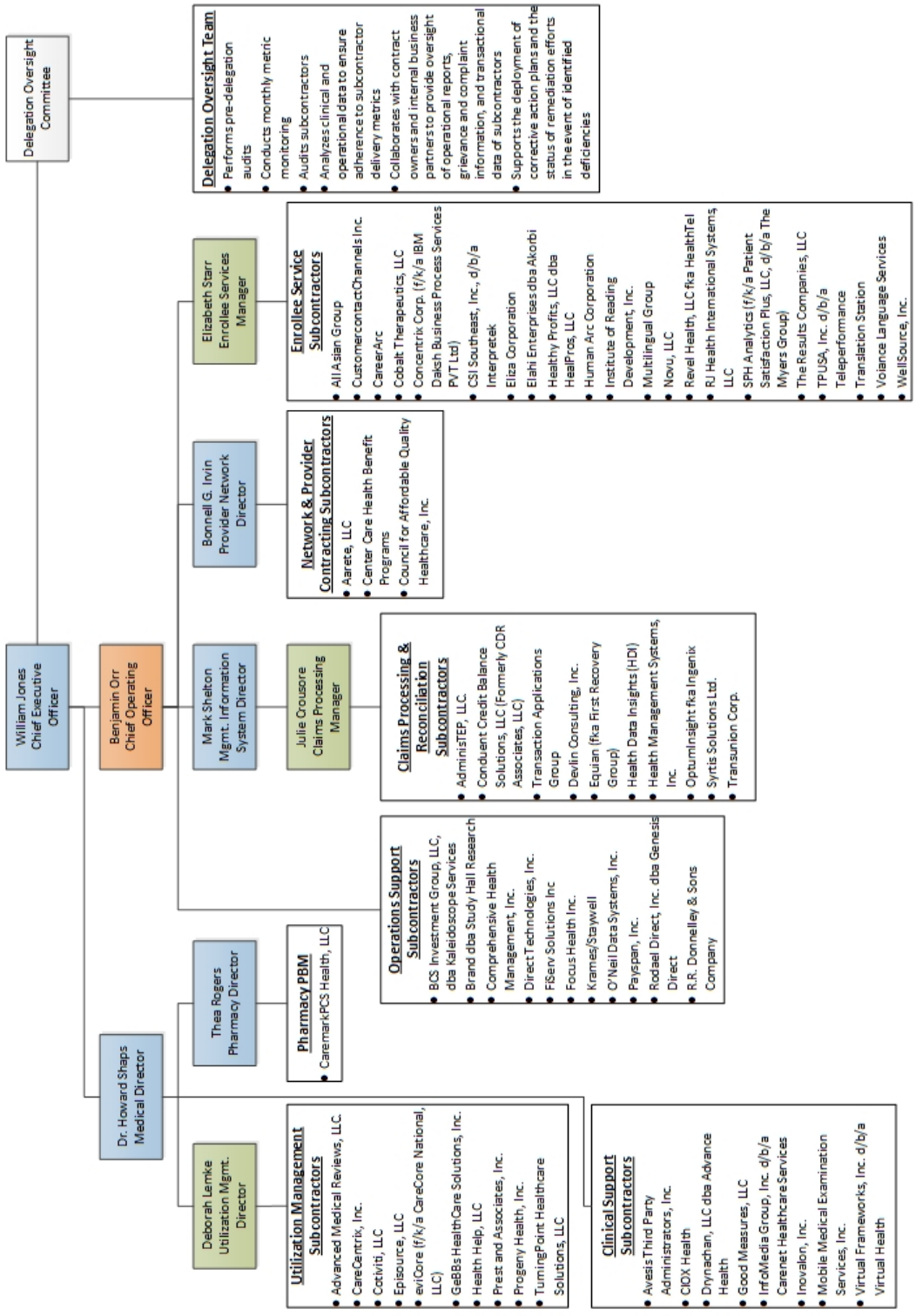
Subcontractor	Function
	assessments
Elahi Enterprises dba Akorbi	Visually and hearing impaired translation services
Healthy Profits, LLC dba HealPros, LLC	Diabetic retinopathy examination screenings
Human Arc Corporation	Outreach enrollment services
Multilingual Group	Written translation services
Novu, LLC	Enrollee wellness reward program
Revel Health, LLC fka Healthtel	Enrollee communications
RJ Health International Systems, LLC	Web based portal for RX claims
SPH Analytics (f/k/a Patient Satisfaction Plus, LLC, d/b/a The Myers Group)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
The Results Companies, LLC	Customer service
TPUSA, Inc. d/b/a Teleperformance	Customer service
Translation Station	Interpreter services – physicians' offices
Voiance Language Services	Grievance letter translation services
WellSource, Inc.	Web access program for telephonic access to health appraisal questions.
Network and Provider Contracting – Bonnell Irvin	
Aarete, LLC	Assist markets with DME provider contracting efforts
Common Health Corporation, Inc. dba Center Care Health Benefit Programs	Credentialing
Council for Affordable Quality Healthcare, Inc.	Source for Provider self-reported data
Claims Processing and Reconciliation – Julie Crousore	
AdminisTEP, LLC	Clearinghouse services for claims and real-time transactions
Conduent Credit Balance Solutions, LLC (Formerly CDR Associates, LLC)	Claims overpayment recovery
Transaction Applications Group	Claims processing and adjudication
Devlin Consulting, Inc.	Overpayment recovery of claims through data mining
Equian (fka First Recovery Group)	Third party liability - subrogation
Health Management Systems, Inc.	Third party liability – coordination of benefits, credit balance and data mining

Subcontractor	Function
OptumInsight fka Ingenix	Payment Integrity, Claims editing, Credit Balance Audit
Syrtis Solutions Ltd.	Third party liability – verification of benefit eligibility
Transunion Corp.	Third party liability – claims
Utilization Management – Deborah Lemke	
Advanced Medical Reviews, LLC.	Physician level independent peer review
CareCentrix, Inc.	Post-acute care services/ Readmissions Management Services
Cotiviti, LLC	Data mining and medical chart review recovery
Episource, LLC	Medical Records Reviews
GeBBs HealthCare Solutions, Inc.	Medical Records
Prest and Associates, Inc.	Physician utilization review and independent review
Progeny Health, Inc.	Utilization Management/ Neonatal Medical Management Services
TurningPoint Healthcare Solutions, LLC	Orthopedic Utilization Management
Clinical Support – Dr. Howard Shaps	
Avesis Third Party Administrators, Inc.	Vision management services and dental management services
CIOX Health	Chart retrieval/HEDIS chart copy services
Drynachan, LLC dba Advance Health	In-home assessments
eviCore (f/k/a CareCore National, LLC)	Utilization management
Good Measures, LLC	Value Added Benefits Program Administrator
InfoMedia Group, Inc. d/b/a Carenet Healthcare Services	24/7 nurse line
Inovalon, Inc.	HEDIS Advantage™ services
Mobile Medical Examination Services, Inc.	Home Bone Mineral Density Screening Program
Virtual Frameworks, Inc. d/b/a Virtual Health	IT platform for care management
Health Help, LLC	Utilization Management
Operations Support – Ben Orris	
BCS Investment Group, LLC, dba Kaleidoscope Services	Print and fulfillment

Subcontractor	Function
Brand dba Study Hall Research	Focus group research
Comprehensive Health Management, Inc.	Management services
Direct Technologies, Inc.	Print and fulfillment
FiServ Solutions Inc.	Print Fulfillment
Focus Health Inc.	Behavioral health utilization management
Krames/Staywell	Print fulfillment
O'Neil Data Systems, Inc.	Print services
Payspan, Inc.	File Processing, Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA), Online Archive, Print Services
Rodael Direct, Inc. dba Genesis Direct	Creative services, print and production, fulfillment and shipping services
R.R. Donnelley & Sons Company	Print services
Pharmacy PBM – Thea Rogers	
CaremarkPCS Health, LLC (CVS)	Pharmacy benefit manager (PBM)

The organizational chart below, **Chart B.3-3** Subcontractor Management Structure, shows where subcontractors will be incorporated into WellCare of Kentucky's organizational structure.

CHART B.3-3: SUBCONTRACTOR MANAGEMENT STRUCTURE



iv. A summary of how each Subcontractor will be integrated into the Offeror's proposal performance of their obligations under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," to ensure a streamlined experience for the Members, providers and the Department.

INTEGRATING SUBCONTRACTORS AT THE LOCAL LEVEL

All of WellCare of Kentucky's subcontractors are expected to meet the specific obligations and performance standards under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices in order to ensure a streamlined experience for Enrollees, providers, and DMS. Chief Operating Officer, Ben Orris, is responsible for overseeing the day-to-day functions and services supplied by operational subcontractors. Supporting Ben in these efforts is our Commonwealth-based Regulatory Affairs and Compliance teams, which includes our Chief Compliance Officer, Rebecca Randall. In conjunction with our local Regulatory Affairs and Compliance teams, our team of local leaders responsible for quickly and directly addressing any issues that arise with our Enrollee and provider facing subcontractors. These local leaders include Dr. Howard Shaps, Medical Director, Deborah Lemke, Utilization Management Director, Thea Rogers, Pharmacy Director, Bonnell Irvin, Provider Network Director, Anthony Piagentini, Provider Services Manager, Julie Crousore, Claims Processing Manager, and Elizabeth Starr, Enrollee Services Manager.

WellCare of Kentucky has multiple mechanisms for becoming aware of emerging subcontractor performance issues, including metric/scorecard monitoring, complaints and grievances (including those from DMS), regularly scheduled subcontractor audits, Enrollee feedback from our Consumer Advisory Boards, Provider Advisory Panels, Joint Operating Committee (JOC) meetings with our subcontractors, and our WellCare of Kentucky Quality and Compliance governance meetings. To ensure we are constantly engaging with our subcontractors, our Regulatory Affairs and Compliance Teams hold regular JOC meetings with our subcontractors to monitor performance level reports and scorecards, identify and address service and quality issues, and design and execute quality improvement initiatives. These meetings include discussions of any performance issues, including outstanding corrective action plans and the status of remediation efforts. We typically hold these meetings monthly, but for subcontractors with broader Enrollee impact, such as Dental and Transportation, we hold them bi-weekly (and even more frequently if needed, such as during Contract implementation).

Delegation Oversight Team

Supporting WellCare of Kentucky in our monitoring and oversight efforts is our Delegation Oversight Team, led by WellCare's Chief Compliance Officer, Lori-Don Gregory, Deputy Compliance Officer, and Chris Price, Vice President Compliance Oversight, our Delegation Oversight Team. This team oversees compliance of services provided by subcontractors to ensure they comply with federal and state regulations, contractual obligations, accreditation standards and company policies and procedures. This team is comprised of subject matter experts for each of the delegated functions. The team leverages audit tools and expertise, our C360 compliance management system, and national best practices to execute a comprehensive subcontractor oversight process. To further illustrate the breadth of experience of our

Delegation Oversight Team, it includes clinical and non-clinical auditors with industry expertise spanning utilization review, complex case management, claims, customer service, and pharmacy, as well as an in-depth understanding of the requirements for a WellCare of Kentucky subcontractor.

Our Delegation Oversight Team works in conjunction with the governance framework of our Delegation Oversight Committee (DOC). Our DOC provides oversight for all delegated subcontractors and continuous guidance and advisory services to our Delegation Oversight program. Our DOC is governed by our Compliance Program and reports to our Corporate Compliance Committee (CCC), and ultimately to the Audit, Finance, and Regulatory Compliance Committee of WellCare's Board of Directors.

MONITORING SERVICE LEVEL AGREEMENTS

We ensure subcontractor compliance through the rigorous monitoring of service level agreements to ensure a streamlined experience for Enrollees, providers, and DMS. Our approach to establishing and monitoring service level agreements is based on our thorough contracting process, rigorous upfront screening process, and comprehensive ongoing review process. Service level agreements are established to ensure compliance with DMS' contractual requirements for covered services, as well as alignment with DMSs key goals for the Kentucky MMC Program.

Monitoring Kentucky MMC service level agreements begins with ensuring they are clearly documented in our contract with our subcontractor. As part of their negotiating and contracting processes, our National Network Performance Team ensures all required state contract standards are included in our subcontracts, and aligns these standards with monetary performance incentives and penalties. Our Senior Manager of Vendor Management and Senior Manager of Regulatory Affairs, who are subject matter experts on the MMC Contract and who provide guidance on any interpretation questions, support them in this effort.

Our pre-delegation audit process validates that the subcontractor has the required elements in place to comply with all of the contractual requirements for the functions delegated to them. Items evaluated as part of the pre-delegation audit include eligibility for government health care programs, policies, procedures, licensures, and staffing levels. The results of the pre-delegation audit are summarized and presented to our Delegation Oversight Committee. If during the initial delegation audit, an item or process is deficient or not compliant with WellCare of Kentucky's expectations, the subcontractor is placed on a corrective action plan (CAP) which must be remediated. Any exceptions must be presented to and approved by our Delegation Oversight Committee.

Once delegated services have commenced, WellCare of Kentucky continues to monitor service level agreements. The primary forum to discuss these metrics is our reoccurring Joint Operating Committee (JOC) meetings with our subcontractors. Key areas of focus for our JOCs are monitoring performance level reports and Delegation Oversight scorecards, identifying and addressing service and quality issues, complaints, and grievances, and designing and executing quality improvement initiatives. All subcontractors delegated for network management have service level agreements to meet or exceed DMSs' network adequacy requirements.

Our ongoing service level monitoring through our JOC structure is supplemented by the compliance monitoring of our Delegation Oversight Team. As part of our governance process, our Delegation Oversight Team reports directly through our Compliance Organization and Chief Compliance Officer, making their review and assessment independent from WellCare of Kentucky's day-to-day operational team. Delegation Oversight uses a risk-based approach to determine the level and frequency of review, and every subcontractor has an annual review. Our reviews include metric-based scorecards (of service levels that are aligned with Kentucky MMC standards), targeted / focused audits, and annual functional audits. Delegation Oversight imposes corrective action plans for subcontractor service level misses as necessary and monitors their completion. In the case of an explicit failure to meet Department standards, the "Improvement Plan" due to WellCare of Kentucky and DMS will mirror the corrective action plan. If a subcontractor fails to remediate the deficiency underlying the corrective action plan, WellCare of Kentucky imposes disciplinary action and fines up to and including de-delegation. Delegation Oversight's activities are managed through our compliance management system, Compliance 360 (C360), which enables accurate tracking and reporting.

A depiction of how each Subcontractor will be integrated into the WellCare of Kentucky's proposal performance of their obligations under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices is shown above in **Chart B.3-3 Subcontractor Management Structure.**

v. Number of proposed FTEs dedicated to RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," by position type and operational area and how the Vendor determined the appropriateness of these ratios.

DETERMINING THE APPROPRIATENESS OF FTE RATIOS

Over the years, WellCare has had significant experience launching new programs, integrating acquired programs and expanding with new populations, geographies, and services with positive results, allowing us to become one of the largest Medicaid managed care providers in the country. As a company with over 30 years of experience developing staffing plans for our Medicaid programs and over eight years of experience providing Medicaid services within the Commonwealth, we have a tested process in place for ensuring the appropriate level of FTEs to continue successful operations of the MMC program. To ensure we have updated our staffing plan to fulfill the requirements of the updated Contract, we have conducted a detailed and thorough information gathering process to ensure that the necessitated staffing levels for the Kentucky MMC Program have been accurately captured and planned for over time. We achieve this through a series of structured review sessions with functional area leaders that span all functions of the organization to ensure a clear understanding of the contract requirements, deliverables, and the strategy in place to effectively achieve and execute those deliverables. Following these review sessions, each functional area is responsible for providing a detailed staffing plan that includes the number and type of FTEs as well as the anticipated dates of hire, over time, including the time leading up to contract implementation. Senior level leadership reviews, revises (if needed), and approves the plan to ensure strategic direction is achieved and the inputs are appropriate to meet the established requirements.

NUMBER OF PROPOSED FTES BY POSITION TYPE AND OPERATIONAL AREA

Table B.3-6 below describes the projected WellCare of Kentucky staff broken down by functional area, position, and FTE count. All positions denoted on this in the table below are physically located in Kentucky and 100% dedicated to the Kentucky Medicaid program.

Table B.3-6 Proposed Full-Time Equivalent Positions in KY

Functional Area and Position	# of FTEs
Key Leadership	
Chief Executive Officer	1 FTE
Chief Financial Officer	1 FTE
Chief Compliance Officer	1 FTE
Medical Director	1 FTE
Pharmacy Director	1 FTE
Dental Director	.25 FTE
Behavioral Health Director	1 FTE
Provider Network Director	1 FTE
Quality Improvement Director	1 FTE
Population Health Management Director	1 FTE
Management Information System Director	1 FTE
VP, Government Affairs	1 FTE
Chief Operating Officer	1 FTE
VP, Market Analytics	1 FTE
Director, Provider Operations	1 FTE
Guardianship Liaison	1 FTE
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator	1 FTE
Claims Processing Manager	1 FTE
Utilization Management Director	1 FTE

Functional Area and Position	# of FTEs
Enrollee Services Manager	1 FTE
Provider Services Manager	1 FTE
Program Integrity Coordinator	1 FTE
Clinical Operations	
Manager, State Pharmacy	1 FTE
Manager, Behavioral Health	1 FTE
Behavioral Health Advocate	1 FTEs
Behavioral Health Care Manager	20 FTEs
Clinical Quality Specialist	1 FTE
Clinical Social Worker	10 FTEs
Manager, Field Care Management	5 FTEs
Manager, Care Coordination	1 FTE
Field Care Managers	33 FTEs
Field Outreach Coordinator	16 FTEs
Inpatient Care Nurse	11 FTEs
SNF Nurse Reviewer	1 FTE
Supervisor, Care Management	1 FTE
Supervisor, Care Coordination	1 FTE
Prior Authorization Nurse	1 FTE
Supervisor, Patient Care Advocacy	1 FTE
Patient Care Advocate	9 FTEs
Quality Improvement Care Gap Coordinator	4 FTEs
Quality Improvement Manager	6 FTEs

Functional Area and Position	# of FTEs
Quality Improvement Project Manager	4 FTEs
Quality Improvement Support Staff	5 FTEs
Quality Practice Advisor	16 FTEs
Provider Network and Provider Relations	
Manager, Network Development	4 FTEs
Manager, Operations Account Management	1 FTE
Network Management Specialist	6 FTEs
Operations Account Representative	5 FTEs
Operations Account Specialist	6 FTEs
Manager, Provider Relations	5 FTEs
Hospital Services Specialist	4 FTEs
Provider Operations Coordinator	10 FTEs
Provider Relations Representative	15 FTEs
Enrollee Services	
Manager, Community Help Line	1 FTE
Supervisor, Community Engagement	2 FTE
Supervisor, Patient Advocacy	1 FTE
Community Engagement Partner	7 FTEs
Director, Public Affairs	
Community Relations Specialist	3 FTEs
Peer Coach	5 FTEs
Enrollee Engagement and Outreach Staff	11 FTEs
Grievances and Appeals Staff	8 FTEs

Functional Area and Position	# of FTEs
Compliance and Regulatory Affairs	
Director, Reporting and Analytics	1 FTE
Director, Strategic Initiatives	1 FTE
Director, Strategic Marky Analysis	1 FTE
Regulatory Affairs Manager	2 FTEs
Regulatory Affairs Specialist	2 FTEs
SIU Investigator	1 FTE
Operational, IT and Administrative Support Staff	
Administrative Support Staff	7 FTEs
Human Resources Business Partner	1 FTE
IER Coordinator	2 FTEs
Manager, Product Operations	1 FTE
Operations Support Staff	1 FTE
Product Manager	1 FTE
Project Management Staff	3 FTEs
Financial Analyst	1 FTE
Business Analyst	5 FTE
Risk Adjustment Auditor Educator	1 FTE
Supervisor, Operations	1 FTE
Encounter Data Analyst	1 FTE

The number of WellCare of Kentucky proposed FTEs dedicated to RFP Attachment C “Draft Medicaid Managed Care Contract and Appendices,” by position type and operational area is shown in **Chart B.3-1 WellCare of Kentucky Organizational Structure.**

Table B.3-7 below describes the staff broken down by functional area, position, and FTE count located in our corporate offices in Tampa, FL that provide support to the WellCare of Kentucky Medicaid program.

Table B.3-7 Proposed Full-Time Equivalent Positions in Shared Services

Shared Services Functional Area and Position	# of FTEs
Clinical Services Support Staff - Clinical Administration, Telephonic Care Management Services, Quality Administration, Business Performance Management, Clinical Informatics, Appeals Processing	397 FTEs
Information Technology Support Staff - Application Delivery, Enterprise Information Management, Systems Architecture	121 FTEs
Legal, Compliance and Regulatory Affairs Support Staff - General Council, Corporate Compliance, Internal Audit, Privacy and Information Security	26 FTEs
Pharmacy Support Staff - Pharmacy Benefit Administration, MTMP	71 FTEs
Operational Support Staff - Enrollment and Billing, Enrollee Communications, Provider Operations, Configuration, Claims Processing, Encounter Data Processing, Payment Integrity, Credentialing, Network Performance	221 FTEs
Finance - Actuarial Services, Accounting, Treasury, Real Estate, Financial Planning and Analysis	44 FTEs
Human Resources - Talent Management and Leadership Development, Compensation, Recruiting, Employee Relations, Training	17 FTEs

B.3 Staffing

- Attachment B.3.a.iv Key Personnel Resumes

WELLCARE OF KENTUCKY KEY PERSONNEL RESUMES

Title	Name
Chief Executive Officer	William Jones, MBA
Chief Financial Officer	Laurie Holden, MBA
Chief Compliance Officer	Rebecca Randall, MBA
Medical Director	Howard Shaps, MD, MBA
Pharmacy Director	Thea Rogers, Pharm.D.
Dental Director	Jerry Caudill, DMD, FAGD, MAGD, CDC, CTCP, FPFA, FICD, FACD
Behavioral Health Director	Marketa Wills, MD, MBA
Provider Network Director	Bonnell Gustafson Irvin, MPA
Quality Improvement Director	Laura Betten, MBA, RN
Population Health Management Director	Shannon Maggard, RN, CCM
Management Information System Director	Mark Shelton
Enrollee Services Manager	Elizabeth Starr, LCSW, MSSW
Provider Services Manager	Anthony Piagentini, MBA
Claims Processing Manager	Julie Crousore
Utilization Management Director	Deborah Lemke, RN, BSN, MHA, CCM
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator	Kevin Fow, RN, BSN
Guardianship Liaison	James Conway
Program Integrity Coordinator	David Blackford

WILLIAM JONES – CHIEF EXECUTIVE OFFICER (CEO)

William Jones is a senior leader with over 25 years of experience in Healthcare. An accomplished executive with experience in working with Boards of Directors, State and Federal Legislators, and Regulators in order to deliver results. A High-Energy, Organizational Leader with demonstrated success in developing sound strategies that are balanced between financial performance, quality, stakeholder satisfaction, and growth. A Team Player that conveys a value proposition and gains buy-in from cross-functional groups for the development and execution of strategies and the implementation of process improvements utilizing Six Sigma, Lean, and other process improvement methodologies. A Change Agent that brings a sense of urgency to drive positive organizational change, with experience in building, turning around/optimizing a company's fundamental infrastructure, technologies, processes and measurement systems to increase profitability and performance. Currently sits on the Board of Directors of Big Brothers Big Sisters of Kentuckiana, American Heart Association, and National Kidney Foundation.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Division President – North Division (NY, NJ, KY, NC) (Aug. 2016 – Present)

- Lead a group of 1,300+ associates with P &L responsibility for a $5.5 billion book of business that includes Medicaid, Managed Long Term Care and Medicare. The North Division serves over 650,000 Medicaid members and 120,000 Medicare members.
- Implemented a regional structure for Quality and Analytics that has produced improvements in both Medicare STARs and Medicaid HPR within the first 6 months.
- Began a turnaround for our Medicare product in NY that has been losing NI for the last 4 years. Turned a positive NI the last two months in a row since after launching the improvement plan 4 months ago.
- Set an aggressive growth plan for the division to grow membership by 20% over the next year.

WELLCARE OF KENTUCKY – LOUISVILLE - KY

State President (Aug. 2016 – Present)

- Led a group of 250+ associates with P &L responsibility for a $2.6 billion book of business that included Medicaid and Medicare.
- Achieved the highest Associate Engagement (Satisfaction) score in the company at 90% for 2017.
- Improved quality and reached the #1 ranking in the State of KY for Medicaid quality while maintaining and improving from a 2.5 to a 3.5 STAR score in Medicare in two years.
- Grew Medicare business from 8,300 members to 14,000 in less than two years and achieved profitability for the first time in plan history in 2017.
- Achieved the highest score in the company on the provider net promoter score (satisfaction) at 87.8%.
- Achieved the highest member satisfaction in Medicaid in KY based on the CAHPS survey 2 years in a row.

HIGHMARK, INC. – PITTSBURGH, PA

Vice President, Payment Integrity and Government Business Operations (Jan. 2016 – Aug. 2016)

- Led a group of 600+ associates with responsibility for Enrollment, Billing, Claims, Service, STARS, etc. for our Medicare Advantage, Exchange Product, and Medigap product lines as well as Payment Integrity functions such as front end editing and medical policy development and application, subrogation, COB, etc.
- Led the Payment Integrity function for the Enterprise, delivering over $50 million in value to the bottom line each year.
- Implemented an organizational re-design that has resulted in $2.6 million in administrative savings.
- Led an Executive team charged with addressing Account Receivable Issues for Highmark Health's hospital system, Allegheny Health Network. Group was able to clean up over $30 million in AR in two months.
- Executive sponsor and ownership of several multi-million dollar programs to include Enterprise Enrollment and Billing, Pre-Payment editing and others.

INDEPENDENT CONSULTANT – JACKSONVILLE, FL

Independent Consultant (Oct. 2015 – Dec. 2015)

- Interim executive services and consulting, providing services to align Finance, Operations and System with Client Company's objective and goals. Develop and execute business plans and provide mentoring to key leaders.
- Provided interim leadership and led a post migration project that primarily focused on claims payment issues. Reduced claims inventory by over 50% in 2 months.
- Delivered a program structure for the outsourcing of Operational and Finance functions to include operational process design, technology migration and retirement, etc.

CALOPTIMA – ORANGE, CA

Chief Operating Officer (Aug. 2013 – Oct. 2015)

- Led a group of 600+ associates with responsibility for Information Systems, Claims Operations, Customer Service, Facilities, Pharmacy Operations, Enrollment, PACE Operations and Program and Project Management.
- Developed and presented strategies and results to the Board of Directors related to risk management, internal operations, State and Federal legislative priorities, etc.
- Led a Board of Directors ad-hoc Committee in developing strategies and tactics that resulted in a reduction of CMS audit conditions from 57 in an audit conducted 2 months after hire, to 6 conditions in a re-audit approximately 1 year later.
- Successfully scaled the business to accommodate a growth rate of over 35% in one year.
- Engineered a 3 year IT strategic plan that includes upgrading or replacing core systems in year 1, supporting systems in year 2 and peripheral systems in year 3 while reducing the overall maintenance expense for our core systems by $700,000.
- Implemented improvements that resulted in increasing our state ranking in overall customer satisfaction to 4th of out of all CA Health Plans in Medicaid, a number 1 NCQA ranking for Medicaid Health Plans in CA and a 4 STAR Medicare rating overall in 2015.

- Re-engineered the Compliance Department including organizational design, training, policies and procedures and processes, including Fraud, Waste and Abuse and Compliance Issue Management and Resolution.
- Improved Pharmacy Operations by building a Pharmacy Authorization process that resulted in over 25 baseline audit issues being resolved and performance levels being achieved consistently for both quality and timeliness.
- Grew our Program of All Inclusive Care for the Elderly (PACE) center from the opening to approximately 80 members in year with 98% retention while improving operating margin ahead of target and being the highest ranked PACE center in CA in overall member satisfaction.

AMERIGROUP CORPORATION – VIRGINIA BEACH, VA

Vice President, Health Plan Services (April 2008 – Aug. 2013)

- Led a group of 180 associates across 13 states that support pricing/benefit configuration, architecture, provider set-up and maintenance for the Medicaid, Long Term Care and Medicare books of business.
- Functional responsibility for the pricing infrastructure of Facets, our core claims processing system.
- Administered configuration best practices and followed the software development lifecycle for configuration changes.
- Led the implementation of several medical expense reduction initiatives including the configuration of code editing software, saving the company $15 million dollars in one year.
- Improved several processes including fee schedule loading, prospective payment system updates and contract/amendment processing that enabled the company to scale rapidly for growth and reduce turnaround times by 50%.
- Implemented compliance programs related to pricing and benefit configuration in support of our Medicare line of business and our state Medicaid customers.
- Structured improvements in the loading and maintenance of provider data that led to increases in enrollment and member/provider selection.
- Implemented a provider relationship management strategy that included provider data reviews, claims testing and feedback loops to ensure the highest levels of satisfaction.
- Worked with State and Federal Regulators to understand and operationalize requirements to ensure compliance and effectiveness.

WELLMARK BLUECROSS BLUESHIELD – DES MOINES, IA

Group Leader, Business Intelligence (Feb. 2006 – April 2008)

- Led a project/portfolio management area responsible for over $20 million in corporate projects.
- Led a team of over 120 associates that included technical, professional and analytic staff.
- Oversaw the overall design, planning and implementation of an integrated data warehouse, healthcare analytic and consulting platform.
- Implemented SAS analytic platform that enabled the development of provider performance scorecards used for incentive programs.
- Implemented a Business Objects Business Intelligence tool that provided a reporting suite to the organization and its clients.

- Integrated Disease and Case Management, Lifestyle and Claims data to build a case for program effectiveness.

BLUECROSS BLUESHIELD OF FL – JACKSONVILLE, FL
Director, Continuous Improvement (Sept. 2003 – Feb. 2006)

- Led the development and implementation of a Six Sigma process improvement program including developing a project pipeline, training and portfolio management.
- First year projects generated a return of over $2 million in combined admin and medical cost savings.
- Implemented a project control framework, standards and portfolio management tools used across the Process Improvement organization.
- Led a group of 20 direct and 25 matrix green and black belts.

BLUECROSS BLUESHIELD OF FL – JACKSONVILLE, FL
Director, Information Technology (July 2002 – Sept. 2003)

- Implemented a program portfolio management toolset that was used for all IT projects.
- Built tools, templates and processes that were used in vetting project ideas for ROI and prioritization.
- Responsible for building the IT Service Operations operating plan and budget.

GOLDMAN SACHS – NEW YORK, NY
Investment Banking Associate/Manager, Support Services (Oct. 2000 – July 2002)

- Led a team of 45 direct and indirect reports.
- Led a team of Analysts and Support staff responsible for developing pitch materials for presentation to clients.
- Responsible for the preparation and review of due diligence materials.

BLUECROSS BLUESHIELD OF FL – JACKSONVILLE, FL
Director, Operations Support (Jan. 1998 – Oct. 2000)

- Led a team of 25 direct and indirect reports.
- Designed and implemented a SAS data warehouse platform.
- Led the development and implementation of a balanced scorecard that was used in monthly, quarterly and annual performance reporting for the division.

BLUECROSS BLUESHIELD OF FL – JACKSONVILLE, FL
Manager, Operations Plan, Budget and Audit (Aug. 1996 – Jan 1998)

- Reported to the Sr. Vice President of Operations and led the development of the Customer Service Operations budget in support of the business and operating plan.
- Led a team of 10 auditors and 2 analysts with primary accountability for the post payment audit function for the company.

BLUECROSS BLUESHIELD OF FL – JACKSONVILLE, FL
Supervisor, NASCO Operations (Nov. 1994 – Aug. 1996)

- Led various claims, call center and in line audit operations functions consisting of 15 direct reports.
- Improved service levels across the board including a 10% decrease in abandoned calls and a 7% decrease in blockage.

BLUECROSS BLUESHIELD OF FL – JACKSONVILLE, FL

Operations Analyst, Corporate Accounts (Sept. 1993 – Nov. 1994)

- Technical and operational analyst in support of key corporate accounts.
- Acted as subject matter expert in the design and implementation of the Inter-Plan Teleprocessing Service in partnership with other Blues plans.

SELECT ACHIEVEMENTS

- Grew Medicare plan by over 56% and turned a profit for the first time in plan history during first year of hire.
- Led infrastructure and process improvements that resulted in a Quality improvement in both Medicare and Medicaid that included a #1 ranking in two different States and 4 STAR Medicare performance.
- Put in place strategy and structure to achieve the highest score in provider satisfaction in the company.
- Achieved the highest member satisfaction rate in the State.
- Earned the highest Associate satisfaction rate in the company two years in a row and finished in the top 10 in the Best Places to Work for in KY.
- Present to and work with Boards of Directors on strategy, controls, risk intelligence, budgets, etc.
- Cultivate strong working relationships with State and Federal Legislators and Regulators by communicating strategies, plans and progress in as well as strategic opportunities for growth and efficiency.
- Turned around a 750,000+ member health plan that resulted in the removal of a Medicare sanction from the plan within the first year of hire.
- Led the conversion and integration of multiple Health Plan acquisitions.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Social Science – Mercyhurst College
- Master of Business Administration – Duke University
- Six Sigma Black Belt Certification – Six Sigma Academy
- Six Boxes Performance Management

LAURIE HOLDEN, MBA – CHIEF FINANCIAL OFFICER (CFO)

Laurie Holden is a strong finance executive possessing extensive government and publicly traded management experience in both For-Profit and Non-Profit organization with diverse industries, including healthcare, manufacturing, distribution, wireless, and information services. Expertise includes fiscal stewardship, organizational leadership, team building, GAAP and SOX compliance management, financial planning and analysis, cash flow management, process improvement, budgeting, and financial operations.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Director, Field Finance – Market CFO (2017 – Present)

- Responsible for the market's financial performance, interpretation, regulatory reporting, enrollment forecasts, Medicare Bid development, Rate Advocacy, and SGA budget development.
- Grew Medicare enrollment by 163% in product design, enhanced quality, and synergies of community activities.
- Lead workgroup identifying and converting Dual membership to DSNP programs.
- Managed $14 million special budget for Kentucky 1115 Waiver.
- Coordinated process improvement with peer departments.
- Created departmental desk procedures and Personal Finance training course for Department of Medicaid Services.
- Identified ROI opportunities to increase sales and quality programs.
- Selected for Field Finance Policy Committee for two consecutive years.

INLAND EMPIRE HEALTH PLAN – RANCHO CUCAMONGA, CA

Chief Financial Officer (2014 – 2016)

- Responsible for the organization's financial reporting, decision support, financial compliance, accounts payable, capitation, risk management, and purchasing functions during a period of rapid growth resulting in 42% enrollment and 57% headcount increases.
- Grew the organization's net equity by 321% and revenue by 117% during tenure.
- Overhauled the accounting departments' internal controls and procedures instilling segregation of duties while decreasing the financial closing period by 51%.
- Redesigned the general ledger chart of accounts, enabling departmental financial and cost reporting by product and categories on an automated basis.
- Compliance Committee member providing oversight of delegated parties for compliance to California state and federal regulations. Established First Tier Downstream or Related Entities (FDR) policies and procedures in accordance with CMS guidelines.
- Secured a contract with a concierge provider to facilitate care management of acutely ill patients with five co-morbidities, decreasing emergency room visits and hospital days.
- Facilitated the design of a quality based risk pool with hospital and physicians, decreasing readmissions and increasing the collaboration between the IPA and hospitals in care delivery.

CALOPTIMA – ORANGE, CA
Director of Financial Analysis (2014)
Controller (2012 – 2014)
Director of Accounting (2006 – 2012)

- Oversaw financial analysis activities, including IBNR, health care cost trend and reporting, profitability analysis, budget, shared risk pools, Medi-Cal's Rate Development Template (RDT), Medicare Advantage bid, and support for strategic planning. Other duties included daily financial and accounting operations. Responsible for presentation of monthly financials to the executive team and quarterly status reports to the Finance and Audit Committees. Managed a staff of 16. This occurred during a period when plan revenue grew from $900 million to $1.7 billion.
- Established an organizational workgroup to for collaboration between medical, claims, and finance departments, focusing on current workflow, high dollar cases, and network monitoring.
- Aligned purchasing and budgeting, ensuring proper oversight of board approved expenditures.
- Oversaw risk management including network financial oversight and financial policies.
- Developed a $1.7 billion annual operating and a $9 million capital budget.
- Achieved consistent clean audit results, resulting in no auditor adjustments for six consecutive years by the Plan's external financial auditor and from the Plan's regulatory auditors.
- Led a HCC six sigma project contributing to $35 million in revenue recoveries.
- Established supplemental billing to the state, generating nearly $2 million in annual revenues.

DG PERFORMANCE SPECIALTIES, INC. – ANAHEIM, CA
Controller (2005 – 2006)

A&G/ALSTYLE APPAREL & ACTIVEWEAR. – ANAHEIM, CA
Controller (2002 – 2005)
Accounting Manager (1998 – 2002)

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS:

- Master of Business Administration (MBA) with concentration in Global Business, University of Redlands – Santa Ana, CA
- Bachelor of Science in Business Administration, University of Phoenix – Riverside, CA

REBECCA RANDALL – CHIEF COMPLIANCE OFFICER

Rebecca Randall is a goal oriented professional with 20 years of comprehensive experience within healthcare policy and compliance among government-sponsored and commercial insurance programs. Experienced in policy research and data analysis, program management, strategic planning and public speaking. Consistently exceeds performance goals and customer service expectations. Motivated leader with strong organizational skills who leads through collaboration, influence and cross-functional teams.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Director, Regulatory Affairs & Product Operations (2017 – Present)

- Direct supervision of three direct reports; direct oversight of 10 departmental staff.
- Identifies, compiles and aggregates regulatory and operational issues across markets to manage risk.
- Establishes the Medicaid regulatory affairs strategy and oversees contract administration activities in Kentucky, including audits.
- Reviews new legislation and regulations and develops implementation plans to ensure compliance within established deadlines.
- Develops procedures and toolkits, and reports and monitors contractually required deliverables, including but not limited to, regulatory reports and performance metrics.
- Directs multiple regulatory projects with aggressive deadlines. Conducts regulatory tracking and analysis to ensure compliance with statutory/regulatory requirements.
- Serves as main point of contact to regulators for all issues/concerns/questions, including corrective action plans.
- Supports the development and implementation of regulatory affairs best practices in new markets.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Director, Regulator Affairs (2014 – 2017)

- Direct supervision of three direct reports.
- Established the Medicaid Regulatory Affairs strategy and oversaw contract administration activities.
- Served as main point of contact to regulators for all issues/concerns/questions, including corrective action plans.
- Directed multiple regulatory projects with aggressive deadlines. Conducted regulatory tracking and analysis to ensure compliance with statutory/regulatory requirements.
- Developed consensus regarding policy positions and responses to proposed contract or regulation changes.
- Managed and supported audits and implementations to ensure regulatory requirements are satisfied.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Manager, Regulatory Affairs (2012 – 2014)

- Responsible for the direct supervision of two staff, Regulatory Affairs Specialists.
- Served as point of contact for Kentucky Department of Insurance prompt payment complaints. Developed internal process for receiving, responding and tracking complaints to ensure compliance with statutes.
- Served as main point of contact to regulators for all issues/concerns/inquiries. Facilitated collaboration with corporate business owners and regulators when appropriate.
- Managed the approval of all materials (member facing, provider, contracts, etc.) among Executive Team and with regulators (when required).
- Served as subject matter expert for the development of new Kentucky Health Benefit Exchange product. Facilitated regulatory filings with the Kentucky Department of Insurance.
- Served as the lead contact within the Kentucky market for compliance audits. Facilitated all data requests, meetings with subject matter experts, in addition to tracking and maintaining all correspondence related to audit requests.
- Responsible for responses to Letters of Concern and requests for Corrective Action Plans issued by regulatory agencies.
- Analyzed, researched and sought input regarding proposed legislation and regulations. Worked closely with corporate partners to ensure compliance with regulatory changes.
- Represented WellCare at various regulatory and stakeholder meetings.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Regulatory and Compliance Specialist (2011 – 2012)

- Supported regulatory analysis, including the review, summarization and dissemination of key regulatory updates and changes.
- Served as main point of contact for Kentucky Department of Insurance prompt payment complaints. Developed internal process for receiving, responding and tracking complaints to ensure compliance with statutes.
- Responsible for the internal development and submission of over 700 reports to their respective regulatory agencies (Department for Medicaid Services, Department of Insurance, Department for Behavioral Health, etc.).
- Assist other departments in understanding and complying with regulatory requirements.
- Tracked all issues referred to the Regulatory Affairs Department up to and including resolution.

KENTUCKY DEPARTMENT OF INSURANCE

Health Policy Specialist II (2009 – 2012)

- Served as a regulatory analyst responsible for the review and approval of commercial health insurance policy filings for compliance with state and federal insurance laws and regulations.
- Performed in-depth research and data analysis on complex health policy issues and made recommendations regarding health insurance benefits and their impact on Kentucky consumers.
- Served on the Department's federal healthcare reform implementation task force to assist with federal grant applications and the promulgation of new state regulations and/or statutes.

- Reviewed proposed legislation for programmatic and budgetary impact during the meeting of the Kentucky General Assembly.
- Lead process improvement initiatives aimed at improving Division efficiencies and internal policies and procedures.
- Developed presentations and training materials for use at health insurance compliance conferences, meetings and trainings.

KENTUCKY DEPARTMENT OF PUBLIC HEALTH
Program Coordinator (2007 – 2009)

- Served as one of three project managers for the statewide pandemic influenza planning grant administered through the Centers for Disease Control and Prevention (CDC).
- Responsible for the development and implementation of the Department's Continuity of Operations Plan (COOP) to ensure essential healthcare services provided by the Department are continued during emergency events such as pandemic influenza.
- Developed and presented training modules and planning guidance for local health departments across the state to develop their own pandemic influenza plans and ensure integration with the state plan
- Coordinated with federal, state and local health officials, volunteers, and advocacy groups to implement new federal and state emergency health planning initiatives.
- Prepared performance reports and monitored internal budgets and timelines for activities associated with the federal grant.
- Served as a member of the Pandemic Influenza Coordinating Committee and various subcommittees designated to oversee pandemic influenza preparedness planning and ensure integration with other federal and state emergency planning efforts Subgroups included: legal preparedness, healthcare facility planning, and community planning in rural areas, infection control, and mass fatality planning.
- Attended public meetings and conferences to meet with federal, state and local officials to deliver presentations on best practices and lessons learned from various disaster events.
- Reviewed state and federal emergency preparedness legislation and provided policy statements for planning impact.

NATIONAL ASSOCIATION OF STATE PROCUREMENT OFFICIALS (C/O AMR MANAGEMENT SERVICES
Issue Coordinator (2006 – 2007)

- Performed in-depth research and developed public presentations, white papers, issue briefs and legislative testimony on behalf of large national association of state procurement officials.
- Managed and assisted Executive Board and committees in developing and implementing strategic plans, budgets and project timelines.
- Reviewed proposed state and federal legislation and/or regulations for potential policy impact and reported findings to the Executive Board.
- Lead process improvement teams for standardized policies and procedures, resulting in uniform protocols to be implemented in procurement divisions across the country.
- Developed monthly association newsletter profiling national news and member updates for the association.

- Served as lead corporate fundraiser, exceeding sponsorship goals each year, including 120% of goal for 2007.

CABINET FOR HEALTH AND FAMILY SERVICES, OFFICE OF POLICY AND BUDGET

Policy Analyst (2000 – 2005)

- Performed detailed healthcare research and data analysis; prepared reports to assist in healthcare policy development and presentation to legislative entities.
- Served as a legislative liaison for the Cabinet and various healthcare associations, legislative committees, executive boards and lobbyists.
- Served as regulation coordinator; responsible for drafting, promulgation and implementation of Cabinet regulations.
- Served as project manager for Cabinet-wide strategic planning initiative; provided monthly progress reports to executive leadership.
- Coordinated and oversaw the work of two fellow analysts engaged in budget preparation, analysis and/or the evaluation of management policies, procedures, legislation and research.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Arts, Psychology – University of Kentucky, Lexington, KY
- Master of Public Administration – Kentucky State University, Frankfort, KY
- Senior Leader Program, Harvard Business Program
- Compliance Certification, WellCare University
- Essentials of Managed Care, WellCare University

HOWARD J. SHAPS, MD, MBA – MEDICAL DIRECTOR

Dr. Howard Shaps is an experienced executive leader focused on the promotion of improved outcomes, cost-effective care with a clear communication style to drive optimal results. Dr. Shaps has leadership expertise in managing multiple associates concurrently in clinical and administrative arenas. Additionally, he has strong communication skills that have enabled collaboration between providers and payers, to achieve positive outcomes, commonly serving as the sole catalyst between the parties. This has been coupled with deep knowledge and understanding of population health working with large patient populations and provider groups.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE HEALTH PLANS, INC.

Kentucky Market Medical Director and Deputy Chief Medical Officer (2019 – Present)

- Oversees the clinical and quality strategy in the Kentucky market.
- Provides direct oversight to the Credentialing Committee, Utilization Management Advisory Committee and Quality Improvement Committee.
- Leads the medical management and medical policy team of 50 associates.
- Clinical subject matter expert for the national contracting, government/regulatory affairs, payment integrity, and provider operations teams.
- Chairs the Reimbursement Governance Committee.
- Clinical expert for market-based initiatives.

WELLCARE HEALTH PLANS, INC.

Chief Medical Director, Population Health Solutions (2018 – 2019)

- Led the strategy and development of a specialty provider performance tool to help improve member outcomes.
- Built a library of reimbursement policies.
- Created and chaired the Reimbursement Governance Committee overseeing payment strategy.
- Built programs to ensure WellCare was responsibly reimbursing providers for member services.
- Helped transition market led organizations to a unified, centrally-based, population health team.

WELLCARE HEALTH PLANS, INC.

Sr. Medical Director, Value Based Care (2018)

- Created the Claims and Reimbursement Policy Committee to initiate the creation of a policy library.
- Developed the strategy to foster a high performing specialist and ancillary provider network
- Serves as lead medical director providing guidance to the Operations, Legal, Regulatory, Compliance, and Medical Economics teams.
- Lead medical director assisting with the clinical development of value based provider contracts.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Market Medical Director (2017 – 2018)

- Responsible for the clinical oversight and outcomes of a 455,000 Medicaid and 10,000 Medicare member population - generating revenues over $2.6 Billion.
- Initiated a large-scale Pharmacy Management program resulting in a decrease utilization of opioids by over 55% and benzodiazepines by over 30% while improving medical expense trend for those members.
- Demonstrated year-over-year improvement in NCQA Medicaid HEDIS scores and increased WellCare of Kentucky's Medicaid raw accreditation score by over 7% compared to the previous reporting year.
- Successfully decreased Emergency Department utilization by over 5%.
- Continued to lead the Care Management and Quality departments.
- Drove year-over-year improved productivity metrics of a 100 member care management team.
- Achieved an Associate Opinion Survey score of 90.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Market Medical Director (2014 – 2017)

- From 2014 to 2017 provided clinical direction to WellCare's Medicaid and Medicare Lines of Business totaling up to 440,000 Medicaid lives and 8,000 Medicare lives.
- Led a team of over 120 WellCare associates in the Care Management and Quality Departments while managing a $10 million budget.
- Transformed WellCare of Kentucky's Care Management Program by improving methods to identify members to manage, worked with associates to improve productivity, and created reporting platforms to assist upper level management. As a result, the Care Management program decreased medical expense by over $19 million in 2016 and over $25 million in 2017.
- Led WellCare of Kentucky's Managed Medicaid program to a Commendable Accreditation rating by NCQA in 2016.
- Directed persistent year-over-year improvement of HEDIS and CAHPS scores since 2014.
- Led WellCare of Kentucky's Performance Improvement Projects including improving the utilization of Attention Deficit Disorder medications in children, ensuring proper follow-up with a behavioral health provider after a psychiatric admission, Emergency Department utilization, and proper care of the post-partum patient.
- Enterprise thought leader driving appropriate use of the Emergency Department.
- Instrumental in the creation of Clinical Coverage Guidelines including Prescribed Pediatric Extended Care, Air Ambulance Transport and Allergy Testing & Treatment.
- Chairman of WellCare of Kentucky's Credentialing Committee, Utilization Management-Medical Advisory Committee and the Quality Improvement Committee.
- Active participant in the Medical Policy and the Pharmacy & Therapeutic Committees.

HEALTH CARE EXCEL – LOUISVILLE, KY

Medical Director, Health Care Excel (2012 – 2014)

- Provided overall medical leadership to the Health Care Excel team.
- Physician director for Health Care Excel's role as a Quality Improvement Organization.

- Physician leader for Health Care Excel's utilization management division.
- Actively lead a team of physicians with oversight of utilization review and quality of care decisions.
- Experience utilizing Milliman Care Guidelines, InterQual Criteria, National Coverage Determinations and Local Coverage Determinations.
- Imparted recommendations regarding reviews for medical necessity relating to ambulatory procedures, inpatient admissions, and specific DRGs.
- Created and implemented procedures for utilization management, quality management and credentialing.
- Participated in corporate strategic analysis, operational oversight, and policy deliberations.
- Extensive knowledge of Value Based Purchasing, Hospital Acquired Conditions, Inpatient Quality Reporting and Outpatient Quality Reporting.
- Assisted with decreasing the number of adverse drug events utilizing both national and local communication platforms.
- Collaborated with team members to assist health care facilities decrease hospital acquired infections.
- Assisted in educating Critical Access Hospitals regarding compliance with present and future CMS measures.
- Active member of the Kentuckiana Health Collaborative and Greater Louisville Medical Society Care Transitions Committee.

EXPRESS SCRIPTS, INC. – LOUISVILLE, KY

Medical Director (2012 – 2014)

- Active team member with Care Continuum, an Express Scripts company.
- Provided utilization management and prior authorization reviews for specialty medications.
- Issued prior authorization determinations for home health services.
- Ensured health plan members safe and appropriate use of complex medicines.

JEWISH HOSPITAL – LOUISVILLE, KY

Medical Director, Department of Emergency Medicine (2010 – 2011)

- Selected by fellow partners to this two-year term position.
- Held direct performance management responsibilities of the 18-member physician staff of the Jewish Hospital Emergency Department.
- Served as physician liaison with other hospital departments regarding critical hospital affairs.
- Developed processes to improve Emergency Department efficiency and effectiveness metrics such as patient length of stay, patients departing without being seen, and door-to-doctor time.
- Improved collaboration between the physician group and the hospital's executive leadership team.
- Improved compliance with CMS core measures by the emergency physician staff - compliance with these measures significantly increased with intensive physician education.
- Assisted Jewish Hospital's Credential Committee in reviewing system-wide Emergency Physician applications specific to the medical staff.
- Served as an active member of Jewish Hospital's Medical Operating Committee.

CVS MINUTE CLINIC – LOUISVILLE, KY
Medical Director, CVS Minute Clinic (2010 – 2011)

- Direct supervision of staff nurse practitioners.
- Handled extensive chart reviews to ensure compliance with Minute Clinic clinical guidelines.
- Evaluated utilization management reviews for the nurse practitioner staff, which allowed for guidance when deviations occurred.
- Provided educational tools for the staff and held educational meetings to enhance the staff's clinical performance.
- Secured a sound working relationship with the executive physician leadership team of the Minute Clinic.

EMERGENCY MEDICINE EMPLOYMENT

JEWISH HOSPITAL HEALTH SYSTEM – LOUISVILLE, KY
Medical Staff Emergency Physician (2002 – Present)

NORTON SUBURBAN HOSPITAL – LOUISVILLE, KY
Per Diem Emergency Physician (2004 – 2005)

MEMORIAL HOSPITAL – SEYMOUR, IN
Per Diem Emergency Physician (2002 – 2003)

ACADEMIC APPOINTMENTS

UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE
Assistant Clinical Professor of Emergency Medicine (2007 – Present)

UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE
Emergency Medicine Resident Coordinator for Jewish Hospital

UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE
Medical Student Case Reviewer

RESIDENCY AND FELLOWSHIP APPOINTMENTS

NORTH SHORE UNIVERSITY HOSPITAL – MANHASSET, NEW YORK
Emergency Medicine Residency, 2002

LOYOLA UNIVERSITY MEDICAL CENTER – MAYWOOD, ILLINOIS
General Surgery Internship, 1999

COMMITTEES

National Quality Forum (2017)

- Technical Expert Panel member for Medicaid Beneficiaries with Complex Care Needs and High Costs.

National Health Care Anti-fraud and Abuse Medical Directors Clinical Advisory Panel (2013 – present)

- Participates in group discussions concerning fraud, waste, and abuse in the US healthcare system.
- Offers recommendations as appropriate during panel discussions.

Jewish Hospital Medical Executive Committee (2012 – 2014)

- Collaborate with physician leaders and hospital staff regarding system-wide challenges.

- Bridge building between the executive committee and fellow physician staff.
- Participated in development of medical staff rules for physician staff reappointment.

Jewish Hospital Medical Operating Committee (2010 – 2011)

- Provided updates to the committee regarding Emergency Department evolution, including dynamic policies and procedures.
- Provided insight to the committee regarding physician behavior, trends and needs
- Assisted with committee projects relating to physician communication.
- Worked jointly with quality committees and the Professional Review Committee to monitor and improve patient care.

Jewish Hospital Emergency Department Service Line, Chair (2010 – 2011)

- Lead monthly meetings between the physician group and ancillary staff leadership to ensure quality care for our patients.
- Worked with ancillary department managers to improve Emergency Department operations as related to patient flow.
- Collaborated with hospital care managers on developing protocols that allowed staff physicians to correctly determine the level of care for admitted patients.
- Conveyed service line reports to the Medical Operating Committee.

Jewish Hospital Professional Review Committee (2008 – 2009)

- Worked with committee members evaluating and solving physician discipline issues.
- Responsible for approving hospital-wide order protocols.
- Formulated disciplinary action for those physicians not meeting requirements for completion of discharge summaries and operative reports.
- Reviewed departmental quality assurance and improvement initiatives.

PROFESSIONAL MEMBERSHIPS

- National Quality Forum
- Kentucky Medical Association
- Greater Louisville Medical Society
- American Board of Emergency Medicine

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Business Administration with Distinction – University of Louisville College of Business – Louisville, KY
- Doctor of Medicine – Boston University School of Medicine – Boston, Massachusetts
- Bachelor of Arts, Psychology – University of Michigan – Ann Arbor, Michigan
- Diplomat, American Board of Emergency Medicine
- Kentucky Medical License 37467
- Indiana Medical License 01056750A
- Provider, Advanced Cardiac Life Support
- Provider, Pediatric Advanced Life Support

THEA ROGERS, PHARM.D. – PHARMACY DIRECTOR

Thea Rogers is a highly motivated proven leader with experience in developing innovative solutions and executing corporate strategy. Expertise in managing health plan pharmacy operations, developing clinical programs, procuring and implementing pharmacy benefit manager services, and collaborating with multi-disciplinary teams and providers to achieve operational and clinical excellence. Demonstrated ability to inspire and manage a diverse team to deliver peak performance. Passion for improving quality of care and health outcomes.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Director, State Pharmacy (2017 – Present)

- Oversees pharmacy utilization and produces informative reports to the Kentucky MMC Program plan market.
- Works directly with the respective Medical Director of the Kentucky MMC Program plan with the Medical Economics department to ensure cost effective management of both medical and pharmacy utilization as part of the Network Improvement Program (NIP).
- Assists in educating clinical pharmacist managers for the Kentucky MMC Program plan providing information on clinical and trend issues. Provides drug utilization review.
- Implements and maintains the NIP program specific to pharmacy utilization.
- Reviews prescribing practices on high utilizing physicians and intervenes as needed providing drug information on pharmacy expenses.
- Collaborates with pharmacy clinical programs department to support and represent.

PASSPORT HEALTH PLAN – LOUISVILLE, KY

Director, Pharmacy Services (April 2010 – April 2017)

- Successfully implemented Part D benefit and PBM for new Medicare Advantage line of business.
- Managed procurement and implementation of PBM for Managed Medicaid line of business while maintaining high operational performance.
- Provided strategy for creation of pharmacy clinical programs to address patient safety, over-/under-utilization, and applicable Star Rating measures in-house and/or in conjunction with PBM
- Created Community Pharmacist led Medication Therapy Management Program achieving a 9:1 ROI...
- Expanded Medicaid Recipient Restriction Program achieving substantial annual savings.
- Expanded Pharmacist led academic detailing provider outreach program resulting in 1 % increase in generic dispense rate (over $1 million in savings) and an increase in provider satisfaction with formulary management.
- Created late refill reminder program resulting in a 3.8% improvement in medication possession ratio.
- Developed PGY-1 Managed Care Pharmacy Practice Residency.
- Lead a motivated high performing pharmacy team achieving highly satisfied scores on employee engagement surveys.

PASSPORT HEALTH PLAN – LOUISVILLE, KY

Clinical Pharmacist (Aug. 2007 – April 2010)

- Provided clinical pharmacy services, formulary education, and served as the clinical pharmacy liaison to the PBM. Coordinated drug utilization reviews and communicated findings and recommendations to health plan committees and providers. Participated with Quality Management Team in the identification and analysis of pharmacy information in order to develop interventions to improve HEDIS, Star measure performance and quality of care.
- Developed clinical guidelines for the use of psychotropic medications in children and adolescent members.
- Developed and disseminated pocket guides for health plan prescribers on high risk medications to avoid in the elderly.
- Collaborated with PBM to develop strategies to optimize clinical and quality outcomes.
- Created pharmacy communications for Plan's Provider and Member Newsletters.
- Responded to written and verbal inquiries from providers, internal staff, and members regarding the drug formulary and prescription benefit.

CENTRAL STATE HOSPITAL – LOUISVILLE, KY

Clinical Pharmacy Manager (Sept. 2001 – Aug. 2007)

- Responsible for the provision of clinical pharmacy support, patient education, and drug utilization reviews.
- Initiated patient education groups on patient care units.
- Developed process for communicating pharmacy intervention alerts to prescribers.
- Created APPE rotation site for pharmacy students.
- Initiated pharmacy participation in multidisciplinary team meetings.
- Led Pharmacy and Therapeutics committee meetings.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Science in Pharmacy – University of Kentucky
- Doctor of Pharmacy, Magna Cum Laude – University of Kentucky
- Psychopharmacy Fellow – University of Kentucky
- Board of Pharmaceutical Specialties Certification Psychiatric Pharmacy

JERRY CAUDILL, DMD, FAGD, MAGD, CDC, CTCP, FPFA, FICD, FACD – DENTAL DIRECTOR

Dr. Jerry Caudill is an experienced Medicaid, Medicare, and commercial dental insurance executive with a demonstrated history of working in the health and wellness industry. Nationally recognized speaker on Medicaid dental administration currently administering over 1.1 million lives in Kentucky market. Skilled in Fraud, Waste, and Abuse investigation and AADC Certified (CDC). Strong healthcare services professional with a DMD from the University of Kentucky, College of Dentistry plus FAGD, MAGD, FPFA, FICD, FACD, and CTCP.

RELEVANT EXPERIENCE AND QUALIFICATIONS

AVĒSIS INCORPORATED, A GUARDIAN COMPANY
Dental Director (2019 – Present)

KENTUCKY BOARD OF DENTISTRY
Teledentistry Committee Member (2017 – Present)

AMERICAN ASSOCIATION OF DENTAL CONSULTANTS
Certified Dental Consultant (May 2016)

- Passed certification exam of AADC. Certified consultants possess the clinical background to render consistent opinions on government and commercial emerging dental trends, utilization review, dental plan coverage, network management, claims policy, standards of care, and fraud, waste, and abuse investigation.

KENTUCKY DENTAL ASSOCIATION
Special Adviser (2016 – 2017)

- Member of the Presidential Advisory Committee to KDA president Dr. Bill Collins.

KENTUCKY DEPARTMENT OF MEDICAID SERVICES
Medicaid Lock-In Committee (2016 – Present)

- Member of the Kentucky Medicaid Lock-in Committee.

AVĒSIS INCORPORATED, A GUARDIAN COMPANY
Dental Director (2013 – Present)

- Kentucky State Dental Director. Administer Medicaid dental benefits for over 1.1 million Kentucky Medicaid members.

AVĒSIS INCORPORATED
Dental Claims Consultant (Aug. 2012 – May 2013)

THE PREMIER DENTAL GROUP (MINNESOTA)
Dental Claims Consultant (2009 – 2018)

ACADEMY OF GENERAL DENTISTRY, CORPORATE DENTISTRY TASK FORCE
Special Adviser (2012 – 2013)

- Served as special adviser on corporate dentistry to the AGD Task Force and contributor to AGD whitepaper Investigative Report On The Corporate Practice Of Dentistry.

COUNCIL OF INTERSTATE TESTING AGENCIES (CITA) DENTAL BOARD
Dental Board Examiner (2009 – Present)

- Examiner for CITA administering the ADEX exam recognized in 47 states and territories including Kentucky.

PRIVATE PRACTICE – NORTH CAROLINA
General Dentist (2002 – 2013)
- Private Practice – General Dentistry including comprehensive orthodontics.

CASTLE DENTAL CENTERS
Dental Director (1998 – 2002)
- Regional Clinical Director, promoted to Regional Dental Director, then promoted to National Dental Director.
- General dentistry including comprehensive orthodontics.

PRIVATE PRACTICE – DUBAI, UNITED ARAB EMIRATES
Dental Director / General Dentistry (1990 – 1997)
- Credentialed with privileges at American Hospital of Dubai -1997.

PRIVATE PRACTICE
General Dentist (1982 – 1989)
- General Dentistry including comprehensive orthodontics, oral surgery, and special needs.
- Previously licensed in both general anesthesia and IV conscious sedation by the Kentucky Board of Dentistry and previously had privileges at three Kentucky hospitals including University of Kentucky Chandler Medical Center in Lexington, and St. Claire Medical Center in Morehead.

SEMINARS – WORKSHOPS – CONFERENCES
- Taught hands-on course in ProFile® rotary endodontics with Thermafil® and conventional lateral condensation obturation to Castle Doctors.
- Taught and mentored Castle doctors in complex removable prosthodontics, full mouth reconstruction, and implant placement & restoration at Castle Dental in multiple states.
- Previously taught expanded duties dental assisting for the University of Kentucky, College of Dentistry.
- A featured speaker at the International Symposium on Maple Syrup Urine Disease – Dental Implications.
- Presenter at 2014 Oral Health Symposium for Medicaid Medicare CHIP Services Dental Association (MSDA) Washington, DC.
- Presenter at 2015 Western Kentucky Oral Health Summit.
- Presenter at 2016 and 2017 Kentucky Dental Association Annual Meeting. Navigating Medicaid.
- Presenter at 2018 University of Kentucky's 24th Annual "Preparing Health Professionals for the 21st Century" and in cooperation with the Kentucky Oral Health Network (KOHN), gave a presentation on Silver Diamine Fluoride – The Old and the New.
- Presenter at 2019 University of Kentucky's 25th Annual "Preparing Health Professionals for the 21st Century" and in cooperation with the Kentucky Oral Health Network (KOHN), gave presentation workshop "Pain Management in Crisis, Opioids & the Role of Dental Benefits Management".

HONORS
- August 26, 2017 Inducted as a Fellow of the Pierre Fauchard Academy (FPFA). The Academy consists of dentists who are among the most outstanding leaders in various fields of

dentistry. This honorary dental service organization was founded in 1936 and is named after a French physician, Pierre Fauchard of France (1678-1761), who is recognized as the "Father of Modern Dentistry" and elevated dentistry to a profession.

- October 19, 2017 Inducted as a Fellow of the International College of Dentists (FICD). Fellowship in the College is extended by invitation only. A nominated dentist must pass a rigorous, peer review process leading to the recognition of the individual's "outstanding professional achievement, meritorious service and dedication to the continued progress of dentistry for the benefit of humankind."
- October 18, 2018 Inducted as a Fellow of the American College of Dentists (FACD). Founded in 1920, the American College of Dentists (ACD) is the oldest major honorary organization for dentists. Its members have exemplified excellence through outstanding leadership and exceptional contributions to dentistry and society. Fellows of the American College of Dentists light the path forward for all those in the oral health profession. Chosen for leadership, model ethics, and service to the profession and to society, members are thoughtfully selected through a thorough vetting process. The American College of Dentists is nonprofit and apolitical and has long been regarded as the "conscience of dentistry."

COMMUNITY SERVICE

- Participated in North Carolina "Missions of Mercy" (MOM's) clinic. The North Carolina Missions of Mercy (NCMOM) portable free dental program is an outreach program of the North Carolina Dental Society. http://www.ncdental.org/membercenter/getinvolved/community-outreach/nc-missions-of-mercy.
- Provided volunteer care at the CARE Clinic in Fayetteville, NC. The CARE Clinic provides free quality health care to eligible uninsured, low income adults who live in Cumberland County and surrounding area. http://www.thecareclinic.org/.
- Organized and procured North Carolina Baptist Dental Bus to provide care to the indigent in Fayetteville, NC. I was a deacon at First Baptist Church of Fayetteville, NC and arranged for and led our church sponsoring this event. http://baptistsonmission.org/Missions/By-Type/Medical-and-Dental/Medical-Dental-Bus.
- Former Assistant Scout Master and Chairman of the Troop Committee for Troop 813, Boy Scouts of America, Direct Service around the world in Dubai, UAE https://www.troopwebhost.org/Troop813Houston/Index.htm.
- Former deputy sheriff and co-leader of the Rowan County Kentucky Search and Rescue Squad.
- Former Director of Civil Defense for Rowan County and Morehead Kentucky.

PROFESSIONAL MEMBERSHIPS

- President – NC Academy of General Dentistry 2012-2013.
- Served as NC AGD board member, Sec/Tres, Vice President, and President Elect 2008-2012.
- Past member - Board of directors - Kentucky Academy of General Dentistry.
- Current member: American Association of Dental Consultants, American Dental Association, Kentucky Dental Association, Academy of General Dentistry, Kentucky Academy of General Dentistry, International Association for Orthodontics, Louisville Dental Society, Pierre

Fauchard Academy, International College of Dentists, American College of Dentists, Council of Interstate Testing Agencies, American Dental Education Association.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Certified Telemedicine Clinical Presenter & Technology Professional (CTCP) – New College Institute, Southside Telehealth Training Academy and Resource Center (STAR)
- American Assoc. of Dental Consultants Certified Dental Consultant 2016
- American Dental Education Assoc. Academy for Academic Leadership Institute for Teaching & Learning Certificate of Completion
- Academy of General Dentistry Master 2003 (MAGD) – Must have earned Fellow status and completed 1,100 hours in approved continuing education including 400 participation hours. Currently have completed well over 2000 hours of continuing education.
- Academy of General Dentistry Fellow 1995 (FAGD) – Completed 500 hours of approved continuing education and passed the 7 hour written Fellowship Exam.
- KY Board of Dentistry 1991 Licensed to provide General Anesthesia and Conscious Sedation as a general dentist.
- United States Dental Institute 1982 to 1987 Completed a 5-year course of continuing education in comprehensive fixed and removable orthodontics and TMJ
- University of Kentucky Dates: 1978 to 1982 – College of Dentistry Major: Dentistry – Lexington, Kentucky Earned: Doctor of Dental Medicine
- Morehead State University Dates: 1977 to 1978 – Morehead, KY Major: pre-dental (Note: having achieved two semesters of 4.0 GPA in pre-dental I was accepted into UK College of Dentistry without completing a Bachelor degree which lacked about six hours)
- Morehead State University – Morehead, KY Dates 1968 to 1971 – Major: Electronics, Earned: Associate of Applied Science

MARKETA WILLS, MD, MBA – BEHAVIORAL HEALTH DIRECTOR

Dr. Wills is a physician executive with over 5 years of managed care experience all of which have been spent focusing on Medicaid and public programs. Dr. Wills joined WellCare as Corporate Medical Director, Behavioral Health in 2015 and has been given increasing responsibility and expanded scope during her time. She has demonstrated success by focusing squarely on the clinical needs of the Member and has a deep understanding of the delicate psychosocial needs of Medicaid populations. A Board-certified psychiatrist, she has been continuously licensed to practice medicine for nearly twenty years.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE HEALTH PLANS, INC.

Corporate Medical Director, Behavioral Health (2015 – Present)

- Conduct utilization reviews and appeals with Providers on behalf of Medicare and Medicaid Members, focusing on Member-centered, evidenced-based, quality care with positive clinical outcomes. Promote integrated medical-behavioral strategies to ensure holistic approach to improving health outcomes.
- Provides overall clinical leadership in behavioral health for the enterprise. This person is responsible for overseeing all clinical aspects of behavioral health.
- Supports the integration of behavioral health into other aspects of clinical services (pharmacy and medical) through effective collaboration with key internal business partners
- Works closely with the clinical leadership team to assure clinical compliance with all company, customer and regulatory requirements for behavioral services.
- Helps establish policy and procedures for behavioral health, including its integration with medical care and pharmacy. This person will be the thought leader for behavioral health, and will provide teaching, training, coaching, and supervision of internal staff.

UNITEDHEALTHCARE – HOUSTON, TX

Associate Medical Director, OptumHealth (2012 – 2015)

- Dedicated medical director to key commercial account with 450K lives. Led team in development of clinical policies and workflows for both utilization management and care coordination functions. Interfaced with customer and account management on key clinical updates and to resolve any escalated issues (claims, billing, coding, emerging technologies, etc.). Liaised with physical health colleagues to ensure seamless medical-behavioral integration of care experience.
- Conducted utilization reviews with Providers for Medicare, Medicaid and commercial Members in facility based setting, focusing on quality and collaborative relationships. Performed quality of care reviews to address any clinical variances or sentinel events that arose. Partnered with facilities to ensure quality health outcomes for our Members.

UNIVERSITY OF TEXAS HEALTH SCIENCES CENTER AT HOUSTON – HOUSTON, TX

Medical Director, Women's Behavioral Program at St. Joseph Medical Center (2011 – 2012)

- Developed strategic plan for development of boutique psychiatric program in academic setting. Accountable for pro-forma development, budget creation and financial management of inpatient service.
- Drove business development by establishing trust-based relationships with community, practitioner, payor, facility, corporate and other potential referral sources. Created and

executed against multi-faceted marketing plan in conjunction with media relationships and PR specialists.
- Designed superior clinical program focusing on delivering evidenced-based medicine with measurable success outcomes. Led multi-disciplinary clinical teams for the quality, efficient, service-driven care of women in crisis.
- Refined operational processes, policies and procedures from intake through discharge planning with a focus on efficiency and service.

MEMORIAL HERMAN HOSPITAL--TEXAS MEDICAL CENTER CAMPUS – HOUSTON, TX
Director of Physician Affairs (2009 – 2010)
- Identified areas of inefficiency in operations of Medical Staff Services department and streamlined processes. Reduced the average turnaround time of physician credentialing process from 65 to 49 days. Overhauled the team configuration resulting in greater processing efficiency and enhanced employee engagement. Implemented performance management system via goal setting, weekly team huddle and visual performance management aids. Coached front-line employees on use of Microsoft programs and written communication. Developed budgets for specified cost centers and met and/or exceeded departmental financial expectations.
- Provided strategic and operational leadership to hospitalist service line issues. Ensured adherence to contractual obligations for hospitalist physicians.
- Established positive relationships with physician leaders throughout the system. Analyzed survey results for annual physician satisfaction survey. Developed campus wide action plan in conjunction with senior executive team at the facility.
- Designed new on-boarding process for house staff. Developed clinical cases covering key quality and safety topics for house staff orientation. Supervised development of new interactive, experiential medical staff orientation. Integrated house staff and medical staff with nursing leadership upon their arrival to campus.

MCKINSEY & COMPANY
Internal Communications Secondment (2008 – 2009)
- Led the planning and execution of selected internal professional development activities for all McKinsey Partners and Directors. Managed team to execute the operational details to support the logistics, social and production elements of Firm-wide Partner conferences.
- Performed operational analyses and implemented/executed accordingly. Selected and managed external vendors and suppliers (e.g., production companies, destination management companies, hotels) who provided services and materials. Set and maintained budgets for each conference. Succeeded in designing and rolling out an initiative to decrease fixed cost structures by $100,000 USD.

MCKINSEY & COMPANY
Associate Consultant (2006 – 2008)
- Served the Ministry of Health in the Province of Ontario for the operational transformation of Emergency and General Inpatient Medicine Departments at Toronto General Hospital, Canada's largest and most prestigious academic medical center. Taught "Toyota lean" techniques to clinical staff and applied to strategies to identify bottlenecks, thereby streamlining admissions and discharges so that patients could receive the appropriate level of

care at the right times. Reduced average 22-hour wait time for GIM admissions down to 8 hours.

- Performed sales channel analysis for a leading corn seed manufacturer with the goal of increasing market share by 10% over the next 3 years. Conducted in-depth agency assessments with field sales-force and assisted Account Managers and Area Sales Managers in developing Territory Plans. Oversaw preparation, problem-solving and analysis of financial data for over 100 territories. Managed Access database for collection and analysis of Territory Planning data.
- Served the Chief Medical Officer of a small hospital network by defining care model focused on superior patient experience. Designed conjoint analysis-driven marketing study to uncover and unleash elements of delivery model most important to patients and their families. Coached CMO on presentation of analysis to senior team. Work is ongoing at the hospital system.

DAY-MONT BEHAVIORAL HEALTHCARE, INC.
Independent contractor: Outpatient Clinic Coverage (2011 – 2011)

- Delivered care to under-served psychiatric patients in an outpatient community setting. Performed initial psychiatric evaluations and provided ongoing psychopharmacologic treatment. Led patient care team composed of nurses, therapists, case managers and other ancillary staff.

ST. VINCENT CHARITY HOSPITAL
Independent contractor: Psychiatric Emergency Room Coverage (2006 – 2009)

- Staffed free-standing Psychiatric Emergency Room of a non-profit community teaching hospital in the inner-city Cleveland Metropolitan area. Delivered patient-centered care including: risk assessment; triage/milieu management; acute management of psychiatric emergencies; community disposition planning; assessment for inpatient hospitalization; substance abuse treatment referrals. Taught students and residents.

NORTH PHILADELPHIA HEALTH SYSTEM
Independent Contractor: Inpatient Coverage (2004 – 2006)

- Served as weekend and evening in-house psychiatrist-on-call for a non-profit, multi-unit hospital system in inner-city Philadelphia. Cross-covered for 2 acute adult inpatient units; 1 gero-psych unit; 1 sub-acute unit; 2 substance abuse step-down units; and emergent consult-liaison services for affiliated general medical hospital. Responded to all psychiatric emergencies.

MASSACHUSETTS GENERAL HOSPITAL/MCLEAN HOSPITAL
Chief Resident, Clinical Fellow in Psychiatry, Harvard Medical School (2003 – 2004)
Resident, Clinical Fellow in Psychiatry, Harvard Medical School (2001 – 2003)

- Awarded the American Medical Association Foundation Leadership Award in recognition of value-added to the field of psychiatry.
- Led interdisciplinary teams in providing high-quality acute psychiatric care in both emergency and inpatient hospital settings. Facilitated daily team rounds to coordinate patient care. Taught junior residents and medical students necessary clinical skills to deliver care.

- Founded the MGH Organization of Minority Residents and Fellows (OMRF). Facilitated the advancement, retention and academic development of physician-trainees by leading workshops and creating networking/mentoring opportunities. Presented with Partners in Excellence Award by CEO for contribution to academic and professional development of physicians of color.
- Elected by peers as SAMHSA Fellows Representative to the Board of Trustees for the American Psychiatric Association (APA). Crafted recommendations and presented to Board of Trustees. Assisted in rolling out several of the recommendations that were approved by the Board.

NEWTON-WELLESLEY HOSPITAL

Transitional Year Intern (2000 – 2001)

- Received the Intern of the Year Award recipient for superior clinical performance in the field of Emergency Medicine.
- Mastered patho-physiologic basis of disease by rotating through medical, surgical, emergency room and intensive care units. Executed and oversaw minute-to-minute care plans for critically ill patients in a fast-paced environment. Provided teaching, education and support to patients and their families.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS:

- MBA, Health Care Management & Finance – The Wharton School, Philadelphia, PA
  - Received the Joseph Wharton Award for academic achievement and professional accomplishments.
- M.D. – University of Pennsylvania School of Medicine, Philadelphia, PA
- AB, Sociology – Brown University, Providence, RI
- Licensed to practice medicine in Ohio, Texas, Georgia, Missouri, New Jersey, Florida, South Carolina, Kentucky
- Board Certified Diplomat in Psychiatry by the American Board of Psychiatry and Neurology
- Board Member of National Alliance on Mental Illness for Hillsborough County
- Received 2016 NAMI Hillsborough President's Award

BONNEL GUSTAFSON IRVIN, MPA – PROVIDER NETWORK DIRECTOR

Bonnie Irvin is a senior healthcare executive whose 20 years of leadership in both provider and payor organizations drives ability to deftly balance competing forces as organizations navigate the era of reform. Offers deep understanding of the complexities of the inner workings of the health insurance industry. Consistently tapped to direct mission-critical initiatives, with a record of executing new programs on time and within budget. Financially fluent consensus builder who leads through influence and motivates cross-functional teams.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Vice President, Field Network Management (June 2017 – Present)

- Newly created market position to focus on building successful relationships with providers by directing the functions of Network Development, Provider Relations and Provider Operations – 47 team members. Manage over 120 hospital contracts and over 25,000 professional and ancillary contracts.
- Created a provider satisfaction program that resulted in the 2nd highest Net Promoter Score across the WellCare enterprise.
- Worked with corporate shared services to create a primary care physician value-based contract that aligns quality and cost by resetting both on an annual basis.
- Led re-contracting efforts with two large healthcare system which resulted in minor rate increases.
- Created value-based agreements and associated methodology for acute care and behavioral health hospitals.

ALLEGHENY HEALTH NETWORK – PITTSBURGH, PA

Vice President, Patient Experience (2014 – Jan. 2017)

- Tapped for newly created position to set and execute strategies to elevate patient experience in era of healthcare reform with its emphasis on value-based purchasing through CMS. Lead design and implementation of AHN's Patient Experience Program and coordinated Press Ganey and HCAHPS scores for the network.
- Designed and implemented Patient Experience Program in collaboration with representatives from the Ritz Carlton, an organization known for its world-class customer service. Coordinated staff and physician training on key elements of patient experience—such as appropriate communication skills and service recovery techniques—to ensure consistency across departments and service lines.
- Led 25 employees from seven hospitals to collaborate on the design of a patient-centered culture. Created system credo, motto, steps of service and values that became part of the playbook now used system-wide for employee training and new hire orientation.
- Created, launched and managed RAVE (Recognize and Acknowledge Valued Employees) program to honor top performers at all AHN entities on a monthly basis and present 12 Service Ambassador awards annually and one "Service Excellence" award to employees across network.
- Implemented Advisory Board iRound product at seven inpatient facilities within five months. Defined questions to be used, coordinated roll out schedule and assisted with training.

- Piloted forum to share ideas and develop patient experience initiatives across network, including bedside shift reporting, purposeful hourly rounding and communication boards. Leveraged influence with facility CNOs and Patient Experience staff to implement new approach that helped to drive a 10% percentile rank increase for HCAPHS domain communication with nurses and a 30% percentile rank increase for HCAHPS domain responsiveness of hospital staff–all achieved with a nurse staffing ratio in the 10th percentile.

ALLEGHENY HEALTH NETWORK – PITTSBURGH, PA
Vice President, Medical Mall Operations (2011 – 2014)

- Recruited by former UPMC senior executive to develop a new component of AHN's integrated delivery system—an outpatient facility that focuses on health/wellness and provides unique amenities that improve patient experience. Translated clinical needs of 15 subject matter experts and regulatory requirements into clear and concise plan for architects, engineers and construction managers.
- Project managed the on-time, under-budget opening of the $150 million+, 172,000-square-foot Wexford Health+ Wellness Pavilion in Wexford, Pennsylvania that delivers $50 million in annual net patient revenue. Invested a year to design world-class facility to accommodate clinical programs and amenities, including demonstration kitchen, child care drop-off center, café and courtyard.
- Coordinated collaboration between clinical and architectural staff to design and build $13.2 million, 24,000-square-foot ambulatory surgery facility in Monroeville, Pennsylvania in 2013. Facility performs 7,000 surgeries/procedures per year.

HIGHMARK BLUE CROSS BLUE SHIELD – PITTSBURGH, PA
Vice President, Provider Contracts & Relations (2009 – 2011)

- Managed 900+ facility provider contracts and 17,000 professional providers in western Pennsylvania, with $5 billion annual spend. Negotiated contracts with hospitals, skilled nursing facilities and ambulatory surgery centers. Led 40 professional, ancillary and facility provider relations staff in 29 counties, ensuring that provider issues were addressed and resolved in timely manner.
- Standardized language across 40 hospital contracts, allowing Highmark to easily administer and amend contracts.
- Converted 95% of professional providers to payment via electronic funds transfer.

HIGHMARK BLUE CROSS BLUE SHIELD – PITTSBURGH, PA
Vice President, Provider Contracting & Reimbursement (2007 – 2009)
Vice President, Provider Reimbursement (2003 – 2007)

- Managed $5 billion in facility and ancillary provider reimbursement, including determining payment rates and methodologies. Oversaw provider audit function and medical policy, as well as associated payment policy. Added provider contracting responsibilities in 2007. Managed four directors, with oversight for 48 business and policy analysts, contracting specialists and reimbursement staff.
- Piloted Highmark's efforts to create a specialist and primary care physician pay-for-performance program, which provided additional reimbursement to those physicians who improved quality of care delivered to members.

- Eliminated capitation as a reimbursement methodology for primary care physicians (PCPs) for both commercial and Medicare Advantage products. Created analysis to determine reimbursement rates for CPT visit codes that kept PCPs relatively whole. Developed talking points for conversion that enabled process to proceed smoothly, resulting in Highmark's retaining all of its PCPs.
- Designed and implemented provider audit plan that aggressively pursued recoveries of overpayments for bariatric surgeries, resulting in collection of $2 million.
- Recovered $800,000 in what had been deemed "unrecoverable advances" from six hospitals and maintained positive relationships with those organizations.

GATEWAY HEALTH PLAN – PITTSBURGH, PA
Vice President, Provider Affairs & Marketing (2001 – 2003)

- Promoted to expanded role, while retaining responsibilities for previous position. Set and executed operational strategy for credentialing, provider relations, network development, provider contracting and marketing departments. Led 30-member team of provider relations representatives, marketing representatives, contract specialists and credentialing specialists.
- Built a 15-hospital, 1,000-physician provider network in central Pennsylvania within nine-month deadline, enabling Gateway to be a contracted HMO by Pennsylvania Department of Public Welfare and immediately adding 20,000 new members to the plan.

GATEWAY HEALTH PLAN – PITTSBURGH, PA
Vice President, Provider Activities & Quality Improvement (1997 – 2001)

- Led overall quality improvement initiatives, including HEDIS activities, to ensure compliance with National Committee for Quality Assurance (NCQA) and Pennsylvania Department of Public Welfare requirements. Managed 20-member team of quality improvement nurses, provider representatives and credentialing specialists.
- Created new quality program focused on rewarding primary care physicians for reaching specific targets on increasing preventive care services provided to members.
- Maintained "excellent" accreditation survey status from NCQA during tenure.

UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC) – PITTSBURGH, PA
President—Ambulatory Surgery Corporation
Associate Director of Finance
Senior Financial Analyst / Budget Analyst / Credit Analyst

KEYSTONE REHABILITATION SERVICES – INDIANA, PA
Controller

RICHLAND MANOR, NORTHERN MEDICAL SERVICES / BEVERLY ENTERPRISE – JOHNSTOWN, PA
Administrator

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Public Administration, with distinction – Carnegie Mellon University—Pittsburgh, PA
- Bachelor of Science, Health Administration, with distinction – Pennsylvania State University – University Park, PA

    - Alumni Board Member, School of Health & Human Development | 2010 – 2017
    - Board of Visitors, Master of Health Administration Program | 2006 – 2017
- Blue Cross / Blue Shield Association Executive Leadership Forum | 2005
- Blue Cross / Blue Shield Association Institute for Business Strategy Development | 2004

LAURA BETTEN, MBA, RN – QUALITY IMPROVEMENT DIRECTOR

Laura Betten is an accomplished Registered Nurse with a Master of Business Administration – Healthcare Management with experience in HEDIS project management, developing HEDIS interventions, increasing HEDIS metrics, NCQA accreditation and analyzing Quality data in a managed care setting focused on the Medicaid and Medicare population. She has been instrumental in developing operational functions and processes creating efficiencies for HEDIS and Risk Adjustment activities, which have been identified as best practices and implemented across all WellCare markets. HEDIS At Molina Healthcare managed Health Plans first HEDIS audit with a 94% retrieval rate, developed processes and work flows that were identified as Best Practices and implemented across corporate health plans.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE KY

Senior Director of Quality Improvement (March 2016 – Present)

- Selected to assist with regional quality program development for quality organizational restructure, improve operational efficiencies, and advance quality outcomes
  Developed HEDIS tool to improve efficiencies for the HEDIS audit – implemented across all WellCare markets.
- •Developed “Charlie” - A member outreach reporting system allowing for a customizable approach to member engagement – implemented in three WellCare markets.
- Created an identification system to enhance the capture of risk adjustment chronic conditions.
- Improved CMS Star Score from 2.86 (2016) to 3.39 (2018).
- AOS scores >90 3 years.
- Created Behavioral Health quality team including BH care gap reports and a provider incentive to enhance continuity of care.
- Implemented a Medicaid 6 member outreach team to target members with population specific health needs.
- Implemented a Medicare 8 member health coach team designed to develop relationships with members to achieve improved health outcomes.
- Crafted an all-encompassing provider incentive program to improve provider engagement and partnership which was identified as a best practice and implemented across all WellCare markets.
- Increased NCQA accreditation score from 80.6 (2016) to 85.8 (2018), achieving a commendable recognition status.
- Developed a Star measure/care gap interactive tool that allowed providers to have precise insight and impact of their interventions to their quality score.
- Implemented a field based approach to provider engagement to increase quality scores by expanding the team from 8 to 18.
- Collaborate with Market Directors to identify, develop and implement specific health activities that promote HEDIS/CAHPS/NCQA scores.
- Leads, educates, directs and integrates initiatives throughout all markets for Health Services contractual, regulatory, and accreditation compliance.
- Provides strategic leadership, administrative oversight, and consultative services to establish and sustain process improvements and operational efficiencies.

- Researches, interprets, and analyzes quality improvement, contractual, accreditation and regulatory standards.
- Translates standard requirements into action plans to achieve positive survey/audit reviews and renewed contracts/licenses.
- Establishes an internal culture of collaboration, integration, and cooperation that transcends all health plan markets for a unified and successful approach to performance and member improvements.
- Coordinates the dissemination of quality, accreditation and compliance information within the organization to ensure all staff are knowledgeable and engaged in activities.

MOLINA HEALTHCARE OF ILLINOIS – OAK BROOK, IL

Manager of Quality Interventions – HEDIS (Feb. 2015 – Oct. 2015)

- Oversees the design, implementation and evaluation of quality improvement related initiatives. Responsible for the development of targeted interventions related to HEDIS performance improvement including member and provider outreach to improve care/service.
- Key leader for Quality Interventions including quality analysis, reporting, and development of program materials, templates and policies. Chairs Plan-wide collaborative workgroups to develop strategies for effective QI Intervention programs.
- Collaborate with data team to ensure implementation of complex analytical database management and manipulation to support program integrity and program evaluation of accreditation and regulatory requirements.
- Conducts periodic audits/reviews of established programs to determine efficiency, adherence to policy and effectiveness. Assists in NCQA accreditation processes and provides compliance program materials. Assist Health Plan in meeting regulatory requirements. Makes written recommendations to be used system wide for process improvement purposes.
- Project Manager for Risk Adjustment audit reaching corporate goal of 65% in 6 weeks for Medicare/Medicaid population.

ANTHEM BLUE CROSS BLUE SHIELD – ST. JOHN, IN

Nurse Consultant, Project Management/Quality/Data Analytics/Provider Relations (July 2011 – Feb. 2015)

- Developed HEDIS Measure Adolescent Well Care (AWC) project to increase HEDIS results from NCQA 50th percentile (55.09 %) to NCQA 75th percentile (60.93%) resulting in an additional $245,000 in revenue.
- Developed project to increase quality HEDIS metrics in high volume providers and increased quality metrics from 42.67 % in 2013 to 51.8% in 2014.
- Analyzed Quality data to identify quality projects, implementation process and evaluated results which identified discrepancies in data and logic for provider bonus payout preventing an $800,000 payout error.
- Conduct baseline physician practice assessments by analyzing practice patterns, assets and challenges, define areas of opportunities or threats and develop improvement plan utilizing industry best practices.
- Measure outcomes and adjust processes to meet quality standards.

- Developed and facilitated implementation of education including quality measures (HEDIS), state regulations, compliance, practice management, financial implications and medical record audits.
- Provide extensive education for documentation guidelines to adhere to HEDIS requirements, how to manipulate Electronic Medical Records templates to capture required data, and implement practice management processes to improve outcomes.

TLC MANAGEMENT, INC. / ROYAL MANAGEMENT CORP. – ST. JOHN, IN / LOMBARD, IL

Clinical Nurse Liaison (May 2009 – June 2011)

- Performed clinical assessments requiring multi-specialty physician coordination, cost of care analysis and decision making authority to determine appropriate healthcare options for patients.
- Guided referrals within the healthcare system.
- Managed and grew large territories from multi-county to multi-state including hospitals, provider offices, long-term care facilities, external vendors, and community resources.

EXTENDED CARE CONSULTING – EVANSTON, IL

Regional Marketing Director (Nov. 2007 – May 2009)

- Managed team of 13 marketing representatives and clinical nurse liaisons representing 26 long term care centers.
- Provided leadership with a broad vision and a critical eye for internal operations and quality assurance while executing the organizations strategy, driving for exceptional results, and motivating team members and business associates.
- Developed strategic business plans for key stakeholders that supported enterprise goals and quality initiatives to reduce expenses and promote revenue growth.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Business Administration, Healthcare Management – St. Leo University
- Bachelor of Science in Nursing – Purdue University
- Registered Nurse, State of Indiana and Iowa
- Six Sigma Lean Certification

SHANNON MAGGARD, RN, CCM – POPULATION HEALTH MANAGEMENT DIRECTOR

Shannon Maggard is a registered nurse with over 23 years of experience in the health care setting. Versatile skill set which includes experience as Director within a managed care company overseeing 90 plus employees. History of both psychiatric and medical management experience in an inpatient setting.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Director, Field Health Services (2017 – Present)

- Develops and implements the quality improvement plan within regional markets in accordance with the mission and strategic goals of the organization, federal and state laws and regulations, and accreditation standards.
- Establishes professional relationships with state, stakeholders and community agencies to facilitate quality processes internally and externally for QI, CM, and UM.
- Analyzes, updates, and modifies standard operating procedures and processes to continually improve QI Department services/operations.
- Manages and develops direct reports who include other management or supervisory personnel and/or individual case managers who have clinical expertise and are trained in Case Management activities.
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches for QI, CM, and UM.
- Establishes budget, obtains approval from senior management and monitor for adherence. Links budgetary expenses to define improvements in member health and/or cost savings.
- Manages and develops direct reports who include other management or supervisory personnel and/or individual case managers who have clinical expertise and are trained in QI, CM, and UM.
- Directs the review of assessments by nurse managers and provides advice in regard to complex, controversial or unique administrative processes, medical procedures and payment guidelines.
- Develops strategies for special program participation and Quality Improvement.
- Develops systems for close coordination of QI related functions with departments whose activities are directly a part of the QI Program, including Credentialing.
- Collaborates with Health Services, Operations, and Information Technology departments to ensure full integration of quality improvement reporting for contract and accreditation compliance.
- Establishes professional working relationships with all providers towards the end goal of establishing a care continuum for the members.
- Leads a continuous improvement of the WellCare Case Management process by developing and disseminating best practices throughout the enterprise.
- Educates WellCare departments on the Case Management Programs, especially in regard to identification of potential cases.
- Maintain collaboration with Inpatient Services, Outpatient Services, Pharmacy, Customer Services and Quality Improvement to ensure early identification of members in need of Case Management.

- Ensures compliance with all state and federal regulations and guidelines for all lines of business in all States.
- Participates in site visit preparation and execution by regulatory and accreditation agencies (state agencies, URAC, NCQA, CMS, AAAHC, EQRO).

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Director of Field Service Coordination (2011 – 2013)

- Developed an innovative model of care for Kentucky that was instrumental in the new Model of Care 2.0 currently being piloted in the Eastern portion of Kentucky, as well as Georgia and Florida.
- Responsible for the development and adherence of a budget for Kentucky Health Services Department.
- Develop and implement policies, procedures, and standards of care necessary for the coordination of care for the members while ensuring the state contractual requirements are met.
- Evaluating the quality, financial, and performance measures set in place and implement necessary changes to ensure compliance.
- Proactively monitor appropriate metrics to drive up efficiency.
- Partner and collaborate with other departments cross functionally regarding care and case management and/or Health Service initiatives.
- Direct the case management process, providing advice when necessary on complex, controversial and/or unique administrative processes, medical procedures and payment guidelines.
- Establish, maintain and foster professional working relationships with all providers and community stakeholders.

WELLCARE OF KENTUCKY – LOUISVILLE, KY.

Manager, Field Service Coordination (2011 – 2013)

- Prominent in the introduction of Region 3 to the Kentucky market. During which I worked to ensure a smooth transition with the startup and successful outcome. This was accomplished by actively working with HR to interview, hire and train field, office and manager positions.
- Created a plan for a mentor program to ensure the long term success of new employees.
- Developed operational plans to ensure case management met contract requirements while delivering quality care during the increase member load in the area.
- Empowered staff to think creatively to meet member needs.
- Performed audits of assessments, care plans and service notes to verify cases were properly established and that member coordination activities occurred and were appropriately documented.
- Monitored associate performance and conducted counseling/corrective action procedures when required. Identified concerns, brought issues to management's attention and offered suggestions for improvement.
- Supervised team members providing direct patient care. Served as a resource person for team members, physicians, patients and families.
- Ensured compliance with organizational-wide and hospital-specific policies and procedures.

HAZARD ARH – HAZARD, KY

Nurse Manager, Surgical Unit (2009 – 2011)

- Implemented a cardiac monitoring system for the surgical unit to ensure continuity of care.
- Provided leadership through appropriate assignment and ongoing prioritization according to patient need, acuity and clinical expertise of the team member.
- Supervised team members providing direct patient care. Served as a resource person for team members, physicians, patients and families.
- Ensured compliance with organizational-wide and hospital-specific policies and procedures.
- Responsible for reinforcing standards set forth by JCAHO, Nursing Policies and Procedures and the quality of care provided assuring a high level of customer satisfaction and physician interaction.

APPALACHIAN REGIONAL HEALTHCARE

Staff Nurse, Nurse Managed (Medical and Behavioral Units), House Supervisor, Case Manager (1996 – 2001)

- Implemented a cardiac monitoring system for the surgical unit to ensure continuity of care.
- Provided leadership through appropriate assignment and ongoing prioritization according to patient need, acuity and clinical expertise of the team member.
- Responsible for reinforcing standards set forth by JCAHO, Nursing Policies and Procedures and the quality of care provided assuring a high level of customer satisfaction and physician interaction.
- Functioned as liaison between physicians and nursing staff to ensure optimum patient care.
- Provided leadership through appropriate assignment and ongoing prioritization according to patient need, acuity and clinical expertise of the team member.
- Assumed responsibility for the counseling and evaluation of nursing and ancillary staff in an objective, consistent and timely manner.
- Provided direct supervision, guidance and support to nursing staff utilizing effective communication skills to address issues and seek feedback from staff.
- Scheduled and maintained nursing staff assignments for 24-hour coverage on a regular basis.
- Maintained appropriate staffing patterns with the guidelines for assigned program to ensure optimum patient care and understanding FTE requirements for program and hospital.
- Worked effectively with the Program Director and Medical Director to monitor and evaluate program standards and guidelines.
- Utilized care management information to identify trends and desired interventions for improved care management of targeted patients.
- Promoted and maintained quality patient care through effective management of team members activities during assigned shift.
- Managed the resolution of precarious issues developed during evening and night hours. Addressed and reported emergent issues as necessary.
- Communicated trends to hospital leadership and worked together on resolutions.
- Operated as a resource person for patients, team members, and physicians.
- Supervised the waiver team members to ensure quality home care was delivered.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Associates Degree in Nursing – Eastern Kentucky University, Richmond, KY

MARK SHELTON – MANAGEMENT INFORMATION SYSTEM DIRECTOR

Mark Shelton is an IT Manager at WellCare Health Plans, where he leads a 26 member Regional Desktop Support Team located across the United States supporting users in the Headquarter and Market locations of WellCare. With over 20 years' experience in Information Technology and Leadership, Mark is a lead by example professional with experience in end user computing support, leading technical teams locally and remotely while providing exceptionally high level of customer service. His background includes a Bachelor of Science Degree in Information Technology Management, an impeccable 21 year career serving in the United States Air Force and CompTIA Certifications in Network and Security Plus.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Manager, IT Client Service (Feb. 2018 – Present)

- Leads a 26 member Regional IT Support team supporting 6000+ users across the United States.
- Manages associate, workstation and user migrations for company acquisitions and integrations.
- Manages Client Services Real-Estate team in support of new market office openings and relocations.
- Lead planner for Client Services during initial build phase of all new market ventures.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Supervisor, Information Technology (Jan. 2015 – Feb. 2018)

- Supervised 11 Regional Systems Support Specialists supporting 3,000# users in 9 different geographical locations.
- Conducted the annual IT briefing and site visits with senior leaders in remote market HQ locations.
- Managed IT support / equipment orders for annual compliance, readiness, and quality inspections across the markets.
- Provided initial training, policy and procedure instruction to all newly hired Regional Systems technicians.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Regional Systems Support Specialist (Aug. 2013 – Jan. 2015)

- Provided direct Tier I, II and III level support/oversight for 300+ members across several geographical locations.
- Managed WellCare's printer order, request, and inventory and tracking procedure/process.
- Lead Desktop Support Project Technician during initial opening of new and relocated offices.
- Tracked, responded too and resolved complex work station and network related problems using the most current tools and techniques.
- Provided extensive desktop and network troubleshooting in Windows 7, Citrix, VPN, Exchange, Active Directory and remote administration environments.
- Managed asset inventory, tracking, deployment and installation throughout 11 geographically separated locations.

UNITED STATES AIR FORCE, 14TH COMMUNICATIONS SQUADRON, COLUMBUS AFB – MS

Section Chief, Client Systems Operations (July 2008 – Aug. 2013)

- Managed 24-hour Network Help Desk and Customer Service Center.
- Provided direct oversight of a 13 member client systems technician team.
- Ensured mission critical communications systems, network services availability and network instruction compliance.
- Directed, tracked, responded to and resolved complex work station and network related problems using logical tools and techniques.
- Change Management Sponsor for installations network.
- Planned and executed Microsoft Operating System upgrades for 2,500 PC's.
- Guided helpdesk technicians through incident resolution or escalation of incidents using BMC Remedy Software.
- Provided extensive network and desktop troubleshooting of Windows XP, Vista, and Windows 7.
- Led CompTIA A+ and Security+ training sessions; ensured the certification of ten IT Helpdesk Specialists.
- Created and maintained user and computer network accounts in Active Directory.
- Provided Tier I and II level support for networked desktop, printers, hardware and software configuration.
- Installed, configured, upgraded, setup and troubleshot operating systems, COTS software and PC hardware.
- Diagnosed system failures to isolate source of issue between equipment, network, systems software, and applications.

UNITED STATES AIR FORCE, 651 AIR EXPEDITIONARY GROUP, CAMP BASTION, AFGHANISTAN (DEPLOYED LOCATION)

Superintendent, Mission Support Flight (Jul 2012 – Jan. 2013)

- Managed a 10 member support team that provided communications, logistics, civil engineering and personnel support functions to 402 personnel and assets valued at $510 million.
- Supervised a 5 member communications help desk operation through the completion of over 7,200 network connectivity, computer and software related trouble tickets.
- Project manager and subject matter expert for 9 IT projects worth $1.4 million.
- Planned higher headquarters directed Windows 7 upgrade; led a 4 member team/upgraded 300 PC's in 60 days.
- Provided daily Tier I, II, and III level help desk trouble shooting support in a Windows environment.

UNITED STATES AIR FORCE, 379TH COMMUNICATIONS SQUADRON, AL UDEID AIR BASE – QATAR (DEPLOYED LOCATION)

Non-Commissioned Officer in Charge, Client System Technicians (May 2010 – Nov. 2010)

- Directed 16 member client systems helpdesk team supporting over 10,000 users and 8,000 networked desktops.
- Troubleshot network issues and provided guidance in extensive desktop support and application configuration.

- Created and maintained user and computer network accounts in Active Directory.

UNITED STATES AIR FORCE, 49TH COMMUNICATIONS SQUADRON, HOLLOMAN AFB – NM
Non-Commissioned Officer in Charge, System Operations (May 2004 – June 2008)

- Supervised six military and two civilian employees that maintained 540 personal computers and associated hardware valued at $1.5 million.
- Troubleshot network connectivity issues, performed operating system installations and extensive desktop support and application configuration.
- Developed and maintained private and public web-pages; provided training to assigned web-page maintainers.
- Displayed superior customer service during resolution of IT related issue to over 550 personnel.
- Constructed priority ticket matrix in accordance with management's specified guidelines.
- Provided extensive desktop troubleshooting of Windows 2000 and Windows XP to over 550 network users.
- Managed Web Content Management office responsible for accurate and currency of over 350 web-pages.
- Provided maintenance and configuration management of 540 computers and network devices.
- Configured networked device protocols for connectivity and compliance standards in a DHCP environment.
- Revamped 300 GB shared drive through establishment of security groups and network security permissions.

UNITED STATES AIR FORCE, LOUISVILLE MILITARY ENTRANCE PROCESSING STATION – LOUISVILLE, KY
Non-Commissioned Officer in Charge, Transportation/Alternate System Admin (May 2001 – April 2004)

- Assigned, projected and completed reservations for over 5,000 Armed Services enlistees' annual movement to basic training locations across the United States.
- Maintained a yearly travel budget in excess of $350,000 annually without incident or discrepancy.
- Assigned as the units Alternate Computer System Administrator and aided in the upgrade of desktop software applications and computer help desk support.
- Maintained server back-up schedule and tapes of the Military Integrated Resource System Database.
- Aided in the maintenance and troubleshooting of 25 desktop systems and main frame computer terminals.
- Conducted pre-enlistment interviews, ensured applicants were morally and physically suitable for military service.

UNITED STATES AIR FORCE, 16TH SECURITY FORCE SQUADRON – HURLBURT FIELD, FL
Work Group Manager/Base Information Security Manager (Jan. 1998 – April 2001)

- Sole computer systems administrator that maintained 60 desktop computers supporting 125 personnel.

- Troubleshot networked and stand-alone desktop hardware and software configuration, performed software upgrades and configured statically assigned networked devices.
- Configured networked desktop systems using statically assigned IP address.
- Replaced and repaired motherboards, floppy drives, hard drives, monitors, video cards and NICs.
- Installed and maintained desktops with Windows 95, 98 and NT operating systems.
- Monitored, updated and posted web-page to intranet.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelors of Science Degree, Information Technology Management – American Military University, Charlestown, WV
- Associates of Applied Science Degree, Information Resource Management – Community College of the Air Force, Columbus AFB, MS
- CompTIA Security+ Certified Professional (2010)
- CompTIA Network+ Certified Professional (2005)

ELIZABETH STARR, LCSW, MSSW – ENROLLEE SERVICES MANAGER

Elizabeth Starr joined WellCare Health Plans in 2013. As Senior Manager of Community Connections, she oversees statewide teams that connect managed care with public health and non-profit organizations to sustain the social safety net across the communities served. She currently oversees teams in Kentucky and Hawaii. Elizabeth has nearly 20 years working with nonprofits and understands the barriers in funding cuts these agencies have been facing over the past few years. This experience and history managing state and federal grants has enabled her to connect with agencies and fill in funding gaps creating more services for WellCare's members and the community. Elizabeth completed her Bachelor of Science in Family and Consumer Sciences at the University of Kentucky and Master of Social Work at the University of Louisville. Following her studies, she became a Licensed Clinical Social Worker while focusing her work in the area of Child Welfare.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE HEALTH PLANS, INC.

Senior Manager, Community Connections (August 2018 – Present)

- Oversee Kentucky and Hawaii statewide Community Connections Department.
- Work with market leadership to drive direction of the Community Connections program.
- Creates and implements market focused strategies that includes positioning WellCare as a thought leader in the community.
- Establishes annual strategic outreach plans including those for special populations as required by the state.
- Manages a team that implements strategic outreach plans across state.
- Create and launch need-based partnerships with social resource organizations, supporting evidence-based programs with positive health outcomes.
- Oversee budget for community spending annually.
- Consult and assist on new business development and launches in new states across business enterprise.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Manager, Advocacy and Community Based Program (Dec. 2013 – Aug. 2018)

- Oversee statewide Community Advocacy Department.
- Work with market leadership to drive direction of the Advocacy program.
- Creates and implements market focused strategy that includes positioning WellCare as a thought leader in the community.
- Establishes annual advocacy outreach plans including those for special populations as required by the state.
- Manages a team that researches social safety net providers in order to populate and update "My Family Navigator," a database of regional social safety net programs and services and identifies creative gap-fill strategies.
- Creates and launches need-based partnerships with social safety net providers, supporting evidence-based programs with positive health outcomes.
- Identifies inbound and outbound grant opportunities in collaboration with Advocacy & Community Based Programs Department.

FAMILY AND CHILDREN'S PLACE – LOUISVILLE, KY
Child Welfare Team Leader (Feb. 2011 – Dec. 2013)

- Team Leader for Child Welfare Team which provides therapeutic supervised visitation services, Center based visitation services; Adoption preservation services and conducts psychosocial parenting assessments for CHFS.
- Provide ongoing supervision to employees.
- Follow a budget and ensure accuracy for program's needs.
- Evaluates and reports outcomes to funders on an ongoing basis.
- Maintains a clinical caseload.
- Supervise Master level students in clinical setting.

THE BROOK HOSPITAL, KMI – LOUISVILLE, KY
Intake and Evaluation Coordinator – PRN (April 2011 – Oct. 2012)

- Conduct level of care assessments for psychiatric and substance abuse hospital services.
- Make recommendations about treatment in conjunction with hospital psychiatrists.
- Coordinate benefits for precertification with insurance companies.
- Specialized in Tricare Assessments for military members and family members.

FAMILY AND CHILDREN'S PLACE – LOUISVILLE, KY
Child Welfare – Program Supervisor/Family Therapist (Dec. 2008 – Feb. 2011)

- Supervise therapeutic visitation program which provides in-home and site-based visits with biological families and sibling groups.
- Collect and analyze data and outcomes for funding and quality assurance purposes.
- Act as contact person with CHFS to delegate referrals to appropriate services within Visitation Program.
- Conduct psychosocial parenting assessments for CHFS and the courts on birth, adoptive and potential foster families.
- Testify on assessments and visitation cases in court when requested.

FAMILY AND CHILDREN'S PLACE – LOUISVILLE, KY
Family Therapist (Oct. 2006 – Dec. 2008)

- Provide Intensive In-Home Therapy to families.
- Facilitate Family Team Meetings.
- Recruitment of referrals from local agencies.
- Assist in program development including development of policies, procedures, and forms.

FAMILY AND CHILDREN'S PLACE – LOUISVILLE, KY
Family Counseling & Grant Writing Team (2006 – 2007)

- Provide individual and family counseling to clients.
- Co-lead social skills elementary school groups.
- Train therapists in Parent-Child Interaction Therapy core skills.
- Assist in writing grants for the agency.
- Conduct psycho-social assessments on families referred from the Cabinet.

FAMILY AND CHILDREN'S PLACE – LOUISVILLE, KY
In-Home Therapeutic Supervised Visitation / Intake Coordinator (March 2006 – Oct. 2006)

- Managed coordination of reports and billing among members of the Interdisciplinary team.

- Assist in program development including development of policies, procedures, forms, and budget and billing of contract.
- Provide supervised visits with parents whose children have been removed and transport the children to visits.
- Apply therapeutic techniques to help families reunify.
- Coordinate intake of visitation program and assessment program with the Cabinet.

GERIATRIC EVALUATION AND SELF-MANAGEMENT SERVICES – LOUISVILLE, KY
Practicum/Internship (2005 – 2006)

- Collaborate with Physical Therapists to conduct assessments on older adults living at home.
- Assess risk factors and propose goals.
- Participate in telephone intervention services.
- Co-lead self-management workshop.

FAMILY & CHILDREN'S FIRST/HANDS – LOUISVILLE, KY (2004 – 2006)

- Work with first time parents to promote healthy childhood development doing home visits.
- Support and educate parents on interaction, stimulation, and parenting skills.
- Make referrals in community when necessary.

METHODIST HOME – VERSAILLES, KY
Youth Counselor (2003 – 2004)

- Monitor Youth ages 12-17 in Residential Treatment Facility.
- Track progress of youth in personal treatment plan.
- Counsel teens with long-term and everyday problems.

CDW-JUVENILE SERVICES – LEXINGTON, KY (2002)

- Accept and process complaints from police officers.
- Work with juveniles and families to keep them out of court by creating diversion programs.
- Monitor diversion programs and implement workshops.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Kent School of Social Work – MSSW – University of Louisville, Louisville, KY
- Bachelor Degree: Family and Consumer Sciences – College of Human and Environmental Sciences , University of Kentucky, Lexington, KY

ANTHONY PIAGENTINI – PROVIDER SERVICES MANAGER

Anthony Piagentini has worked at WellCare of Kentucky for four and a half years and has been the Sr. Director of Provider Relations for WellCare of Kentucky for the past year. Prior to that, Anthony was the Sr. Director of Business Development WellCare Health Plans. Anthony is a 20-year business executive with a variety of healthcare experience. Anthony is also a veteran of the United States Marine Corps Reserve. He served honorably between 2003 and 2011 including a tour in Ramadi, Iraq in support of Operation Iraqi Freedom. His formal education includes his undergraduate degree in Economics. He also studied in Taichung, Taiwan for a year studying Mandarin, Chinese. Anthony finished his education by receiving his MBA in Global Management from the University of Phoenix.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Director, Provider Relations (2018 – Present)

- Manage the provider relations team for the WellCare of Kentucky market including all institutional, professional, and behavioral health providers.
- Only market to exceed expectations on both Medicare and Medicaid risk adjustment including exceeding the Medicaid goal by 40%.
- Highest provider relations satisfaction score by providers in the Kentucky market; 2nd highest score in 16 markets within the WellCare national brand.
- Exceeded market and corporate employee engagement score averages.
- Worked with network contracting to triple our proportion of Members assigned to high performing providers.
- Restructured the team improving productivity by separating the institutional and professional team management structures.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Director, Business Development (2015 – 2018)

- Responsible for growing WellCare's Medicaid business focusing on southern states (Kentucky, Tennessee, Louisiana, Arkansas, Mississippi, Alabama, and Florida) and complex Medicaid populations.
- Led the Florida market business development team placing 1st in 44 separate bids and growing the existing market by over $2 billion annually including expansion into long term care.
- First market development leader hired by WellCare to grow business in a field environment.
- Assisted the Vice President of business development in creating the 'Playbook' for field engagement activities and helping to train colleagues hired to cover other regions of the country.
- Primary responsibilities including conducting hundreds of face to face meetings with providers, advocacy organizations, and key thought leaders in each state to provide accurate, on-the-ground intelligence for critical Medicaid growth decisions.
- Had a primary leadership role in multiple Medicaid bids including Iowa, Pennsylvania, Mississippi, Kansas, and Florida.
- Regularly advise legislators, Medicaid Directors and other Cabinet level positions on best practices for Medicaid reform based on their policy objectives.

- Led the effort within WellCare to create a new managed care product for Medicaid beneficiaries with Intellectual and Development Disabilities including operational improvements, government affairs policy positions, and business development tactics.

RESCARE INC.

Vice President, Managed Care (2013 – 2015)

- Managed the strategic and tactical relationships with all Managed Medicaid payers focusing on organizations overlapping with existing ResCare operations.
- Created ResCare's Managed Care strategy, focusing on establishing ResCare as a leader in coordinated care models for complex Medicaid populations (e.g. ABD and IDD)
- Wrote ResCare's first white paper titled "Medicaid Reform Principles for People with Intellectual and Developmental Disabilities" and distributed it to key policy makers, legislators, and managed care contacts.
- Launched ResCare's first Health Homes operations in Kansas for people with IDD in conjunction with all three KanCare payers.
- Worked with a leading Managed Medicaid payer on an industry pioneering partnership designed to operate a coordinated care model for people with IDD in anticipation of a state RFP.
- Led the Strategic Business Development Team to examine regional and national growth opportunities including the creation of a new line of business focusing on Behavioral Support Services.
- Updated the organization's Business Intelligence platform to report on revenue by payer allowing management to target new growth opportunities by payer.
- Worked closely with Government Relations to include regular meetings with senior state government officials to influence Medicaid policy and improve ResCare's development opportunities.
- Presented at multiple national events to include a Democrat Governors Association Roundtable presentation alongside the Governor of Connecticut and Vermont.
- Led the Case Management project to automate all Residential Services operations through a mobile platform supported by a multi-functional central database.

OMNICARE SPECIALTY CARE GROUP

Executive Director, Operations and Business Development (2012 – 2013)

- Responsible for the operational execution of over half of the brand support services operations business including 6 clients and over $20 million in annual revenue.
- Led a team of 190 employees across 4 levels of management.
- Represented operations on all brand support services business development presentations to national pharmaceutical and biotech customers.
- Successfully awarded business from multiple clients creating over $11 million in revenue growth (over 20% of current revenue).
- Collaborated with the Director of IT to standardize multiple service offerings and develop software product platforms creating human resource cost savings and more competitive launch plans.

- Worked with organization leadership to create a new IT organization and established the collaboration techniques to support the new organization's communication between operations and IT.
- Led the organization's employee engagement survey response significantly improving year-over-year employee engagement resulting in improved productivity and retention.
- Represented Omnicare Specialty Care Group at multiple conferences including headline speaking engagements.
- Interviewed and published in Pharmaceutical Executive magazine concerning industry trends related to health care reform.

INVENTIV HEALTH INC.
Executive Director, Business Development (2010 – 2012)

- Responsible for the marketing, thought leadership, and sales of inVentiv Patient Access Solutions, a custom reimbursement and patient access services provider.
- Worked as acting General Manager of a $30 million business unit achieving over 35% margins, managing all aspects of operations, account management, information solutions, finance, and business development including the direct management of over 230 employees.
- Regularly presented to the inVentiv Health Executive Committee during monthly and quarterly general management meetings.
- Created the business case, received approval, and strategically led the implementation of MicroStrategy, an industry leading reporting platform.
- Created, designed, and launched the first inVentiv Health cross-functional service focused on supporting specialty pharmaceutical and biotechnology products.
- Established a pipeline of over $40 million in annual revenue and contracted for $2.5 million in new business in first 12 months.
- Worked collaboratively with inVentiv's consulting segment, Campbell Alliance, on multiple specialty product consulting projects.
- Assisted inVentiv Corporate in establishing and implementing a Biosimilars strategy.
- Spoke at several industry conferences in the US and Paris, France on reimbursement and access strategy, operations, Biosimilars, payer policy, and public policy

SANOFI-AVENTIS U.S.
Sr. Manager, Reimbursement, Patient Assistance Programs, Sample Administration (2007 – 2010)

- Managed strategy and operations, including over 60 operations staff, of all specialty and non-specialty branded reimbursement and patient assistance programs including Oncology, Hematology, Osteo-arthritis, and orphan disease states.

SANOFI-AVENTIS U.S.
Manager, Purchasing Process and Systems (2005 – 2007)

SANOFI-AVENTIS U.S.
Senior Sales Representative (2003 – 2005)

AVENTIS PHARMACEUTICALS
Procurement Analyst (2001 – 2003)

ROBERT A. BECKER INC.
Account Coordinator (1999 – 2001)

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Business Administration, Concentration in Global Management – University of Phoenix
- Bachelor of Arts, Economics, Concentration in Mandarin Chinese – Washington and Lee University
- Full Emersion Mandarin Chinese Language Program – Tunghai University

JULIE CROUSORE – CLAIMS PROCESSING MANAGER

Julie Crousore is an effective communicator and project leader with strong planning, analysis and implementation skills. Proven ability to lead teams, coordinate complex and detailed projects, and drive initiatives to successful completion. Exceptional skills to create interaction and build rapport with individuals from multiple organizations and departments to ensure the most favorable outcome for all team members.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE KY

Senior Manager, National Operations Account Management (June 2014 – Present)

- Responsible for the daily activities of the National Operations Account Management team located though out Kentucky. This includes 1 Manager, 2 Senior Operations Account Representatives, 4 Operations Account Representatives and 6 Operations Account Specialists.
- Serves as the Operational liaison between the Market and Shared Services.
- Monitors, analyzes and identifies root cause to prevent errors from reoccurring.
- Partners with Provider Relations and other Market staff to provide operational support both directly and indirectly to Providers and Facilities.
- Proactively monitors claims data to ensure providers are being reimbursed accurately for their services.

WELLCARE OF KENTUCKY – LOUISVILLE KY

Manager, Provider Relations (Sept. 2011 – June 2014)

- Responsible for the daily activities of the Provider Relations team in Region 1, 2 and 4 in Western and Southcentral Kentucky.
- Meets with Hospital and Provider Groups to assess current situations that could jeopardize patient access to care.
- Monitors all claims issues to determine if there are systemic issues and reports as necessary to management team.
- Provides support and leadership for various delegated entities and large groups.
- Assists Network Development as necessary to extend new Provider contracts.

CARE CENTER – BOWLING GREEN, KY

Senior Benefit Plans Systems Analyst/Project Manager (Jan. 2005 – Sept. 2011)

- Responsible for Electronic Data Interchange (EDI) and remote repricing setup, testing and daily operation of the medical claims repricing system.
- Coordinate and perform Quality Audits on random samples of the 15,000+ monthly claims volume for claims repricing accuracy.
- Perform the set up and testing of all complex contract rates for claims repricing accuracy.
- Project Manager for Operation Red Glow, a project that requires review and set up of multiple contracts and implementation of a paperless contract system.
- Ensure that all provider demographic information is updated timely and accurately for a network of 16,000+ Providers and communicated to contracted Payers and Third Party Administrators.
- Provide guidance to Provider Relations support staff for resolution of data issues and claims issues.

- Create and manage numerous Provider reports for all Center Care team members as needed and/or required for Payers, Third Party Administrators and Outside Vendors.
- Project Manager for current Lean Sigma Project for provider recredentialing. The project is to reduce the process time of the recredentialing process from 120+ days to 90 days.
- Coordinate and assist Information Systems with onsite upgrades and provide onsite troubleshooting of pc issues before contacting the Help Desk.

CARE CENTER – BOWLING GREEN, KY
Provider Relations Representative (April 2002 – Jan. 2005)

- Contacted Providers to secure contracts for Provider Enrollment.
- Perform Quality Assurance checks on 10,000+ Enrolled Providers.
- Redesigned the monthly payer updates to create more user-friendly and customized files to reduce vendor loading time and error ratio.
- Educated healthcare community regarding various Payer and Third Party Administrators through tailored presentations, blast faxes and one-on-one interactions.
- Served as a liaison between the Provider and Insurance Company to resolve claims issues.

CARE CENTER – BOWLING GREEN, KY
Sale & Member Services Secretary (April 2000 – April 2002)

- Coordinated Open Enrollment meetings.
- Redesigned the client database and filing system.
- Supported daily activities of 4 Sales Representatives, 6 Member Services Representatives and the General Manager.

CARE CENTER – BOWLING GREEN, KY
Receptionist (Oct. 1997 – April 2000)

- Answered multi-line phone system.
- Supported staff members with various duties for the network and the Third Party Payer.
- Coordinated meetings and activities for various departments within the corporation as well as external vendors.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Science, Management – Western Kentucky University, Bowling Green, KY Minor: Information Systems
- Lean Sigma Training, Commonwealth Health Corporation, December 2010
- Dale Carnegie Leadership Training For Managers, January 2006.
- Health Insurance Associate, Spring 2002. Health Insurance Association of America, Washington DC
- Managed Healthcare Professional, Spring 2001. Health Insurance Association of America, Washington, DC

DEBORAH LEMKE, RN, BSN, MHA, CCM – UTILIZATION MANAGEMENT DIRECTOR

Deborah Lemke is an experienced Health Care Executive with demonstrated expertise encompassing progressive management experience in nursing spanning a variety of settings including academic and community acute care hospitals, home health care, consulting and managed care. Diverse knowledge and leadership in clinical operations, hospital operations, managed care, revenue cycle, complex project management, state and federal regulations governing health care. She has experience with Case Management, Clinical Documentation Improvement, Revenue Cycle, and Managed Care.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE HEALTH PLANS, INC.

Regional Director of UM /Director of Clinical Appeals/DRG Validation (2018 – Present)

- Strategic leadership and accountability for all utilization management in the North region and clinical appeals. Leading a Team of 110 FTE comprises of clinical managers, supervisors, nurses, mental health professionals and non-clinicians.

UNITED HEALTHCARE – COMMUNITY AND STATE, MN

Health Services Director, Delaware Health Plan (2015 – 2018)

- Strategic leadership and accountability for all clinical programs for membership of 90,000 Medicaid members. Led a team of 75 FTEs; comprising of RNs, LPNs, SW telecommute staff, case management assistants and eight managers. Accountable for overall local market health plan clinical operations for all Medicaid products including achievement of annual clinical, quality, affordability and utilization management goals. Coordinated with internal and external business partners to meet business goals.
- Collaborated with Health Plan Director of Quality and Medical Director to support achievement of state quality initiatives, HEDIS measures and compliance with requirements of State's annual performance review.
- Ensured contractual compliance in all clinical and medical management areas through auditing and External Quality Review Audits resulting in minimal corrective action plans.
- Obtained LTSS reference account status in 2016.
- Achieved 90% member satisfaction on LTSS CAHPS survey.
- Redesigned care model to achieve improved member experience.
- Collaborated with Quality department on Performance Improvement Initiatives for LTSS.

NOVIA SOLUTIONS – POWAY, CA.

Interim System Director Care Coordination (2015)

- Implemented new care coordination model in collaboration with consulting team to position client for future success in value-based purchasing model of delivery.
- Moved from episodic level of care-to-care continuum coordination model for a three-hospital system encompassing 600 beds.

UNION HOSPITAL OF CECIL COUNTY – ELKTON, MD

Director of Case Management and Palliative Care (2013 – 2014)

- 125 bed Community hospital. Provided leadership and strategic direction for both programs encompassing care transitions, population health, readmission strategy, utilization of

resources, denials management, and strategic direction for palliative care program both inpatient and outpatient. Responsible for nine FTEs and $3 million budget.
- Increased palliative care referrals by 24 % in first six months.
- Established outpatient palliative care program in collaboration with palliative care provider and social worker.
- Reduced readmissions all cause within first six months by 2%.
- Established tele-health program in collaboration with CIO and in partnership with AT&T for high-risk patients to reduce ER visits and readmissions.
- Partnered with Maryland Department of Health in providing extended care to high-risk patients with COPD, CHF and Diabetes to prevent readmissions through community based case management program.
- Established NP home visits to high risk patients in conjunction with case management.
- Collaborated with skilled facilities to reduce readmissions by establishing a standardized "hand-over".
- Utilized "lean principals" for project management.
- Co-hosted "Care beyond Our Walls Symposium" with community leaders.

MERCY FITZGERALD HOSPITAL – PHILADELPHIA, PA

Director, Care Coordination and Clinical Documentation (2012 – 2013)

- 250 bed Community hospital part of Mercy Health System. Provided leadership and strategic direction to care transitions, utilization management, denials management and clinical documentation improvement programs. Responsible for 23 FTEs and $3 million+ budget.
- Met LOS and readmission targets within first six months.
- Improved denials by 21% in first year; under budget by 14%.
- Met CDI productivity metrics of greater than 90% within first year.
- Implemented new care transition model to mitigate financial penalties

QUORUM HEALTH RESOURCES, LLC – BRENTWOOD, TN

Manager, Revenue Cycle Division/Senior Consultant (2009 – 2012)

- Consulting and Management Company specialized in revenue cycle assessments, improvements, implementations, turnarounds and clinical documentation initiatives. Assisted clients in developing strategies to mitigate risk and develop action plans to improve middle revenue cycle with strong ability to connect clinical and financial initiatives. Conducted project management for revenue cycle, recovery audit contractor, and case management process improvement and turnarounds.
- Improved revenue cycle for 900 bed academic acute care hospital in reducing 7 million in denials resulting in incremental cash collection of >2 million in seven months with case management redesign and implementation.
- Improved revenue cycle for 30 bed PPS hospital in turnaround of 1.2 million with middle revenue cycle redesign; Case Management implementation with significant reduction in patient status errors.

QUORUM HEALTH RESOURCES, LLC – BRENTWOOD, TN

Independent Consultant (2008 – 2009)

- Provided subject matter consulting expertise for revenue cycle management, CMS value-based program, recovery audit contractor exposure, case management, utilization management and nursing and hospital operations.
- Redesigned case management department. Dropped length of stay from 4.4 days to 3.9 days.
- Improved physician engagement in correct patient status resulting in correct billing of services 100%.

CHRISTIANA CARE HEALTH SERVICES – NEWARK, DE

Director of Case Management / Reimbursement Services / Regulatory Compliance (2003 – 2009)

- Led all aspects of daily operations of Utilization Management and Reimbursement at both campuses of 900 bed Tertiary Care Community Hospital. Managed 50 FTEs, budget in excess of $4 MM. Conducted education seminars on observation status, and correct billing. Assisted senior leadership in meeting federal regulatory CMS requirements as changes occurred.
- Created Managed Care Contracting guidelines for all on-site third party payers.
- Successfully transitioned and assisted with contracting all Medicaid activity to three Managed Care companies.
- Reduced managed care denials by 3% in 2007 through an assertive appeals management approach.
- Established weekly monitoring meeting with Managed Medicaid companies to assure timely reimbursement.
- Achieved 35% decrease in number of long stay patients and 21% decrease in number of days in 2005.
- Reduced length of stay from 5.36 to 5.16 in 2005. Received Performance Improvement award.
- Led steering committee for Recovery Audit Contractor preparation.
- Improved access to care and decreased ED boarding hours through length of stay management.
- Developed “shared governance model” within case management department.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Science, Healthcare Administration, Sigma Beta Delta – Wilmington University, New Castle, DE
- Bachelor of Science, Nursing, La Salle University – Philadelphia, PA
- Registered Nurse Diploma, Germantown Hospital School of Nursing – Philadelphia, PA
- Commission for Case Management: obtained 2004 current expiration 2019
  Nursing Licensure – Delaware (Compact State) (active), Pennsylvania (Inactive status), New Jersey (active), Florida (active)

KEVIN FOW, RN – EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) COORDINATOR

Kevin Fow has over 30 years of experience as a Registered Nurse, including Management Experience. Established track record of success in Quality Review and Case Management An organized and detail-oriented professional able to prioritize and delegate tasks effectively to ensure successful outcomes. Highly self-motivated, self-disciplined, and driven.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Quality Improvement Project Manager (June 2018 – Present)

- Independent Physician Association Liaison; coordinate reporting, meetings, etc.
- EPSDT Coordinator; educational presentations, measure specialist immunizations.
- Chart reviews for RAPS, HEDIS, Healthy Kentuckian and others as needed.
- Public health collaboration project manager; meeting with public health offices across the Commonwealth of KY to develop strategies to develop mutual support.
- Rheumatoid Arthritis measure specialist; member and provider contacts to encourage and educate on best practice medication use.

EVOLENT / PASSPORT HEALTH PLAN – LOUISVILLE, KY

Quality Review Nurse (2015 – 2018)

- Responsible for all aspects of abstracting, reviewing and documenting HEDIS (Healthcare Effectiveness Data and Information Set) and Healthy Kentuckian Medicaid chases.
- Developed HEDIS educational tools for providers and internal teams.
- Developed and presented HEDIS educational presentations to providers.
- Developed and implemented HEDIS improvement measures.
- Assisted Sentinel Events, Medical Record Review and EPSDT teams.

PASSPORT HEALTH PLAN – LOUISVILLE, KY

Embedded Case Management (2011 – 2015)

- Embedded in medical home primary care offices to identify, assess and coordinate care for Passport Health Plan members.
- Community based case management.
- Implementing safe and appropriate cost-effective healthcare strategies.
- Identifying members with care gaps to be closed by the provider.
- Collaboration with payer, member, family and provider.

PASSPORT HEALTH PLAN – LOUISVILLE, KY

Transition Triage Care Manager (2010 – 2011)

- Identified and contacted member's transitioning from inpatient to home setting for care coordination assistance.
- Contact with member 's provider informing of member discharge information
- Telephonic contact with member to for assessment of medical and socioeconomic needs
- Referral of members with socioeconomic needs to appropriate community resources
- Identification and resolution of barriers to necessary medical care.

PASSPORT HEALTH PLAN – LOUISVILLE, KY

Nurse Care Manager Behavioral Health (2006 – 2010)

- Telephonic and onsite case management and utilization review for member's with behavioral health diagnoses.
- Telephonic and onsite utilization review of inpatient and partial hospital behavioral health admissions.
- Telephonic case management for members with behavioral health needs to reduce barriers to necessary care.
- Community resource referral for member's with socioeconomic need.

CENTRAL STATE HOSPITAL – LOUISVILLE, KY

Nurse Manager (2004 – 2006)

- Supervised 26 bed acute psychiatric unit assuring nursing care was conducted according to nursing standards of practice. Monitored unit employee performance and staffing to assure safe quality of care.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Science Nursing, University of Louisville School of Nursing
- Registered Nurse in good standing, Commonwealth of Kentucky
- Certified Case Manager (CCM)

JAMES CONWAY – GUARDIANSHIP LIAISON

James Conway has eighteen years of professional experience in clinical behavioral health care, serving both Medicaid and Medicare recipients. Nationally recognized Certified Case Manager certification through The Commission of Case Management Certification. Since 2011, established numerous on-going liaison relationships with both KY Department of Community Based Services foster care and KY Department of Aging and Independent Living state guardian leadership in all eight KY Medicaid regions. During 2014, detected and reported an out of state residential billing discrepancy that saved the MCO a potential six-figure loss. During 2014, advocated the leadership of the Kentucky Department for Aging and Independently Living to undertake a pilot program for state guardianship members in personal care to start receiving behavioral health services at their placement, and thus overcoming the numerous restrictive obstacles to accessing office-based treatment.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUKCY – LOUISVILLE, KY

Behavioral Health Advocate, Senior – Foster Care, Adoption, and Guardianship (Dec. 2016 – Present)

Social Worker, Senior Coordinator - Foster Care, Adoption, and Guardianship (2015 – Dec. 2016)

Field Service Coordinator - Social Work, Foster Care, Adoption, and Guardianship (Sept. 2011 – July 2015)

- Evaluate wards of the state of Kentucky for case management services. Assess for current and on-going needs and partner with the MCO Care Coordination team to identify the appropriate level of care.
- Develop partnerships with state social services leadership in order to access community, residential, or inpatient placement options. Provide referral to supporting providers in order to maintain stability and provide needed level of care.
- Identify high consuming membership and determine the most effective clinical acute care path. Establish on going contact with community providers and care takers to ensure the best level of care is provided. Provide support for eventual transition of state wards to waiver status or aging out status as needed.
- Ensure compliance with HIPPA, HEDIS, NCRQ, and the across the board Culture of Compliance expectations for all case management membership through effective documentation, regular audits and leadership monitoring.
- Provide state-wide and regional face to face contact as needed to state wards who need intense assessment to determine community- based provider support to maintain stability at a state placement site.

SEVEN COUNTY SERVICES – LOUISVILLE, KY

Principal Case Manager (April 2010 – Sept. 2011)

- Provided case management service and make referrals to needed clinical acute care as needed for clients with severe mental illness, dual diagnosis, severe medical conditions, and a low socio-economic backgrounds.
- Was among the agency leaders in total billing for severe mental illness case management ($95,368 in FY 2011) and rated first agency-wide in billable hours.

- Facilitated with treatment team to provide a multi-faceted recovery service planning through clinical assessment, case management, monitoring of client pharmacological progress, documentation, and service coordination.
- Provided successful clinical interventions in both office-based and in-home environments throughout eastern Jefferson County KY.
- Served on Seven Counties Job Evaluation Team and volunteered service for staff conducted holiday events to benefit clients with weak family support.

SEVEN COUNTY SERVICES – LOUISVILLE, KY

Senior Case Manager (July 2007 – March 2010)

- Created a new case load of Medicaid clients in fiscal year 2008 while partnering with Bridgehaven of Louisville. Provided enhanced case management services through Seven Counties and Bridgehaven staff.
- Created a new case management case load in fiscal year 2009 at the new Center One location in Eastern Jefferson County, which was a new one-stop concepts for CMHC treatment in Kentucky.

WELLSPRING ARDERY HOUSE – LOUISVILLE, KY

Program Coordinator (Dec. 2002 – June 2007)

- During fiscal year 2005, provided supervision of staff for this residential program for the chronically mental ill. Provided clinical acute care for 31 Medicaid and Medicare clients with a history of long-term and multiple behavioral health inpatient treatment episodes. Supervised a staff of 10 full and part time clinicians who provided recovery based clinical interventions on a 24 hour basis.
- Responsible for overseeing salary, food, and maintenance expenditures with an annual program budget of over $240,000.
- Responsible for maintaining clinical documentation and CARF standards for residential treatment facility accreditation.

WELLSPRING ARDERY HOUSE – LOUISVILLE, KY

Assistant Program Coordinator (Nov. 2001 – Dec. 2002)

- Provided clinical case management support for the SMI population who have a history of multiple hospitalizations. Supervised self-administration of up to fifteen residential clients. Supervised client meal planning and preparation. Conducted a therapeutic life skills group and produced clinical documentation of interactions and treatment progress.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Arts, Psychology – Spalding University, Louisville KY
- Certified Case Manager Certification through The Commission of Case Management Certification, December 2014
- Completed Health Services Motivational Interviewing training, Louisville KY - October 2014
- Completed Assessing and Monitoring Suicide Risk Core Competencies Training, Louisville KY – November 2014

DAVID BLACKFORD – PROGRAM INTEGRITY COORDINATOR

David Blackford has more than eighteen years of experience in the healthcare insurance industry, including several years in an investigative capacity. Proficient in all phases of Microsoft Office. Prior experience with STARS (Services Tracking, Analysis and Reporting System) and IBM's Fraud and Abuse Management System. Recognized by the Defense Criminal Investigative Services for my role in the arrest of an identity fraud offender.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Investigator (2017 – Present)

- Manages large caseloads and investigates allegations and complex issues pertaining to potential health care fraud by providers or members.
- Documents investigations, including preliminary and final case reports for both internal tracking and regulatory reporting purposes.
- Identifies trends and aberrant activity to generate leads for fraud investigations and analyzes claims data to detect fraudulent activity in a pro-active manner.
- Prepares cases for referral to law enforcement officials for prosecution.

OPTUM – LOUISVILLE, KY

Senior Investigator (2011 – 2017)

- Responsible for calculating overpayment demand letters for multiple clients, including Employer & Individual, Medicare, and Medicaid. Managed distribution of department workload, including metrics and forecasting to ensure timely results. Drafted and revised departmental Policies and Procedures. Ensured compliance with regard to statutory lookbacks and practices.

WELLPOINT – LOUISVILLE, KY

Benefits Analyst (2010 – 2011)

- Responsible for quality of custom and standard benefit plans by ensuring business process steps are entered accurately. Maintains department SharePoint site, which keeps auditors up to date with pertinent shared documents and upcoming tasks.

WELLPOINT – LOUISVILLE, KY

Grievance Counselor (May 2011 – Feb. 2013)

- Reviewed, analyzed and processed claims to determine the extent of the company's liability and entitlement. Conducted investigation and review of customer grievances and appeals involving service and benefit coverage issues. Contacted customers to gather information and communicate disposition of case. Ensured appropriate resolution to inquiries, grievances and appeals within specified timeframes established by either regulatory/accreditation agencies or customer needs.

NATIONAL GOVERNMENT SERVICES – LOUISVILLE, KY

Data Technician (2005 – 2007)

- Lead in a variety of duties involved in the collection, interpretation and documentation of data. Recommended new methods for collection and documentation of data; write and revise procedural manuals as required. Provided technical support for provider education webinars. Improved efficiency in reporting departmental workload.

CIGNA MEDICARE – NASHVILLE, TN

Investigator (2004 – 2005)

- Conducted data mining activities using STARS/VIPS, performed comprehensive analysis of data, prepared statistical/financial analyses and maintained up-to-date case files for management review. Recommended possible interventions for loss control and risk avoidance based on the outcome of the investigation. Coordinated with multiple cross-functional areas such as Operations, Medical Management, Pharmacy, Contracting, Compliance and MRU. Developed and maintained a rapport and cooperation with the Federal, State and local law enforcement and regulatory agencies which aided in investigative efforts.

HUMANA MILITARY HEALTHCARE SERVICES – LOUISVILLE, KY

Customer Service Representative (Jan. 2008 – Oct. 2008)

- As a part of this unit, conducted claims profile reviews to identify those providers/recipients whose billing patterns indicated potential fraudulent behavior. Created overpayment worksheet to calculate extrapolated overpayment in cases referred to TRICARE Management Activity. Referred providers guilty of aberrant billing practices to Department of Defense for corrective action

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor' of Justice Administration at the University of Louisville

C.

Technical Approach

1. Subcontracts

C.1. SUBCONTRACTS

a. **Describe the Vendor's approach to subcontracting services for this Contract, and how the Vendor will ensure ongoing collaboration with Subcontractors for a streamlined and coordinated approach to serving Enrollees and Providers.**

b. **Describe how the Vendor will ensure responsiveness of its Subcontractors to all requests from DMS for reporting, data and information specific to operation of the Medicaid managed care program. How will Subcontractors be held accountable for a delay in or lack of response?**

c. **Provide a listing, including roles and locations, of known Subcontractors that will support the Contract resulting from this RFP.**

d. **Describe the relevant experience of each Subcontractor. Indicate whether the Vendor has subcontracted with the entity for prior contracts of similar size and scope.**

C.1. SUBCONTRACTS

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Sections 4.3 Delegations of Authority and 6.0 Subcontracts of the Draft Medicaid Managed Care Contract and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

a. Describe the Vendor's approach to subcontracting services for this Contract, and how the Vendor will ensure ongoing collaboration with Subcontractors for a streamlined and coordinated approach to serving Enrollees and Providers.

WellCare of Kentucky selects highly qualified Subcontractors to complement and enhance the services we provide to our Enrollees and Providers. Our approach to Subcontractor oversight and to establishing and maintaining compliance with regulations is based on our thorough contracting process, rigorous upfront screening process and comprehensive ongoing review process.

Our organization structure has always supported the goals of ensuring high-needs Enrollees get access to the services and supports they need. WellCare of Kentucky began providing services within the Commonwealth in 2011 and has always believed in the power of one collaborative team covering all care needs and only selects high quality Subcontractors with which to work on these important goals. Within this model, we have developed a structure in which WellCare of Kentucky arranges for and oversees Subcontractor services.

WellCare of Kentucky acknowledges the enhanced contract requirements pertaining to Subcontractors and fully supports these changes. We have required each of our Subcontractors to agree to meet all contract requirements as well as provide full transparency on financials. During the development of this proposal we have informed them of these new requirements; nearly every Subcontractor has complied. Upon award, if we do not have compliance with any Subcontractor, WellCare of Kentucky will seek an alternate vendor and will submit such vendor for DMS approval in advance.

Prior to delegating any functions to a third party, we perform due diligence including a comprehensive assessment to prospectively evaluate the Subcontractor's ability to perform the activities to be delegated. The comprehensive vetting and due diligence process is a

requirement in our delegated subcontracts, and compliance must be demonstrated prior to a delegated Subcontractor becoming active with WellCare of Kentucky. We perform oversight and monitoring of the delegation activities through scorecards, data analysis, focused reviews, and annual audits. We develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and the Contract. All pre-delegation audits for new Subcontractors are based on the National Committee for Quality Assurance (NCQA), and state and federal requirements.

We will not delegate to an entity unless it achieves a successful passing score on its pre-delegation audit. Our pre-delegation audit process confirms the Subcontractor has the structural elements, i.e. policies, procedures, staff, licensure, etc., in place to comply with all of the contractual requirements for the functions assigned to them.

Additionally, Subcontractors have to comply with the expectations of the company on an ongoing basis. After delegation, the team continues to monitor performance. In addition to the confirmation, we require the submission of supporting documentation to demonstrate compliance. Examples of documentation may include codes of conduct, compliance policies, copies of training materials, training rosters, etc. WellCare of Kentucky's extensive oversight of Subcontractor performance reflects our commitment to deliver high quality services and our understanding that Subcontractors' performance is a reflection of WellCare of Kentucky's focus on quality. Weekly operations oversight consists of meetings with our vendors to review key performance indicators, perform joint root cause analysis, and discuss opportunities to improve processes. The Quarterly Joint Operating Committee (JOC) meetings are used as a higher-level status check and to set strategy for subsequent efforts.

TECHNOLOGY SUPPORT VIA C360

Our approach to addressing subcontractor performance via a progressive escalation process is supported by our compliance management system, C360. C360 manages all elements of the audit and oversight process, including communications, documentation and evidence, and the automatic assignment of corrective action plans (CAPs) for non-compliant elements. It also provides transparency to all management levels involved in the oversight of subcontractors and enables accurate tracking and reporting. Standard reporting includes monitoring and auditing activities performed, status of audits and monitoring plans, metrics on outstanding CAPs, and trending of subcontractor performance through scorecards.

b. Describe how the Vendor will ensure responsiveness of its Subcontractors to all requests from DMS for reporting, data and information specific to operation of the Medicaid managed care program. How will Subcontractors be held accountable for a delay in or lack of response?

ENSURING RESPONSIVENESS

Our Subcontractor Oversight Team led by Rebecca Randall is supported by multiple subject matter experts across our company. As part of their negotiating and contracting processes, our National Network Performance Team ensures all required state contract standards are included in our subcontracts, and they also align these standards with monetary performance incentives and penalties. This ensures our subcontractors are held accountable for state requirements and

timeliness standards for reporting of data. In addition, our Network Performance Team handles initial subcontractor onboarding, including orientation to our processes and expectations, completion of pre-delegation documentation, and coordination of pre-delegation audits. This ensures that our subcontractors have adequate knowledge of WellCare of Kentucky processes and have been given clear and concise expectations. Finally, our Team uses their national purchasing experience to identify best practices from other markets so that they can be incorporated to improve our operations and quality of care. They also periodically re-procure our subcontracts to ensure we are partnering with the strongest organizations and obtaining the best value for the subcontracted services.

ACCOUNTABILITY

WellCare of Kentucky selects highly-qualified Subcontractors to complement and enhance the services we provide to our enrollees and providers. Our approach to establishing and monitoring service level agreements is based on our thorough contracting process, rigorous upfront screening process, and comprehensive ongoing review process. Service level agreements are established to ensure compliance with the Commonwealth of Kentucky and DMS' contractual requirements for covered services, as well as alignment with the key goals for the Program (e.g. Quality Performance Measures).

WellCare of Kentucky takes steps to insure our Subcontractors are responsive to all requests from DMS by including a schedule of regulatory reports in their contract with which they have to comply; this schedule contains deadlines for DMS reporting and data requirements. As part of the contract, we assign penalties including financial damages for non-compliance.

WellCare of Kentucky manages complete and timely data including encounter data from our subcontractors using several methods. Our contracts have specific language detailing the requirement for data submissions. Encounter transactions must meet standard rules set by the SNIP edits as well as comply with all state and federal validation guidelines. Any encounter that does not meet these requirements is reviewed, adjusted, and resubmitted by the subcontractor within thirty days of the initial notification of rejection. Our subcontractor submits 100% of all encounters to us within 90 days from date of service, with an overall acceptance rate of no less than 95% or as superseded by specific state or CMS Service Level Agreement. This scoring will be monitored monthly and aggregated annually using the Encounter Scorecard Monthly reports.

Monitoring SMMC service level agreements begins with ensuring they are clearly documented in our contract with our subcontractor. Our Subcontractors are held as accountable as our internal business partners. As previously discussed, our Network Performance Team includes these requirements in our contract as part of the negotiation process. These contract agreements also include giving Subcontractors a schedule on regulatory reports that they have to comply with, which contain deadlines for DMS reporting and data requirements. As part of the contract, penalties, including financial damages for non-compliance, are defined. An example of this was a recent situation in which our Transportation provider in our Florida market did not show for a scheduled trip causing our Enrollee to miss the medical appointment. As this is ultimately Staywell’s responsibility (our Florida health plan), we received a Liquidated Damage from the Agency. However, per our Subcontractor Oversight process, we “passed through” the Liquidated Damage to our subcontractor. More importantly, we required them to

implement a remediation plan that identified alternate transportation providers for this Enrollee, while reducing overall reliance on the provider who failed to show. Staywell also opened an IAP to track it to completion.

WellCare of Kentucky's Regulatory Affairs and Compliance Team imposes corrective action plans on delegated subcontractors as necessary and monitors their completion. If a subcontractor fails to remediate the deficiency underlying the corrective action plan, we impose disciplinary actions up to and including termination of subcontractor. WellCare of Kentucky's Regulatory Affairs and Compliance Team's activities are managed through the company's governance tool, Compliance 360 (C360), which enables accurate tracking and reporting.

c. *Provide a listing, including roles and locations, of known Subcontractors that will support the Contract resulting from this RFP.*

WellCare of Kentucky's subcontractors for the January 2021 contract **have complied with all proposed contract and RFP requirements**; current subcontractors who did not comply have been removed from our proposed January 2021 list.

The table below is a list of subcontractors for WellCare of Kentucky.

Table C.1-1 WellCare of Kentucky Subcontractors

Subcontractor	Role	Location
Aarete, LLC	Analytics, market intelligence, and implementation support	200 E. Randolph Street, Suite 3010 Chicago, IL 60601
AdminisTEP, LLC	Clearinghouse services for claims and real-time transactions	2600 Technology Drive, Suite 700, Plano, TX 75074
Advanced Medical Reviews, LLC.	Physician level independent peer review	600 Corporate Pointe, Suite 300 Culver City, CA 90230
All Asian Group	Translation services	18-44 College Point Blvd. College Point, NY 11356
Avesis Third Party Administrators, Inc.	Vision management services and dental management services	10324 S. Dolfield Road Owings Mills, MD 21117
BCS Investment Group, LLC, dba Kaleidoscope Services	Print and fulfillment	121 Anclote Blvd Tarpon Springs, FL 34689
Brand dba Study Hall Research	Focus Group Research	4409 West El Prado Blvd., Tampa, FL 33629
C3/CustomercontactChannels Inc.	Call Center	Huntington Square I 3400 Lakeside Drive, Suite 515 Miramar, FL 33027

Subcontractor	Role	Location
CareCentrix, Inc.	Post-acute care services/ Readmissions Management Services	20 Church Street, Suite 1200 Hartford, CT 06103
CareerArc	Career service & employment and training support for our enrollees	3400 W. Olive Ave., Ste. 220 Burbank, CA 91505
CIOX Health	Chart retrieval/HEDIS chart copy services	925 North Point Parkway, Suite 350 Alpharetta, GA 30005-5214
Cobalt Therapeutics, LLC	Behavioral health website training for Enrollees	55 Nod Road, Avon, CT 06001
Common Health Corporation, Inc. dba Center Care Health Benefit Programs	Credentialing	800 Park Street Bowling Green, KY 42101
Comprehensive Health Management, Inc.	Management services	8735 Henderson Road, Building #2 Tampa, FL 33634-1143
Concentrix Corp. (f/k/a IBM Daksh Business Process Services PVT Ltd)	Claims processing	2000 Wade Hampton Blvd. Greenville, SC 29615
Conduent Credit Balance Solutions, LLC (Formerly CDR Associates, LLC)	Claims overpayment recovery	307 International Circle, Suite 300 Hunt Valley, MD 21030
Cotiviti, LLC	Data mining and medical chart review recovery	One Glenlake Parkway, Suite 1400 Atlanta, GA 30328
Council for Affordable Quality Healthcare, Inc.	Source for Provider self-reported data	2020 K Street, NW, Suite 900 Washington, DC 20006
CSI Southeast, Inc., d/b/a Interpretek	Sign language interpretation	75 Highpower Road Rochester, NY 14623
CVS - CaremarkPCS Health, LLC	Pharmacy benefit manager (PBM)	One CVS Drive Woonsocket, RI 02895
Devlin Consulting, Inc.	Overpayment recovery of claims through data mining	5505 W. Chandler Blvd, Suite 20 Chandler, AZ 85226
Direct Technologies, Inc.	Print and fulfillment	600 Satellite Blvd Suwanee, GA 30024
Drynachan, LLC dba Advance	In-home assessments	4055 Valley View Lane, Suite

Subcontractor	Role	Location
Health		400 Dallas, TX 75244
Eliza Corporation	Interactive voice recognition – Enrollee risk assessments	5615 High Point Drive Irving, Texas 75038
Elahi Enterprises dba Akorbi	Visually and hearing impaired translation services	6504 International Pkwy, Suite 1500 Plano TX 75093
Episource, LLC	Medical Records Reviews	500 W. 190th Street #400 Gardena, CA 90248
eviCore (f/k/a CareCore National, LLC)	Utilization management	400 Buckwalter Place Blvd. Bluffton, SC 29910
Equian (fka First Recovery Group)	Third party liability - subrogation	5975 Castle Creek Pkwy N Dr. Indianapolis, IN 46250
FiServ Solutions Inc.	Print Fulfillment	255 Fiserv Drive Brookfield, WI 53045
Focus Health Inc.	Behavioral health utilization management	10801 Starkey Road #104-101 Seminole, FL 33777
GeBBs HealthCare Solutions, Inc.	Medical Records	600 Corporate Pointe, Suite 1250 Culver City, CA 90230
Good Measures, LLC	Diabetes Prevention Program	30 Rowes Wharf, Suite 410, Boston, MA 02110
Health Help, LLC	Utilization Management	16945, Northchase Drive, Suite 1300 Houston, TX 77060
Health Management Systems, Inc.	Third party liability – coordination of benefits, credit balance and data mining	5615 High Point Drive Irving, TX 75038
Healthy Profits, LLC dba Heal Pros, LLC	Provides diabetic retinopathy examination services	3500 Piedmont Rd NE Ste 325, Atlanta, GA 30305
Human Arc Corporation	Outreach enrollment services	16260 N 71st Street, Suite 350 Scottsdale, AZ 85254
InfoMedia Group, Inc. d/b/a Carenet Healthcare Services	24/7 nurse line	11845 IH 10 West, Suite 400 San Antonio, TX 78230
Inovalon, Inc.	HEDIS AdvantageTM services	4321 Collington Road Bowie, MD 20716

Subcontractor	Role	Location
Krames/Staywell	Print fulfillment	800 Township Line Road Yardley, PA 19067
Mobile Medical Examination Services, Inc.	Home Bone Mineral Density Screening Program	1241 East Dyer Road Suite 145 Santa Ana, CA 92705
Multilingual Group	Written translation services	18-44 College Point Blvd. College Point, NY 11356
Novu, LLC	Enrollee wellness reward program	5401 Gamble Drive, Suite 300 St. Louis Park, MN 55416
O'Neil Data Systems, Inc.	Print services	12655 Beatrice Street Los Angeles, CA 90066
OptumInsight fka Ingenix	Payment Integrity, Claims editing, Credit Balance Audit	11000 Optum Circle Eden Prairie, MN 55344
Payspan, Inc.	File Processing, Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA), Online Archive, Print Services	7751 Belfort Parkway, Ste 200 Jacksonville, FL 32256
Prest and Associates, Inc.	Physician utilization review and independent review	401 Charmany Dr., Suite 305 Madison, WI 53719
Progeny Health, Inc.	Utilization Management/ Neonatal Medical Management Services	450 Plymouth Rd, Suite 200 Plymouth Meeting PA 19462
Revel Health, LLC fka HealthTel	Inbound/outbound HRA and health care communications	123 North 3rd Street, Suite 605 Minneapolis, MN 55401
RJ Health International Systems, LLC	Web based portal for RX claims	237 Main St., First Floor Middletown, CT 06457
Rodael Direct, Inc. dba Genesis Direct	Creative services, print and production, fulfillment and shipping services	8514 Sunstate Street Tampa, FL 33634
R.R. Donnelley & Sons Company	Print services	35 West Wacker Drive Chicago, IL 60601
SPH Analytics (f/k/a Patient Satisfaction Plus, LLC, d/b/a The Myers Group)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys	11605 Haynes Bridge Road, Suite 400 Alpharetta, GA 30009
Syrtis Solutions Ltd.	Third party liability – verification of benefit eligibility	1601 Rio Grande, Suite 330 Austin, TX 78701
The Results Companies, LLC	Customer service	100 N.E. 3rd Ave, Suite 200 Fort Lauderdale, FL 33301

Subcontractor	Role	Location
TPUSA, Inc. d/b/a Teleperformance	Customer service	5295 S. Commerce Drive, Suite 600 Murray UT 84107
Transaction Applications Group	Claims processing and adjudication	7950 Legacy Drive, Suite 900 Plano, TX 75024
Translation Station	Interpreter services – physicians' offices	3460 Chamblee Dunwoody Way Atlanta , GA 30341
Transunion Corp.	Third party liability – claims	555 West Adams Street Chicago, IL 60661
TurningPoint Healthcare Solutions, LLC	Orthopedic Utilization Management	59 Skyline Drive, Ste 1100, Lake Mary, FL 32746
Virtual Frameworks, Inc. d/b/a Virtual Health	IT platform for care management	115 Fifth Avenue, 2nd Floor New York, NY 10003
Voiance Language Services	Grievance letter translation services	2650 E. Elvira Road, Suite 132, Tucson, AZ 85756
Wellsource	NCQA certification PHM4	8100 SW Nyberg Street, Suite 450 Tualatin, OR 97062

d. Describe the relevant experience of each Subcontractor. Indicate whether the Vendor has subcontracted with the entity for prior contracts of similar size and scope.

WellCare of Kentucky's current subcontractors are expected to continue to provide service under the new contract and each subcontract will be modified to explicitly hold each subcontractor to the same terms and conditions in WellCare of Kentucky's contract with DMS.

Aarete, LLC	
Relevant Experience	Aarete brings experience and depth from our work supporting other government sponsored payers. They use this experience to help bring forth ideas and implementation support to WellCare of Kentucky. All parties involved are focused on ensuring WellCare of Kentucky continues to provide high quality care for the Enrollees while also engaging providers in supporting those efforts.
Prior Contracts	Yes

AdminisTEP, LLC	
Relevant Experience	AdminisTEP has deep experience providing support for back-office

AdminisTEP, LLC	
	healthcare business functions through a secure, efficient, transparent web-based portal allowing easy operate our fully customizable data exchange platform.
Prior Contracts	Yes

Advanced Medical Reviews, Inc.	
Relevant Experience	Advanced Medical Reviews had provided physician peer review services since 2005. Advanced Medical Reviews handles approximately 187,000 peer reviews annually. Advanced Medical Reviews performs peer reviews for many nationwide and regional health plans.
Prior Contracts	Yes

All Asian Group	
Relevant Experience	All Asian Group specializes in translating into all Asian, Oriental, Arabic, and languages only. Translation documents range from Manuals, Directories to Brochures, letters, and flyers for private health insurance companies and other industries. As a language service provider, All Asian Group provides document translations and desktop publishing services into all Asian and Oriental languages.
Prior Contracts	Yes

Avesis Third Party Administrators, Inc.	
Relevant Experience	Avēsis began managing government dental and eye care benefits in 2006. Now, as a member of the Guardian family, they are responsible for overseeing services on contracts that are more than 25 years old with the State of California's Denti-Cal program. Avēsis and their parent company, Guardian, administer vision and dental benefits for nearly 16 million enrollees across the United States. Most of these enrollees, 66% or 10 million, have employer-sponsored vision or dental plans administered by Guardian. Nearly six million of their covered dental and eye care lives are through government health programs managed by Avēsis. This includes the delivery of services through 43 active contracts with two state governments and 13 national and regional health plans. They currently operate in 20 states and the District of Columbia. A majority of their government program enrollees, 95%, are Medicaid enrollees, while a much smaller percentage are Medicare Advantage/MMP enrollees.

Avesis Third Party Administrators, Inc.	
Prior Contracts	Yes

BCS Investment Group dba Kaleidoscope Services	
Relevant Experience	Kaleidoscope Services is a full service print shop, mail-house, and fulfillment center for purpose driven mail. For over 15 years, we have been a leading provider of HIPAA compliant, purpose driven mail to companies in the healthcare, insurance and financial industries
Prior Contracts	Yes

Brand dba Study Hall Research	
Relevant Experience	Study Hall Research will conduct focus groups to explore and better understand the current state for WellCare of Kentucky Medicaid Enrollees in Kentucky. Learning and insights from the groups will be used to finalize, improve, modify, and optimize WellCare of Kentucky's service practices, products, offerings or other Enrollee-facing initiatives across Kentucky. Research will be conducted in one market in each of the five Kentucky Medicaid regions (as designated by CMS) which are Paducah, Louisville, Bowling Green, Lexington, and Pikeville. Recruiting will be from randomly generated lists of Medicaid Enrollees provided by WellCare of Kentucky. The research is fully HIPAA-compliant and has all necessary WellCare of Kentucky certifications, training and authorizations to interact with such data. Sample questions used by the focus groups are available in the Decision Guide attached to this submission.
Prior Contracts	No

C3/CustomercontactChannels Inc.	
Relevant Experience	C3, a division of Everise has a suite of experience-focused business solutions to craft a winning strategy for clients. Everise CX, a flagship product, nimbly extends premium customer support that seamlessly spans channels, cultures and traditional workplace boundaries - 500,000 time a day. • Omnichannel customer care and loyalty • Multilingual hubs in Asia and Europe • Back Office Support • Content moderation • Social Media Support

C3/CustomercontactChannels Inc.	
	• Home-based Agent options.
Prior Contracts	Yes

CareCentrix National, Inc.	
Relevant Experience	CareCentrix has proven its ability to positively impact cost of care, patient outcomes, and readmission reduction across all lines of business. CareCentrix covers more than 1 million government lives (MA and Medicaid) and over 25 million Commercial lives and have saved our clients over $450,000,000 annually. CareCentrix has driven a 14% reduction in readmissions for a regional MA plan and a 9% reduction in readmissions for a regional Medicaid plan.
Prior Contracts	Yes

CareerArc	
Relevant Experience	CareerArc is an HR technology company that was founded in 2009 with a mission of leveraging modern technology to challenge existing norms in the HR industry and help companies put their people first. CareerArc has worked in various capacities with local workforce investment boards, public entities across the United States, community colleges and four year colleges and private firms to implement jobs/ career development programs.
Prior Contracts	Yes

Common Health Corporation, Inc. dba Center Care Health Benefit Programs	
Relevant Experience	Center Care is a provider-based preferred provider network located in Bowling Green Kentucky that began operations in 1989 serving self-insured employers and health benefit administrators. Since the early 1990's Center Care has contracted with large commercial managed care organizations (MCOs) for provider network and credentialing services in Kentucky. In 2011 Center Care Partnered with WellCare of Kentucky to serve Kentucky's Medicaid population. Center Care was instrumental in building and credentialing our provider network in Kentucky. Today, Center Care is NCQA accredited for provider credentialing and recredentialing services. Center Care presently manages a preferred provider network with over 20,000 physicians, hospitals, and other health care providers located across the Commonwealth of Kentucky; middle Tennessee; southern Indiana; and southern Ohio. Center Care's

Common Health Corporation, Inc. dba Center Care Health Benefit Programs	
	payor customers serve commercial, managed Medicaid, and Medicare Advantage markets.
Prior Contracts	Yes

Conduent Credit Balance Solutions, LLC (Formerly CDR Associates, LLC)	
Relevant Experience	Conduent Credit Balance Solutions, LLC (formerly CDR Associates, LLC.) has been working hospital credit-balance accounts since 1989. Conduent Credit Balance Solutions is a leader in the industry, holding a high reputation amongst the providers and insurers with which it works in conjunction with.
Prior Contracts	Yes

CIOX Health	
Relevant Experience	For 40 years, Ciox has advanced the healthcare industry through better health information management and exchange of health information. Handling over 40 million requests for health information each year for more than a million unique requestors, our tremendous scale drives the necessary insights for Ciox to modernize workflows, facilitate secure access to clinical data, and improve the accuracy and flow of health information. Ciox Health, the industry's largest and most secure health information exchange company, is uniquely positioned to partner with WellCare of Kentucky in HEDIS medical record retrieval operations to capture optimum results and cost efficiencies.
Prior Contracts	Yes

Cobalt Therapeutics, LLC	
Relevant Experience	Cobalt was founded in 2013 and is based on over 20 years of research. Cobalt Therapeutics provides software as a service (SaaS) for digital cognitive behavioral therapy for four conditions.
Prior Contracts	Yes

Comprehensive Health Management, Inc.	
Relevant Experience	Comprehensive Health Management, Inc. (CHMI) is WellCare of

Comprehensive Health Management, Inc.	
	Kentucky's affiliated third-party administrator. Like WellCare of Kentucky, CHMI is a wholly owned subsidiary of WellCare Health Plans, Inc. CHMI provides a variety of administrative services for all of WellCare's managed care plans, such as claims administration, financial and actuarial, legal, human resources, information technology, and other administrative services. It is the employer of record for all WellCare associates.
Prior Contracts	Yes

Concentrix Corp. (f/k/a IBM Daksh Business Process Services PVT Ltd)	
Relevant Experience	Concentrix has been providing service to WellCare since 2007 and has over 16+ years of claims processing experience for other health plans. Our claims processing experience spans over 16+ years and they have been delivering this service for 3 of the Top 10 Health plans, 2 of the leading Blues and a Medicare/Medicaid Major. They do process all type of claims- Medical (Professional and institutional), Dental, Vision, Behavioral Health, Workers Compensation, Student Health, Flexible Spending Account across Commercial and Government plans.
Prior Contracts	Yes

Cotiviti, LLC	
Relevant Experience	Cotiviti, Inc. (representing itself and its subsidiaries and affiliates) is a leading solutions and analytics company that is reshaping the economics of health care, helping clients uncover new opportunities to unlock value. Cotiviti's solutions are a critical foundation for health care payers in their mission to lower healthcare costs and improve quality through higher performing payment accuracy, quality improvement, risk adjustment, and network performance management programs. Cotiviti Holdings was founded as Connolly in 1979 as a provider of payment accuracy solutions to the retail industry and launched retrospective claims accuracy solutions to the healthcare industry in 1998.
Prior Contracts	Yes

Council for Affordable Quality Healthcare, Inc.	
Relevant Experience	Since the mid-2000s, CAQH has worked to simplify provider-health plan relationships. CAQH developed what is now known as CAQH ProView, is

Council for Affordable Quality Healthcare, Inc.	
	the trusted source and industry standard for self-reported provider data. More than 1.8 million physicians, chiropractors, nurses, and other professional providers nationwide have created and attested to profiles in CAQH ProView. Each month, 10,000 new providers begin using the CAQH ProView system. The comprehensive data set entered by these providers, which contains more than 225 data elements - including credentialing, enrollment, provider directory maintenance, and claims - powers a variety of critical processes for more than 900 health plans, hospitals, and other organizations.
Prior Contracts	Yes

CSI Southeast, Inc., d/b/a Interpretek	
Relevant Experience	Interpretek has been providing American Sign Language (ASL) interpreting services since 1993. Michael J. Rizzolo, CEO, founded this service enterprise based on community ASL interpreting in Rochester, NY. Interpretek's parent corporation became operational on September 1, 1993. Today, Interpretek primarily serves 8 metropolitan areas with on-site, community interpreting resources and provides video remote interpreting (VRI) across the United States. Interpretek has been providing services to WellCare since 2009. Over the course of our relationship, Interpretek has provided ASL interpreters to several thousand WellCare enrollees nationwide. The Interpretek team is highly committed to excellent and expedient coordination of services.
Prior Contracts	Yes

CaremarkPCS Health, LLC (CVS)	
Relevant Experience	They are a leading PBM that provides specialty/biotech services, disease management, and other health services related to prescription benefit management. Since first providing PBM services in 1969, they have grown to become a national leader in providing programs currently serving more than 2,000 clients and their enrollees across all 50 states, Puerto Rico, and the Virgin Islands. Through mail, retail, and specialty distribution channels, they administer programs for a diverse client base, including corporations, MCOs, insurance companies, government entities, unions, third-party administrators, and other organizations that pay for health care products and services.
Prior Contracts	Yes

Devlin Consulting, Inc.	
Relevant Experience	Devlin Consulting, Inc. has provided services to WellCare for about 8 years and to health insurers for about 15 years. They consistently find several millions of dollars of overpays that WellCare recovers each year. They do this for several Medicaid states for WellCare as well as their Medicare membership. DCI works closely with internal WellCare staff to ensure they maintain a high quality of work. They do this by interfacing with the corporate recovery team as well as each individual market. This allows us to review payment rate and payment policy issues with WellCare to ensure claims are appropriately priced.
Prior Contracts	Yes

Direct Technologies, Inc.	
Relevant Experience	Direct Technologies is a HITRUST certified organization that provides healthcare materials to enrollees. They have a long-standing partnership with WellCare. They have successfully fulfilled the mandatory Open Enrollment materials for over 12 years.
Prior Contracts	Yes

Drynachan, LLC (Signify Health)	
Relevant Experience	Signify Health, through its wholly owned subsidiaries, Drynachan, LLC and Censeo Health, LLC, and WellCare have been partners since 2012 to perform prospective in-home health evaluations and ancillary services for WellCare's Medicare Advantage and Medicaid populations. Signify Health partners with each of our clients to produce an industry leading robust and compliant in-home health risk evaluation program that delivers the best outcomes and results for both the client and their enrollees. . Since 2016, Signify Health has completed more than 100,000 evaluations in the state of Kentucky.
Prior Contracts	Yes

Eliza Corporation	
Relevant Experience	HMS Eliza has partnered with WellCare since 2006. HMS' Eliza is a set of integrated and coordinated health engagement solutions proven to drive Enrollee action and behavior change. Leveraging data and using a flexible, person-centric approach, Eliza maximizes outreach through multi-modal communications and targeted Enrollee touchpoints. It is

Eliza Corporation	
	the gold standard of Enrollee engagement solutions, proven to reduce healthcare costs, improve outcomes, and enhance Enrollee experience. HMS Eliza enhances Enrollee retention and associated revenue, helps lower costs due to health risks, improves HEDIS, STARS and QRS quality scores, and supports NCQA accreditation.
Prior Contracts	Yes

Elahi Enterprises dba Akorbi	
Relevant Experience	Akorbi has experience understanding CMS regulations, section 1557 ACA regulation, understanding the reporting requirements for state and federal level, Service Level Agreements for Plans, and state requirements which allows us to ensure they are meeting service requirements at all levels. Akorbi has 16 years of health plan experience providing services of interpretation, translations, vetting of linguist and other vendors, compliance training requirements, and testing for vendors and interpreters to ensure all downstream delegates are meeting requirements.
Prior Contracts	Yes

Episource, LLC	
Relevant Experience	Episource is a leader in the medical record coding market, having coded more than 18 million charts over the past 5 years, as well as one of the original companies in this market, dating back to 2006. Having completed projects in all 50 states they have expertise in both federal and state laws that pertain to the work they complete for our clients. Episource guarantees a coding accuracy rate of at least 95%, and utilizes our Senior Clinical Staff to audit at least 20% of every project they complete. This has allowed Episource to earn the business of regional and national health plans such as Anthem, Aetna, United Healthcare, and Humana. Since inception, they have maintained a client retention rate of over 95%, unheard of in this industry.
Prior Contracts	Yes

eviCore (f/k/a CareCore National, LLC)	
Relevant Experience	eviCore healthcare (eviCore) is a leading provider of medical benefits management (MBM) solutions that assist health plans in reducing costs

eviCore (f/k/a CareCore National, LLC)	
	and help patients receive the most appropriate and necessary care based on their clinical presentation. Their MBM expertise gained from 25 years' experience brings their clients practical, innovative, and effective strategies that reduce costs while guiding providers and their patients to higher quality, evidence-based care. With more than 4,900 employees, 9 facilities, and a national presence, eviCore offers 11 major solutions: Cardiology, Comprehensive Oncology, Gastroenterology, Lab Management, Medical Oncology, Musculoskeletal, Post-Acute Care, Radiation Oncology, Radiology, Sleep, and Specialty Drug Management. Relying on our teams of specialized medical professionals and their expert application of advanced technologies, they ensure that each patient receives the right care at the right time. *KENTUCKY EXPERIENCE* Currently, eviCore has the following experience in the state of Kentucky: • 8 current health plan partners • 1.26 million unique Medicaid, Medicare, and commercial lives 284,000 prior authorization requests (from 1/1/2018-6/30/18) • 99% overall provider satisfaction survey (2018 EDGE survey).
Prior Contracts	Yes

Equian (fka First Recovery Group)	
Relevant Experience	Equian consumes a monthly paid claims file, reviewing it to identify cases where a third party is responsible for reimbursement. Notice of WellCare of Kentucky's right of recovery is provided to the third-party insurance company or the attorney handling the Enrollee's case. When settlement proceeds or policy limits are sufficiently reimbursed, the plan is delivered funds and reports, less Equian's contingency fee.
Prior Contracts	Yes

FiServ Solutions Inc.	
Relevant Experience	Fiserv has over thirty years of experience producing and delivering Enrollee ID cards for the health insurance industry. Today, Fiserv works with more than 40 companies in the health insurance industry, including many who provide Medicare and Medicaid services. Fiserv is HITRUST certified and delivered over 100 million ID cards to enrollees in 2018, both electronically and through direct mail services.

FiServ Solutions Inc.	
Prior Contracts	Yes

Focus Health Inc.	
Relevant Experience	FOCUS Health, Inc. is a URAC accredited Independent Review Organization (IRO) that provides peer review services for managed care entities. FOCUS was incorporated in Florida in 2004 and has been continually in operation since that time. They have a panel of over 40 reviewers composed of Board Certified Psychiatrists and Licensed Psychologists with licensure throughout the United States. They provide Medical Necessity and Administrative reviews for multiple health plans across the United States. Their customers include commercial insurance products as well as government funded products (Medicare and Medicaid).
Prior Contracts	Yes

GeBBs HealthCare Solutions, Inc.	
Relevant Experience	GeBBS reviews medical records for WellCare of Kentucky to ensure proper documentation and capture diagnosis for HCC coding. GeBBS Healthcare solutions has been in the Healthcare Service business 14+ years GeBBS codes 40 million charts a year and has over 2,00 medical coders. They bring qualified staff with combined experience of more than 10 years. GeBBS has utilized medical record reviewers to abstract risk adjusted conditions for 10 plus years in the risk adjustment space. GeBBS has worked with more than 3 major plans and over 5 clients in all aspects of risk adjustment reviews. GeBBS has maintained a 98% accuracy rate with outside vendor audits performing the services described above.
Prior Contracts	Yes

Good Measures, LLC	
Relevant Experience	Good Measures has worked with Medicaid populations, public plans, retirees, and community associations in inner cities and rural communities for nearly a decade. This process is part art, part science; our senior team has more than 20 years of experience in this area. . Good Measures has enrolled Medicare members, engaged them in the coaching support of the DPP and Diabetes Self-Management Education

Good Measures, LLC	
	Program, and are starting to see results related to weight loss and AlC reduction.
Prior Contracts	Yes

Health Help, LLC	
Relevant Experience	HealthHelp is a specialty benefit management company that has partnered with WellCare to administer a new quality review program for medical oncology and radiation therapy. HealthHelp has managed the above programs for last nine years for over six million enrollees for multiple national payers with multiple lines of business including Medicare Part C, Commercial, and Medicaid.
Prior Contracts	Yes

Health Management Systems, Inc.	
Relevant Experience	HMS, a wholly owned subsidiary of HMS Holdings Corp. (Holdings), delivers the broadest range of solutions in the industry to improve financial and health outcomes for at-risk organizations. Incorporated in 1974, HMS began providing comprehensive overpayment recovery and cost avoidance services for large-scale healthcare programs in 1985. Throughout their more than three decades of experience, they have developed and acquired the specialized resources required to support our clients' efforts to maintain the financial integrity and program integrity of its healthcare plans. Today, the more than 2,500 employees of Holdings and its subsidiaries work to apply our proven best practices to save state government agencies and other healthcare program clients billions of dollars through comprehensive cost containment solutions. Their current clients include more than 40 state Medicaid agencies, more than 290 health plans, three federal agencies, and 650 employer groups. Seventeen HMS service specialists currently work to fulfill the requirements of our WellCare contracts.
Prior Contracts	Yes

Healthy Profits, LLC dba HealPros, LLC	
Relevant Experience	HealPros will provide mobile diabetic retinopathy examination screenings (DRE) and Self-Administered ALC Kits, FIT Kits, Micro Albumin Kits, and related supplemental services that cover the

Healthy Profits, LLC dba HealPros, LLC	
	processing of the images and the reporting of results. DRE screenings use non-mydriatic fundus or scanning laser ophthalmoscope cameras as part of an overall effort to improve HEDIS Stars measures related to gaps in care for diabetic Medicare Advantage, Medicaid and/or Commercial members.
Prior Contracts	No

Human Arc Corporation	
Relevant Experience	Human Arc has served enrollees with enrollment and eligibility in government programs for more than 30 years and contracts with Medicaid MCOs in more than 30 states. As part of our continuous education process, they remain up-to-date with Medicaid federal and state regulations and are cognizant of proposed rule changes. Their research team keeps us informed of such changes on a monthly basis. Since 1984, Human Arc has helped millions of patients and health plan enrollees with low or no income, those who are aged, and those with disabilities to enroll in government-funded assistance programs. In February 2017, they became a wholly owned subsidiary of Centauri Health Solutions, Inc. This acquisition facilitated the implementation of technology enhancements designed to improve collaboration and achieve data-driven results for our clients.
Prior Contracts	Yes

InfoMedia Group, Inc. d/b/a Carenet Healthcare Services	
Relevant Experience	WellCare has partnered with Carenet since 2011 and together, they help over 3 million enrollees in 22 states stay healthy and happy. Specifically, in Kentucky, Carenet started providing 24/7 Nurse Advice Line services for 460,000 Medicaid and Medicare enrollees in 2011. For 30+ years, Carenet has provided solutions that help healthcare consumers make better decisions while improving the quality and cost of care. The company was established in 1988 as a patient-management operation within a large Texas-based hospital system. Recognizing Carenet's untapped potential and the growing need for more accessible, affordable care management solutions, a group of private investors purchased the company in 2004. Today, by combining a deep clinical history and consumer engagement expertise, Carenet helps over 100 healthcare organizations maximize performance while educating, empowering and motivating more than 50 million consumers across the United States, the District of Columbia and Puerto Rico.

InfoMedia Group, Inc. d/b/a Carenet Healthcare Services	
Prior Contracts	Yes

Inovalon, Inc.	
Relevant Experience	Inovalon has supported WellCare in quality measurement and reporting since 2012. During this time, they have developed an understanding of the health plan's data, state reporting requirements, and business processes and goals. Additionally, with almost decades of proven success delivering quality outcomes measurement analytics to 74 percent of the market, Inovalon provides a client-focused, NCQA-certified solution to help WellCare meaningfully improve their organization's quality measurement and reporting requirements.
Prior Contracts	Yes

Krames/Staywell	
Relevant Experience	StayWell serves thousands of payer and provider organizations throughout the country, and they impact more than 100 million people annually. Our prestigious client list includes national payer organizations, prominent medical centers, health system and hospitals as well as health care professionals, employers, retail pharmacies, government agencies and association clients.
Prior Contracts	Yes

Mobile Medical Examination Services, Inc. (MedXM)	
Relevant Experience	Through MedXM's partnership with Quest Diagnostics they have access to over 3500 medical professionals who share consistent person-centric care ethics and 2200 Patient Care Centers nationwide. At MedXM, a Quest Diagnostics Company they customize our approach for each health plan to address the differing needs of its population. A national leader in design and implementation of preventive care technology and health risk assessments, MedXM believes that only a tailored approach based on Enrollee geography, economics, language, and social background could yield optimal results for the plan. This has led to our industry-leading success rate.
Prior Contracts	Yes

Multilingual Group	
Relevant Experience	Multilingual has been providing document translations and desktop publishing services since 2010. With capabilities for translating into all Romance, Oriental, Arabic, and other European languages, Multilingual specializes in Spanish and Asian languages, housing our All Spanish and All Asian departments to handle these requests. Translation documents range from Manuals, Directories to Brochures, letters, and flyers for private health insurance companies and other industries.
Prior Contracts	Yes

Novu, LLC	
Relevant Experience	NovuHealth designs programs that drive and motivate high value health care activities among hard to move populations. This process requires consulting based on business objectives, ingesting complex data sets to create segmented targets, creating multi-channel options for enrollees to engage in, as well as rewards, both financial and intrinsic incentives, to increase activation and drive behavior change.
Prior Contracts	Yes

O'Neil Data Systems, Inc.	
Relevant Experience	O'Neil is one of the largest providers of data-driven, Enrollee communications for the managed healthcare industry. Every day O'Neil repurposes, produces, and delivers millions of time sensitive Enrollee communication documents in both electronic and paper format. O'Neil has three production facilities located in Los Angeles, CA, Plano, Texas, and Monroe, North Carolina. O'Neil currently has approximately 497 employees company wide. O'Neil specializes in all aspects of managed healthcare Enrollee communications including commercial, Medicare, Medicaid, individual membership, and pharmacy benefit management communications. O'Neil is knowledgeable and understands current government and CMS requirements and solutions in place to assist its clients in their communications with their enrollees, and keep clients in compliance with applicable laws and regulations.
Prior Contracts	Yes

OptumInsight fka Ingenix	
Relevant Experience	Optum Insight's credit balance business was developed in 1995 in conjunction with Optum payer and provider clients to better resolve credit balance accounts for hospitals and health systems on behalf of health insurance plans. Optum continued client relationships with a 95% retention rate and more than 1,700 hospitals and health systems have allowed a strong footprint to be established where they work with Revenue Cycle Operations and Patient Accounts personnel daily. Optum's relationships in the provider community have allowed Optum to receive greater levels of detailed provider data. With that data, Optum has implemented proprietary business intelligence technologies increasing Optum efficiency by automating the resolution of credit balances and increasing recovery amounts to health insurance plans while decreasing recovery timelines.
Prior Contracts	Yes

Payspan, Inc.	
Relevant Experience	Payspan is a payments technology company founded in 1985 to facilitate payments through secure check and electronic methods. Initially Payspan's emphasis was on business-to-business payments for such banking partners as Wachovia, PNC, and Suntrust banks. Payspan began facilitating payments to healthcare providers for Wellcare in 2007 and the companies have been valued partners since that time. Payspan's payment network to healthcare providers is the largest in the U.S. and facilitates over $1 billion in claim payments for 600+ health plans every four days.
Prior Contracts	Yes

Prest and Associates, Inc.	
Relevant Experience	Prest & Associates is the oldest and one of the largest independent review organizations specializing in psychiatry, addiction medicine, and behavioral healthcare. Susan R. Prest, M.A. and James Richard Prest, M.D. founded the company in 1991 to apply their vast administrative and clinical experience to improve quality of care and protect patients' rights through the independent review process. Prest & Associates, LLC has had a longstanding relationship with WellCare and it has always been a positive one.
Prior Contracts	Yes

Progeny Health, Inc.	
Relevant Experience	ProgenyHealth is a mission-driven company with a multidisciplinary team of innovators dedicated exclusively to solving the clinical, economic, and social challenges inherent in the management of premature and medically complex newborns. Doing so successfully requires a comprehensive, person-centric UM/CM program, executed by NICU-specialists, adaptable to the changes in the healthcare system, and aligned to provide the individualized support each entity needs to drive the best possible health outcomes for each infant. ProgenyHealth has over fifteen years of experience, exclusively focus on premature and medically complex infants, with more than 65,000 NICU admissions managed to-date within the Medicaid managed care and commercial markets.
Prior Contracts	Yes

Revel Health, LLC fka HealthTel	
Relevant Experience	Revel Health conducts inbound and outbound member communication on behalf of WellCare related to specific Programs selected by WellCare such as Health Risk Assessments, Flu Vaccine Reminders and others. All member-facing communications are branded as WellCare and content of all communications are approved by necessary internal and external approval bodies. All data shared with Revel or collected by Revel is securely stored and managed. Revel Health has been in business for 12+ years with an exclusive focused on working with health payer organizations to engage their members in health action Programs. In our 12 years, we have not lost any customers and continue to grow year over year.
Prior Contracts	Yes

RJ Health International Systems, LLC	
Relevant Experience	RJ Health Systems International, LLC was incorporated in 1983 in the State of Connecticut. They are currently located at 237 Main St., First Floor, Middletown, CT 06457. They participate in the drug information sector, referred to as a pharmaceutical information consulting firm. RJ Health Systems International, LLC is engaged with over 250 clients, including state agencies, healthcare professionals, MCOs, Pharmacy Benefit Managers, and pharmaceutical manufacturers. RJ Health Systems International, LLC launched its current portfolio of database products in 2000, servicing markets relating to medical drug claims adjudication. Their product portfolio represents 19 years of

RJ Health International Systems, LLC	
	application and convergence of client requests to provide a comprehensive and reliable library of drug intelligence.
Prior Contracts	Yes

Rodael Direct, Inc. dba Genesis Direct	
Relevant Experience	Genesis has been in business for over 20 years serving many clients nationwide. The work Genesis does for WellCare, allows WellCare of Kentucky to connect with their enrollees and prospective enrollees in more meaningful ways through programs such as AEP and ANOC. Our relationship with WellCare has been built over years of meeting and exceeding expectations and delivering a quality, consistent product. Working with WellCare, they have built and refined their integrated direct-mail marketing platform based on trust and confidence.
Prior Contracts	Yes

R.R. Donnelley & Sons Company	
Relevant Experience	RRD is a 14 plus year partner to WellCare in creating, producing, and fulfilling CMS related Medicare and Medicaid Enrollee communications. As a subcontractor to WellCare, RRD manages many state specific daily data driven Enrollee material communication programs. RRD's national geographic footprint of production facilities allows for "in state" or "near state" fulfillment of Enrollee communication materials. This enhances the speed to market of required or requested communications to WellCare's enrollees. In summary, RRD understands the importance of Security, Compliance, and Accuracy of Enrollee data and communications. RRD has strict measures and programs in place for security, proprietary tools that support compliance requirements and technology driven workflows that process data accurately, quickly, and securely.
Prior Contracts	Yes

SPH Analytics (f/k/a Patient Satisfaction Plus, LLC, d/b/a The Myers Group)	
Relevant Experience	SPH Analytics has been providing insights to clients for more than 25 years and serves payer and provider clients in all 50 states. Overall, SPH Analytics' solutions are used by more than 1,300 provider facilities and more than 300 health plans. They manage data for more than 44

SPH Analytics (f/k/a Patient Satisfaction Plus, LLC, d/b/a The Myers Group)	
	million patients/enrollees daily, and they conduct over 16 million experience surveys per year. They embrace initiatives and solutions to meet all three aspects of the Triple Aim framework; namely improved population health, cost of care, and Enrollee experience. SPH Analytics has provided call center support and mail fulfillment services to health plans and provider for more than 20 years, for the purposes of market research, experience surveying, and motivating patients/enrollees to improve their health and close care gaps. With a 100% focus in the healthcare industry, all of their projects relate to improvement of patient outreach, increase in patient loyalty, meeting regulatory CMS/State requirements, and/or reduce outsourcing costs for their clients. Healthcare organizations throughout the nation rely on us for dependable outbound and inbound Live Agent and Interactive Voice Response (IVR) dialing services, data collection, and insightful analysis to continually improve and compete in today's market.
Prior Contracts	Yes

Syrtis Solutions Ltd.	
Relevant Experience	Syrtis has been operating the ProTPL program for over a decade. During this time, Syrtis' cost avoidance and TPL services have been adopted by leading Medicaid fee for service and manages care plans along with the Department of Defense due to its exclusive prospective methodology and the speed in which it delivers active and accurate eligibility data. Syrtis currently processes over 3.5 million eligibility inquires per month for 77 lines of business in 26 states.
Prior Contracts	Yes

The Results Companies, LLC	
Relevant Experience	The Results Companies. LLC (f/k/a Results Technologies. Inc.) is a premier global customer experience provider for Fortune 500 companies and has uniquely designed, built and operated award winning call centers that have set the standard for innovative, customer-focused contact solutions. Results offers a full range of services that include customer service, acquisition, enrollment, retention, membership support services and transaction processing to outbound sales and retention campaigns. Results' success and proven ability to respond to their Partners' growth has enabled the expansion of their global footprint to 20,350 employees in 29 locations in the United States, the Philippines, and Latin America. The Results Companies' expertise extends beyond call centers. Results is an expert

The Results Companies, LLC	
	in people, analytical technologies, brand fulfillment, and creating strategic advantages for its Partners.
Prior Contracts	Yes

TPUSA, Inc. d/b/a Teleperformance	
Relevant Experience	TPUSA has been a vendor for WellCare for over 10 years and several other health plans that cover both Enrollee and provider customer service as well as back office, FAX Auth Work, licensed sales and non-licensed services.
Prior Contracts	Yes

Transaction Applications Group	
Relevant Experience	Transaction Applications Group, Inc., a Nebraska corporation ("TAG") is an Affiliate of NTT DATA Services, LLC. NTT DATA Services, LLC is a wholly owned subsidiary of NTT DATA Corporation, which is headquartered in Japan. NTT DATA provides end-to-end IT services like Business Process Outsourcing, Application Services, Infrastructure Services, etc. to its customers across different industry segments. Within Healthcare business segment, they service over 100 organizations consisting of Health plans, Healthcare Providers, and Life Sciences organizations.
Prior Contracts	Yes

Translation Station	
Relevant Experience	Translation Station, Inc., a woman-owned small business, was founded in 1998 and has grown smartly and steadily over the last 20 years. They have extensive experience in medical interpretation services and many of their customers are healthcare insurers and providers, both small and large. They currently have 10 full-time employees (scheduling team, accounting team, and management) and hundreds of independent contractor interpreters, both certified and experienced, who perform the interpretation services. While they are based in Atlanta, Georgia, they provide services in many states throughout the country. Specifically with regard to WellCare, they provide services in at least 16 states including Kentucky. They have been providing services to WellCare of Kentucky since 2012 and their presence in Kentucky continues to grow. Over time, they have increased their interpreter

Translation Station	
	pool to cover many locations (within Kentucky and beyond), and as such feel confident in their ability to secure interpreters for WellCare requests in both existing markets that they service as well as in any new markets.
Prior Contracts	Yes

Transunion Corp.	
Relevant Experience	TransUnion is a leading global information solutions company. For 50 years, they have provided data, insights, and services to empower businesses, healthcare organizations, government agencies, and consumers to make better financial decisions. Today, they have 7,300 associates working in 33 countries. They generate over $2 billion in revenue annually and are publicly traded on the NYSE (ticker: TRU). Our headquarters is located in Chicago, Illinois.
Prior Contracts	Yes

TurningPoint Healthcare Solutions, LLC	
Relevant Experience	TurningPoint Healthcare Solutions manages the safety and quality of care for 25M insured members in 28 states throughout the country. TurningPoint's program supports the safety and quality of musculoskeletal care that Enrollee's receive. Through their program, TurningPoint enables WellCare to ensure that Enrollees consistently receive evidence based high quality surgical care from their surgeons
Prior Contracts	No

Virtual Frameworks, Inc. d/b/a Virtual Health	
Relevant Experience	HELIOS, Virtual Health's Care Management software platform, enables unparalleled collaboration and coordination with the Enrollee and their care team and provides broad visibility across the healthcare organization. By connecting the entire care team across one integrated ecosystem, WellCare can go beyond traditional care management and drive increased efficiency, transparency, and cost reduction.
Prior Contracts	Yes

Voiance Language Services	
Relevant Experience	Voiance Language Services, LLC is a wholly owned subsidiary of CyraCom International, Inc. With over 20 years of experience supporting healthcare, the company provides 24/7 language services including on-demand over-the-phone interpretation (OPI) and video remote interpretation (VRI) through professional interpreters and linguists which includes over 2,500 employees. The company currently supports over 2,500 healthcare clients, including 4 of the top 5 national health plans and various state health plans, in support of Medicare, Medicaid, Specialty, individual, group, and commercial products. Voiance's provision of service is limited to live-conduit, unified phone and video interpretation services clients need to communicate with Enrollees in a language other than English. Interpreters are trained to serve as a confidential conduit via conference call and communicate what is discussed between agent and end user only.
Prior Contracts	Yes

WellSource	
Relevant Experience	WellSource has been in business for 40 years. WellSource harnesses the power of technology to create scientific, evidence-based health risk assessment solutions and wellness tools that deliver actionable data so health and wellness professionals can achieve better outcomes and compliance. WellSource currently provides its HRA to over 7 million participants; serving 160 clients in 12 countries, 40 US states and employs 28 employees.
Prior Contracts	No

2. Collaboration

C.2. COLLABORATION

a. **Provide a recommended approach for conducting monthly meetings that the Vendor must attend with the Department, other agencies, and other contracted MCOs. In your response, provide the following, at a minimum:**

   i. Meeting formats the Vendor proposes that will result in successful collaboration.

   ii. Examples of issues, ideas, and innovations that the Vendor thinks should be addressed during the initial three (3) to six (6) meetings, the rationale for each, and whether collaboration for each will require implementation of short-term and/or long-term solutions.

b. **Describe lessons learned from similar collaborations that the Vendor has experienced, and how those could be applied in moving forward with monthly meetings.**

C.2. COLLABORATION

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 9.0 Organization and Collaboration of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

As the largest Medicaid plan serving the Commonwealth for nearly a decade, WellCare of Kentucky has been proud to collaborate with DMS, other agencies, and other managed care organizations (MCOs) to advance DMS' goals of a healthier Kentucky through consistent leadership on issues that matter DMS. We know that the only reason we have been successful in Kentucky is through the effective collaboration we have had with our partners DMS and the Cabinet for Health and Family Services (CHFS). We understand that for WellCare to help improve health care for Kentuckians, we desire to build the trust necessary to innovate and transform the system to best serve Enrollees and to meet DMS' goals. In the early years of the program, WellCare established a broad footprint across the Commonwealth with six regional offices and we stood with DMS as the only MCO to maintain a network in Region 8 and to welcome nearly 100,000 Enrollees displaced by a departing MCO. And it is that collaboration and trust that will continue to propel our programs forward as we go into the next contract term, whether it is through the implementation of the new substance use disorder (SUD) Waiver to help Enrollees find a path to recovery, efforts to promote DMS' goals, or initiatives that ease provider administrative burden through shared credentialing activities. Throughout our 8 years in Kentucky, our leaders and locally placed staff have been present with DMS, connecting directly to agency leaders and other MCOs to solve shared operational challenges and lead innovations in clinical and quality outcomes across populations.

With much of our team still in place since the very beginning of launching managed care in Kentucky, we bring a wealth of experience and expertise to collaboration efforts. Under the executive leadership of WellCare of Kentucky CEO Bill Jones, COO Ben Orris, and our Chief Compliance Officer, Rebecca Randall, WellCare's commitment to collaboration starts at the top and integrates through every member of our staff. Our commitment to collaboration is demonstrated in several ways, including but limited to the following examples:

- *Local.* Our staff lives and works in the communities they serve and consistently connects with partners in every region to collaborate on issues unique to those regions.
- *Engaged.* Bill, Ben, Rebecca, and the integrated leadership team today participate regularly with DMS, other agencies, and other MCOs through meetings, forums, ad-hoc discussions, and stakeholder engagements.
- *Responsive.* We have a long history of responding quickly and effectively to the issues raised by DMS. By dedicating Rebecca as the point of contact for DMS and her direct line of accountability to Ben and Bill, we have built an operational structure that facilitates rapid decision-making and the implementation of new solutions.
- *Innovative.* Time and time again, WellCare of Kentucky has been a leading voice during collaborations on key issues. Whether it is helping to expand services for sex offenders or design, build, and implement a solution to help Enrollees re-enter the workforce, WellCare of Kentucky is the go-to plan to lead transformation and change through our collaborative efforts with DMS, other agencies, and the other MCOs.

This experience and expertise has informed the recommendations for ongoing collaborations and meetings, which we have detailed below.

a. Provide a recommended approach for conducting monthly meetings that the Vendor must attend with the Department, other agencies, and other contracted MCOs. In your response, provide the following, at a minimum:

WellCare of Kentucky leadership, including our departmental directors for compliance, behavioral health, population health, quality improvement, pharmacy, and others have regularly participated in ongoing meetings with DMS and other state agencies, such as the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID), the Department for Community Based Services (DCBS), and the Department of Public Health (DPH). While some of these formal workgroups have occasionally been placed on hold, we have always made it a priority to collaborate and inform DMS on key issues, initiatives, and results for our Enrollees in the Commonwealth.

Our leadership team and dedicated staff look forward to continuing that process through the formal meeting structure of the collaborative workgroups. **Figure C.2-1** describes the WellCare of Kentucky leadership team and the various Kentucky-based agencies and meetings we collaborate with to improve healthcare services and processes for all major stakeholders, community partners, and Enrollees.

LEADERSHIP & COLLABORATION

WELLCARE LEADERSHIP TEAM	COLLABORATIVE PARTNERS IN THE COMMONWEALTH
Benjamin Orris, Chief Operating Officer (COO)	The Department for Medicaid Services (DMS)
Howard Shaps, MD, MBA - Medical Director	The Kentucky Cabinet for Health and Family Services (CHFS)
Thea Rogers, PharmD - Pharmacy Director	The Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID)
Jerry Caudill, MD - Dental Director	The Department for Community Based Services (DCBS)
Rebecca Randall, MPA - Chief Compliance Officer	Managed Care Organization (MCO) Colleagues
Marketa Wills, MD - Behavioral Health Medical Director	The Department for Public Health
Lori Gordon - Senior Behavioral Health Director	Advisory Council for Medical Assistance (MAC)
Laura Betten, RN - Quality Improvement Director	Technical Advisory Committee (TAC)
Shannon Maggard - Population Health Director	Monthly Medical Director Meeting

Figure C.2-1 WellCare of Kentucky Leadership and Collaboration

i. Meeting formats the Vendor proposes that will result in successful collaboration.

To ensure successful collaboration with DMS moving forward WellCare of Kentucky's directors and executive leadership team recommends the following meeting formats:

In-Person Meeting Structure. An in-person meeting structure to be hosted at the DMS' office in Frankfort on a monthly basis or as the schedule dictates. With nearly a decade of experience in Kentucky, WellCare of Kentucky knows that taking the time to meet face-to-face with our colleagues, DMS, and other stakeholders provides the best opportunity to collectively come together and discuss the most significant issues and initiatives regarding the Medicaid population.

The following WellCare of Kentucky leadership has participated in ongoing collaborative meetings in the past, with some, such as the Pharmacy Director Workgroup still meeting on a regular basis.

- Ben Orris – Chief Operating Officer (COO)
- Howard Shaps, MD, MBA – Medical Director
- Thea Rogers, PharmD – Pharmacy Director
- Jerry Caudill, DMD – Dental Director
- Rebecca Randall, MPA – Chief Compliance Director
- Marketa Wills, MD, MBA – Behavioral Health Director
- Lori Gordon, LCSW, MBA – SKY Executive Director
- Laura Betten, RN, MBA – Quality Improvement Director
- Shannon Maggard, RN – Population Health Management Director

Targeted, Focused Meeting Groups. We recommend hosting smaller collaborative meetings based on subject matter with a targeted area of focus. This could include quality improvement initiatives, pharmacy solutions for antimicrobial stewardship and the better management of antipsychotics for children, and behavioral health-specific issues such as those pertaining to substance abuse and the ongoing implementation of DMS' SUD Waiver.

In both past and current collaborations with DMS such as the Pharmacy Director Workgroup, we have found that smaller, targeted subject-based meetings allow us to concentrate exclusively on more relatable technical aspects of each subject. A larger combined meeting, consisting of directors across all areas of care, may not adequately allow for enough time or detail for critical matters to be discussed.

With the implementation of this more streamlined structure (which resembles both past and current meeting formats but at a larger scale), we recommend that each workgroup reports their agendas and action steps up to the DMS' Operations Meeting.

This meeting format would allow us to work quickly and efficiently with the smaller, more subject-focused teams on policy development and new initiatives, while also maintaining open communication and sharing MCO updates with the Deputy Commissioner, the Director of Quality Outcomes and Oversight, as well as other Departmental staff. The Operations Meeting, as it does today, would also address high-level issues that require further discussion and escalation for resolution or to formulate next steps.

Regular Department Updates and Timelines for New Policies. At WellCare of Kentucky, our organizational structure promotes autonomy and independent decision-making. This facilitates our ability to maintain a flexible and nimble state of operational readiness that allows us to adapt and prepare for new policies. This process includes ensuring that the proper staffing, infrastructure, and approved processes are in place well before a new project or program begins provided sufficient lead time. Through a better understanding of the DMS' strategy and vision, we can align new program and policy implementations to meet DMS' need and established timelines.

Adhering to Contract Requirements. WellCare of Kentucky representatives attending monthly Operational meetings with DMS will include our Pharmacy Director, Medical Director, Quality Improvement Director, Population Health Management Director, Utilization Management Director, Dental Director, Behavioral Health Director, Compliance Director, or their designees and other appointed staff members, as needed. As a strategic partner to the Commonwealth since 2011, we have years' of experience collaborating with DMS, other Cabinet agencies, and our MCO counterparts and will continue to contribute our experience, staff, and processes to ensure the success of the workgroups, as well as our lessons learned regarding operational best practices.

Our dedicated team, including the aforementioned directors, will be prepared to present best practices for topics identified through collaboration with DMS and other MCOs, as requested. All meetings will be conducted in compliance with applicable federal antitrust laws. We acknowledge that DMS will establish the schedule for the meetings and may increase, cancel, or reduce the meetings, as needed.

EXAMPLES OF SUCCESSFUL COLLABORATIONS WITH THE COMMONWEALTH

The following examples represent some of the successful collaborations between WellCare of Kentucky and DMS.

DMS Operations Meeting. We participate in the monthly Operations Meeting hosted by DMS to discuss pressing issues, new initiatives, reporting, and policy changes. Our leadership team meets regularly to discuss ongoing operational, quality, population health, and utilization metrics, as well as brainstorm ideas regarding administrative, clinical, and process issues that affect WellCare of Kentucky, DMS, other MCOs, and local stakeholders. Our discussions in these meetings have led to several successful collaborations. For example, we recently provided in-depth data analysis that alerted DMS of potential issues with eligibility flags that were driving incorrect cost-sharing information to be published, and opportunities to improve the incarceration periods. Through our collaboration with DMS and their IT partners, we were able to assist with identifying the errors, making the necessary corrections to the state's enrollment system, and ensuring the issues were resolved. This improved the accuracy of the information we received on eligibility files for all Kentucky MCOs, not only WellCare of Kentucky's, which resulted in better service to all the providers and Medicaid Enrollees in the Commonwealth.

Additionally, we recently began presenting our quarterly and annual care coordination metrics and outcomes to DMS at the Operations Meeting; with emphasis on specific programs and initiatives we are implementing to achieve various programmatic outcomes. This presentation covers topics that include a utilization management operational overview for both physical and behavioral health; the top diagnoses, delivering facilities, and admitting facilities for WellCare of Kentucky Enrollees; emergency department utilization, costs, claims, and determent strategies; Enrollee and provider appeals; medication utilization; care and disease management metrics, including top conditions of Enrollees; and updates on all quality initiatives.

Monthly Medical Director Meeting. WellCare of Kentucky attends the monthly Medical Director Meeting to collaborate directly with the clinical leads from DMS and learn about new directives for the Medicaid program.

This meeting includes the following members:

- WellCare of Kentucky Medical Director
- WellCare of Kentucky Behavioral Health Director
- Other MCO Medical Directors
- DBHDID Medical Director
- DCBS Medical Director
- DPH Medical Director

Through our discussions and the project improvement plans (PIP) initiated at these meetings, we have contributed as a thought leader to bring innovative ideas to the table while collaborating with our colleagues to improve the health of all Kentucky Medicaid Enrollees. We cover topics that address significant areas of clinical importance, such as reducing Neonatal Intensive Care Unit (NICU) admissions, pharmacy initiatives, behavioral health issues and whole-person integration, opioid use disorder (OUD), and emergency department utilization, to

name a few. On occasion, we travel as a group to different community hospitals, medical facilities, and universities both in the Commonwealth and out-of-state to engage in clinical summits and to meet with local medical teams. The following examples describe a few of the successful collaborative PIPs initiated by the Medical Director Meeting:

- *Antipsychotic Medication Use in Children and Adolescents.* Running from 2014-2017, the PIP goals aimed to decrease the use of multiple antipsychotics in children and adolescents, decrease the use of higher than recommended dosages, and increase first-line psychosocial care, metabolic monitoring, and follow-up visits.
- *Prenatal Smoking.* Beginning in 2016, the prenatal smoking PIP is still in process, and aims to increase prenatal tobacco screenings and smoking cessation interventions, decrease the number of pregnant women who smoke, and establish and improve the prenatal smoking abstinence rate, as well as the number of prenatal smokers with follow-up care to monitor the success of the cessation interventions.
- *Reducing Potentially Preventable Hospitalizations and ED Visits for Ambulatory Care Sensitive Conditions (ACSC).* Initiated in 2019, the PIP includes ongoing collaborative meetings with DMS, IPRO, and representatives from each of the MCOs. The PIP goals include reducing the percentage of Enrollees (representing all age ranges) with hospitalization or emergency department visits for asthma, COPD, short-term complications of diabetes, and heart failure.
- *Management of Physical Health Risks in the Seriously Mental Ill Population.* We worked with the other MCOs to identify solutions to provide better management of physical health issues (e.g., hypertension, diabetes, asthma) for the serious mental illness (SMI) population. Through increased outreach and integrated care coordination for this population, and the recruitment of new providers throughout the Commonwealth, we saw a significant increase in the application of assessments, screenings, and interventions for physical health conditions.

Participation in MAC/TAC Meetings. WellCare of Kentucky and our leadership team regularly attends and participates in the Kentucky Medicaid Advisory Council (MAC) and the Technical Advisory Committee (TAC) meetings to offer our input, expertise, and recommendations. Consisting of 19 members from associations across the Commonwealth representing the entire continuum of care—dental, pharmacy, nursing, optometry, to name a few—the MAC provides a forum where we not only share valuable lessons, recommendations, and successes but also learn from the expertise and input from the council members and other local stakeholders.

In May of 2019, our Chief Operating Officer, Ben Orris, presented at the MAC on various topics to assist our stakeholders and state agencies with better understanding the value of managed care. The information presented included our care coordination and quality programs, improving health outcomes and access to care, community connections addressing social determinants of health (SDOH), pay-for-quality (P4Q) initiatives, provider partnerships and satisfaction survey results, funding of local programs and initiatives, progress on the integration of physical and behavioral health, and Enrollee service enhancements. Following the formal presentation, Ben fielded several questions from committee members.

On a similar note, we ensure our dedicated market subject matter experts (SME) regularly attend TAC meetings, which focus on more specific topics of interest such as dental, pharmacy, primary care, foster care, and behavioral health to provide focused support, based on years of local expertise and experience, to the various committees.

MCOs Working Together on Shared Project Improvement Plans (PIP)

WellCare of Kentucky has collaborated with the local MCO leadership teams on collaborative PIPs for several issues, including:

- Management of Physical Health Risks in the Seriously Mentally Ill Population
- Antipsychotic Medication Use in Children and Adolescents

Behavioral Health Operations Meeting. Our Behavioral Health Director for Foster Care Dr. Timothy Houchin and Executive Director for Foster Care Lori Gordon, have participated in the former behavioral health operations meetings and continue to provide recommendations to DMS on shared issues. For example, we recently provided an approach for using provider type and specialty fields to distinguish and identify behavioral health services and substance abuse services from non-behavioral health services. Throughout our participation in the operations meetings, we regularly presented on the topics of network adequacy, performance improvement plans (PIP), community advocacy, behavioral health and substance abuse expenditures, and utilization and payment measures. Working collaboratively with the other local MCOs in the Commonwealth, we developed the following tools and resources:

- *Managing Physical Health Risks in the SMI Population.* Together, we developed a behavioral health reference and resource toolkit for primary care providers (PCP) with recommended monitoring and screening; a provider assessment form for communication between providers; revised clinical practice guidelines (CPG) for SMI; and educational material for Enrollees with SMI and their friends and families.
- *Managing Antipsychotic Medication Use in Children and Adolescents.* Together, we developed a CPG for atypical antipsychotics in children and adolescents; a provider assessment, screening, and monitoring tool; educational mailings on assessment, treatment, and follow-up care to families with Enrollees newly prescribed an antipsychotic medication; and educational mailings to providers.

Leadership in Foster Care. Led by the future SKY Provider Relations Liaison Leann Magre, WellCare of Kentucky currently serves the single largest concentration of Foster Care and Adoption children across the Commonwealth. **With approximately 8,000 children under our care and guidance, we often know these children and their personal histories, goals, and barriers better than anyone else.** LeAnn has personally championed on behalf of our foster care children and their caregivers, and along with our dedicated team of professionals has worked closely with the Department of Community Based Services (DCBS) and other state agencies, such as the Child Review Program (CRP), on shared goals and program recommendations for nearly a decade. Under her direction, WellCare of Kentucky provides program recommendations to DCBS upon request and has developed formalized training for DCBS guardians and families to facilitate their understanding and access to all MCO resources.

Leadership in Pharmacy Initiatives. The currently active Pharmacy Director Workgroup has proven to be one of our most successful collaborative efforts with DMS to date. Our Pharmacy Director, Thea Rogers, PharmD, participates in monthly meetings focused on identifying and resolving some of the most pressing pharmacy-related issues affecting both DMS and the MCOs in the Commonwealth. Through this collaboration, we have worked on many successful initiatives, including developing uniform prior authorization criteria for buprenorphine and Hepatitis C, the creation of standardized pharmacy management dashboard for shared metrics and trending, and a streamlined policy communication process for informing local pharmacists. Most recently, we have initiated discussions with DMS regarding specific pharmacy cost outliers and identifying less costly medication alternatives to decrease wasteful spending.

ii. Examples of issues, ideas, and innovations that the Vendor thinks should be addressed during the initial three (3) to six (6) meetings, the rationale for each, and whether collaboration for each will require implementation of short-term and/or long-term solutions

The following section includes the issues, ideas, and innovations proposed by the WellCare of Kentucky leadership team as topics to be addressed during the initial three to six collaborative meetings with DMS. We acknowledge that meetings will be used to consider issues such as opportunities to improve health outcomes of Enrollees, addressing SDOH, and efforts for population health management.

Our leadership team chose to have our clinical and administrative thought leaders focus on four in-depth issues that significantly affect MCOs, our government partners, local stakeholders, and Medicaid Enrollees in the Commonwealth. The topics include both our ideas regarding the subject matter and innovations that are either currently available or that we believe are needed to address the issue. As requested, each example includes our rationale and addresses whether or not the collaboration requires the implementation of short-term or long-term solutions.

#1: ADDRESSING SUD AND THE OPIOID EPIDEMIC

Rationale

Substance abuse, particularly the diversion and abuse of prescription drugs, along with heroin and fentanyl, remains one of the most critical public health and safety issues facing the Commonwealth today. Over the past decade, the number of drug-related overdoses has been steadily on the rise in Kentucky—devastating families and communities, stretching social services resources, and negatively impacting economic growth. As part of DMS' SUD Waiver, WellCare of Kentucky is contracting with the 22 methadone clinics across the Commonwealth to increase access to medication-assisted treatment (MAT).

In addition, one of the many tragic results of the opioid epidemic is the ongoing impact of its effect on parents and their ability to safely care for their children. Unfortunately, this has caused a significant increase in the rise of children in the foster care system nationwide. From 2012 through 2015, the Commonwealth experienced a 13% increase in parental substance use as the primary reason for removing children from their homes and their families—the single largest reason for children removed from their homes and the largest percentage increase.

Children in foster care have an increased risk for SUD given their family history and the trauma experienced from watching their parents use drugs.

Implementation of Short-Term and Long-Term Solutions

Short and Long-Term Solutions

- Contract with the 22 methadone clinics across the Commonwealth as part of the implementation of the new SUD Waiver
- Collaborate with DMS and the other MCOs on the successful transition of new provider type categories developed for the SUD Waiver. This process includes discussing initiatives for provider education and identifying new providers through proactive outreach that can contribute services that support the SUD Waiver
- Collaborate with DMS, the University of Kentucky (UK), the CHFS, opioid use disorder (OUD) providers, and other MCOs in the Commonwealth on new initiatives
- Leverage our support, resources, and continued funding for treatment programs across the Commonwealth to contribute to the Commonwealth's goal of reducing overdose deaths by 40% over three years across the 16 counties from the Helping End Addiction Long-Term (HEAL) study
- Leverage our ACT for Opioids Program—a comprehensive suite of opioid misuse prevention and treatment program components, including expanded access to MAT treatment, evidence-based pharmacy point of sale (POS) edits for prescribing opioids, a low back pain management program, and predictive analytics to identify Enrollees at high risk for opioid misuse
- Continue developing our partnership with the Court Appointed Special Advocate (CASA) network to identify potential interventions to address opioid issues within the foster care system. By April 11, 2019, three focus groups will have completed with CASA in northern Kentucky, Louisville, and Lexington

Strategic Partners and Key Stakeholders

- CHFS
- University of Kentucky
- University of Louisville
- Justice and Public Safety Cabinet
- Other MCOs
- BHSO/Newly Covered Methadone Clinics

MCO Subject Matter Experts

- Behavioral Health Director
- Behavioral Health Director
- Medical Director

Goals and Outcomes

Goals:

- Align with the shared vision of the university and the Commonwealth of implementing SUD/OUD policies and treatment to reduce opioid-related overdose deaths by 40% over three years across the 16 counties involved in the HEAL study
- Implement value-based solutions through provider partnerships to treat individuals suffering from OUD with a comprehensive, holistic approach to whole-person care, including medical, psychological, and psychosocial interventions

Outcomes:

- Decrease and prevent opioid-related overdose deaths throughout the Commonwealth
- Through effective OUD treatment, reduce new cases of Hepatitis C, infectious endocarditis, and other complications of IV drug use. This includes the expansion of additional Syringe Exchange Programs (SEP) throughout the Commonwealth
- Increase access rates and the number of available providers providing MAT and other treatment services
- Through educational prevention programs, drive down the misuse of opioids by children in the foster care system, as well as prevent children from having to enter the system due to parents using opioids

#2: ENROLLEE DATA ACCURACY/FILE SHARING COMPONENTS (834)

Rationale

WellCare of Kentucky recognizes the importance of collaborating with the other health plans and DMS to reduce the complexity and improve the accuracy of the data exchanges between the stakeholders responsible for Enrollee care. Various organizations, such as the Department of Corrections (DOC), and the local health plans, often document and have access to updated Enrollee demographic data not reflected in the 834 file's data elements. Developing data exchanges to connect these "sources of truth" would improve the accuracy and timeliness of information used for Enrollee on-boarding, communications, care coordination, and claims processing.

In 2017, DMS placed more than 8% of our population in a warning or suspended enrollment status for having inaccurate address information, however, no process was ever created for using corrected address information attained by the MCOs to improve the accuracy of the 834 files. Additionally, the current 834 file includes historical data elements for every Enrollee that are not required for current adds, changes, or terminations in enrollment. This excess data causes processing times found to be 800% higher than other WellCare Medicaid health plan markets across the country. By including excess historical data, as well as other limitations on the 834 file, the system becomes at risk for data accuracy issues due to not having enough space to contain a comprehensive, accurate historical record for some Enrollees.

Most recently, DMS has emphasized identifying incarcerated Enrollees. However, as most of this information is self-reported, a notice of incarceration is typically not received until eight to ten months following the beginning of the incarceration (on average). We have identified

alternative approaches for ensuring that data is validated against official records. We have also developed proprietary methods for ensuring awareness of incarceration upon receipt of services to prevent situations where we are not informed until a much later date.

Lastly, other Medicaid markets provide significant data elements, including detailed termination reasons and a notification identifying the previous MCO. These data elements would help us evaluate process improvements that would increase Enrollee satisfaction and provide opportunities for better care coordination.

Implementation of Short-Term and Long-Term Solutions

Short-Term Solutions:

- Limiting the 834 files to current adds, changes, and terminations
- Adding additional dis-enrollment reason codes on the 834 file
- Alerting the current MCO to the identity of previous MCOs directly on the 834 file

Long-Term Solutions:

- Establishing an electronic feed between various CHFS departments to maintain accurate Enrollee data
- Developing a process for accepting and validating Enrollee data from the MCO. Example: As DMS updates third-party insurance information received from an MCO through their data monitoring process, we could develop a similar process whereby an MCO can attest to and validate pertinent information, such as corrected addresses, phone numbers, and email addresses

Strategic Partners and Key Stakeholders

- DMS
- DOC
- DCBS
- Office of Administrative and Technological Services
- Other MCOs

MCO Subject Matter Experts

- Enrollment Manager
- Operations and Enrollment Project Manager
- Application Development Director
- Application Development Manager
- Strategic Market Analysis Director

Goals and Outcomes

Goal:

Reduce Kentucky's inaccuracy of Enrollee data records to less than the current estimated 15% through electronic data exchanges from state departments and health plans

Outcomes:

- Improve delivery of written communications from the use of current and alternate addresses
- Improve ability to initiate on-boarding communications and care coordination outreach telephonically with current phone numbers
- Expedite identification of incarceration and increased accuracy, resulting in reduced payment of ineligible dates of service and decreased provider abrasion due to inaccurate identification

Goal:

Revise the content of the 834 file to include only the information necessary to process changes or terminations

Outcomes:

- Reduce the current processing time to levels comparable with other markets
- Reduce the potential error rate of isolating the most current Enrollee data elements, or from missing historical data that has been omitted due to lack of space
- Obtain better explanation codes for enrollments and dis-enrollments to coordinate transitions of care and understand Enrollee choices
- Reduce the size of the electronic records to be stored, maintained and protected

#3: INCREASED ACCESS TO TRANSPORTATION SERVICES

Rationale

Feedback from our local Community Impact Councils (CIC) held throughout the Commonwealth has consistently identified increased access to transportation services as a critical need in several counties, and the number one need in eight counties, including Caldwell, Hopkins, Knox, Laurel, Mercer, Muhlenberg, Perry, and Whitely. Transportation plays a significant impact on helping Enrollees address their comprehensive, whole-person needs through regularly attending medical appointments for their physical and behavioral health co-morbidities and chronic conditions.

As evidence of this need, WellCare of Kentucky has provided more than 48,000 transportation-related service referrals to Enrollees who require assistance traveling to medical appointments, the grocery store, employment, food pantries, and community agencies that provide resources to address SDOH. Before we connect an Enrollee to a local, non-profit community partner for transportation services, we assist the Enrollee with the process for qualifying for a transportation request with DMS and the entity directing the non-emergency medical transportation (NEMT) program. As many Enrollees do not qualify for transportation services (e.g., car title but the vehicle is not operational, a family member needs vehicle for work), we then assist by leveraging our community partners. To date, we have provided more than 23,000 non-billable medical transportation services for cases such as these.

In addition, the CIC hosted in Muhlenberg County resulted in a medical voucher program (MVP) in partnership with Pennyrile Allied Community Services, Inc. (PACS) for individuals with limited

income to use for transport that addresses their whole person needs (e.g., dental, vision, hearing, pharmacy, and behavioral health). We then expanded the voucher program to other counties, including Hopkins and Caldwell and the remaining seven PACS service areas. Before the program was established, PACS personnel would spend valuable time attempting to identify available resources to meet the transportation needs of their clients. Now they can instantly schedule a ride anywhere in the region—**between July 2017 and March 2019, 1,614 WellCare of Kentucky Enrollees received 36,969 total services.**

To show the impact that transportation has in these regions, we found that on average, Enrollees accessing PACS transportation services have 3.5 chronic conditions, including 66.2% with hypertension; 34.1% with asthma; 35.9% with diabetes; and 31.4% with obesity. In addition, we found Enrollees to have 1.5 behavioral health conditions, including 42.8% with depression; 53.4% with a mental illness; 18.0% with severe mental illness; 12.4% with bipolar disorder; and 16.2% with substance use issues.

Upon one year of increased transportation services in the region for Enrollees with diabetes, we found a 17.4% reduction in emergency visit costs; 12.6% reduction in emergency visits; 41.4% reduction in non-emergent emergency visits; 38.9% reduction in inpatient admissions; and 36.3% reduction in hospital stay days. For Enrollees with asthma, we observed a 43.2% reduction in inpatient admissions, 63.9% reduction in hospital days, and 72% reduction in visits related to asthma exacerbations.

Implementation of Short-Term and Long-Term Solutions

Short Term Solutions:

- Expanded services to support community partners providing transportation
  - Example: Similar to the PACS MVP program, we implemented another program in the Knox, Laurel, and Whitley counties. Through a partnership with Rural Transit Enterprise Coordinated, Inc. (RTEC), a “Healthy Stop Program” was established to provide transportation that focused on healthy food access, education assistance, and employment assistance

Long Term Solutions:

- Continue to improve the current system with innovative supports to increase utilization for individuals in need
- Increase access to community resources by expanding destinations that are billable
- Decrease barriers to transportation access:
  - Example: Individuals who have a car in their name but have not actually owned the vehicle/had tags in the system for X amount of time to remove barriers that exist for service utilization of the current program
  - With new legislation for both community paramedicine and telemedicine, we can leverage the resources of WellCare Health Plans, Inc. (WellCare) to implement new initiatives at their health plans in other states that help alleviate the transportation burden

Strategic Partners and Key Stakeholders

Our past CICs included input from the following organizations based on their local knowledge of the

needs in the community. WellCare of Kentucky will leverage their local knowledge and support in future transportation initiatives that will build upon the services we already provide.

- *Mercer County:* Bluegrass Community Action Partnership, Mercer County Health Department, Goodwill Industries, Mercer County Elementary, Mercer County Community Endowment, Salvation Army, Mercer County Extension Office, Southern KY AHEC, Bluegrass.org, Haggin Hospital, Saint Barnabas church, Harrodsburg Health and Rehab, Heritage Hospice, Mercer County Board of Health, Passport Health Plan, Caresource, United Way of the Bluegrass, Ampersand Sexual Violence Resource Center, SkillsU Mercer County, Mercer County Public Library, Bluegrass Community and Technical College, and Mercer County Intermediate School
- *Knox County*: Barbourville ARH, PACT, Knox County Health Department, Lay Family Resource Center, Berea College PFE, PACT/KRHIT, KCEOC, St Joseph London, Bluegrass Care Nav, American Cancer Society, and Rural Transit Enterprise Coordinated, Inc.
- *Laurel County:* PACT Program, DCBS, UK TAP, St Joseph's London, South Laurel High School Youth Service Center, Laurel Health Department, Laurel County Life Center, Mollie Harris, and ASAP
- *Whitley County:* Senior Citizens Center, Whitley County Health Department, Office for the Blind, Bell-Whitley Community Action Agency, Baptist Health Corbin, DaySpring, SNAP-ED, Cumberland River Victims Services, and Home Health
- *Muhlenberg County:* Felix Martin Foundation; Hope2All; Chamber of Commerce; UK Extension; Muhlenberg County Health Department; Sanctuary; Bremen FRYSC; Community Health Clinic; Pennyroyal; and Muhlenberg County Baptist Association
- *Hopkins County:* Elizabeth's House; Hopkins County Health Department; Pennyroyal; Saint Vincent DePaul; Madisonville Housing Authority; and Pennyrile Allied Community Services
- *Caldwell County:* UK Extension; Caldwell County FRYSC; PACS; Housing Authority of Princeton, Living Hope Ministries; Caldwell County FRYSC; Princeton City Council; and the Mayor of Princeton

MCO Subject Matter Experts

- Community Engagement Partners—for ongoing development of the PACS program and as a thought leader for developing similar programs in different regions of the Commonwealth
- Community Engagement Senior Manager
- Operations Director

Goals and Outcomes

Goals:

- Increase access to PCP
- Increase access to other medical care providers
- Increase access to pharmacy services
- Increase access to social resource organizations

Outcomes:

- Reduce non-emergent ED visits
- Reduce inpatient admissions

- Reduce hospital days
- Reduce overall costs of healthcare utilization
- Remove barriers to receiving services (medical and non-medical)
- Increase compliance with medications and healthy behaviors
- Increase access to social resources (healthy food, financial assistance, etc.)

#4: HEPATITIS C PREVENTION

Rationale

Incidence and prevalence rates in the Commonwealth indicate that significant improvement for the management and prevention of Hepatitis C has become a critical need. The leading cause of liver transplants in the country, Hepatitis C-related complications cause an estimated 19,000 deaths each year.

While Hepatitis C can be cured, the cost of treatment is expensive. Nationwide, individuals with Hepatitis C account for 2.8 million hospital stays at the cost of more than $15 billion annually, with publicly insured individuals and non-whites bearing a disproportionate burden. According to CHFS, Kentucky's Medicaid program spent $69.7 million on pharmacy claims to treat 833 beneficiaries ($83,735/individual) in the last fiscal year.

With no vaccine to prevent Hepatitis C, the best method to help the people of Kentucky and decrease Medicaid spending is through prevention, which includes decreasing unhealthy behaviors that spread the disease, such as drug injections. Today, we see increased intravenous drug use by individuals sharing syringes to inject heroin and other substances as the current opioid epidemic continues to drive new Hepatitis C infections across the Commonwealth. According to the Centers for Disease Control and Prevention (CDC), Kentucky reported 1,089 new cases of Hepatitis C—the most per capita in the entire country and more than twice the national rate.

Hepatitis C is caused by the sharing of needles typically used by individuals using drugs, who subsequently have a high incidence of contracting the virus. As one of the states hit hardest by the national opioid epidemic, the people of Kentucky struggle with high rates of addiction, overdose deaths, and Hepatitis C. The CDC analyzed measures that include overdose deaths, per capita income, unemployment, and sales of painkillers to determine which counties in the nation were at the highest risk for a disease outbreak. **Of the 220 most vulnerable counties in the nation, 54 are in Kentucky—with the majority located in the southern and eastern regions of the Commonwealth.**

Recent studies show the success of implementing syringe exchange programs (SEP) to reduce the spread of Hepatitis C, which allow individuals using drugs to trade dirty needles for clean needles. Given the number of individuals affected by the opioid epidemic, these programs can help those with addiction issues prevent the spread of disease to others. Unfortunately, many of the counties at risk for a disease outbreak have not approved a SEP for their region.

Currently, WellCare of Kentucky serves over 430,000 Enrollees. Within that population, we are tracking and monitoring the following data:

- 7,542 (1.68%) have a Hepatitis C diagnosis

- 215 (2.89%) utilize treatment through Medicaid
- Total Cost = $3,186,908 for May 2019 (PMPM $7.17)
- 475,544 prescriptions for opioids in 2018 = $19,116,540 in costs

Implementation of Short-Term and Long-Term Solutions

Short-Term Solutions:

- Assist the four local health departments (LHD) approved for SEPs with the implementation of the SEP program and operational start-up logistics. This includes Hopkins, Taylor, Scott, and Bath counties that we support through the WellCare of Kentucky LHD liaison responsible for coordinating face-to-face meetings and ongoing communication with the LHD. ***We provided a $1,500 grant to the Barren River District Health Department to support their Hard Reduction Needle Exchange program.*** This program provides needle exchange, education, and referral services for the Barren, Butler, Edmonson, Hart, Metcalfe, Simpson, and Warren counties.
- Increase use of the HCV screening across the Commonwealth, specifically the University of Kentucky (UK) hospital's universal screening for use in emergency departments across the Commonwealth.
- Enhance efforts that raise awareness, including education, literature, media, and events focusing on Hepatitis C prevention for the public, WellCare of Kentucky Enrollees, healthcare providers, social service partners, and elected officials. Our local community engagement partner in eastern Kentucky attend regional Help End Addiction for Life (HEAL) meetings in Perry, Letcher, Harlan, and Owsley counties to discuss Hepatitis C prevention and treatment. HEAL meetings bring together thought leaders and local support staff that includes the UNITE Coalition, ASAP Board, LHD staff, community health workers, and FQHCs, as well as physicians and clinic and hospital administrators

Long-Term Solutions:

- Support the 59 remaining LHDs for the approval of the SEP, with the focus on the most vulnerable counties (Bell, Leslie, Clinton, Knot, and Estill) through our LHD liaison to coordinate face-to-face meetings and communication
- Expand the number of healthcare providers trained and qualified to care for individuals infected with HCV, especially in rural Appalachian regions. These activities include collaboration with specialists, universities, and hospitals to develop “pop-up” HCV Clinics in the underserved counties of eastern Kentucky for screening and treatment assistance
- Explore the implementation of telehealth as an option to connect Enrollees in rural areas with specialists located in urban areas of the Commonwealth
- Collaborative outreach to Enrollees with chronic Hepatitis C infections for treatment assistance and referrals for additional services. These activities include community resources, related therapies, drug treatment, and MAT

Strategic Partners and Key Stakeholders

- CHFS and LHDs
- DMS

- Other MCOs
- Healthcare Providers: family practitioners, internists, pediatricians, hepatologists, substance use providers, etc.
- Public Universities: University of Louisville and University of Kentucky
- Substance use counselors
- HepConnect/Harm Reduction Coalition
- Sobriety Treatment and Recovery Teams (START)
- Drug Court
- Kinship Families Coalition of Kentucky
- Local churches and other organizations

MCO Subject Matter Experts

- Behavioral Health Senior Director
- Behavioral Health Director
- Medical Director
- Quality Improvement Director
- Community Engagement Senior Manager
- Care Coordination Senior Director
- Pharmacy Director

Goals and Outcomes

Goal:

Increase the number of SEPs in Kentucky and raise awareness through education, media, literature, events, and expanded access to providers capable of treating Hepatitis C

Outcomes:

- Increase the treatment utilization of Hepatitis C prescriptions to reduce Hepatitis C co-morbidities (e.g., liver disease, cirrhosis, and liver transplants)
- Decrease hospitalizations with Hepatitis C as an underlying diagnosis
- Decrease the number of opioid prescriptions

b. Describe lessons learned from similar collaborations that the Vendor has experienced, and how those could be applied in moving forward with monthly meetings.

As described below, the lessons learned throughout our tenure as the leading MCO in Kentucky have proven invaluable to the development of new initiatives driven by collaboration with DMS and other state agencies.

LESSON LEARNED #1: ONGOING COLLABORATION AND INTEGRATED MEETINGS LEAD TO POSITIVE RESULTS, AND THE RESOLUTION OF COMMON ISSUES AND PRIORITIES.

In our experience, the current Pharmacy Director Workgroup has been one of the most successful ongoing collaborations between DMS and the MCOs in the Commonwealth. Our Pharmacy Director, Thea Rogers, has participated in these ongoing monthly meetings and seen

firsthand the importance of working collectively to identify common issues and develop collaborative solutions that benefit the Medicaid Enrollees throughout Kentucky.

With the focus on helping our Enrollees receive better care and access resources that improve their quality of life, we have learned that regular contact with our peers sustains the ongoing critical discussion that helps us identify serious issues and develop solutions based on the input and expertise of every committed stakeholder involved in the process. The following examples describe the successes of this collaboration experienced by Dr. Rogers and her peers:

- *Uniform Prior Authorization Criteria.* The workgroup collaborated on developing uniform prior authorization criteria for buprenorphine and Hepatitis C products to streamline the process and approach for managing these particular therapies. The project began when Dr. Rogers communicated with the state medical director, who had concerns about Enrollee access to these medications. We identified a region of the Commonwealth that had little to no access to specialists required for prescribing based on our Hepatitis C criteria. Although we later found there were several local providers who received additional education and training to obtain the necessary certifications, this information was not readily available using the standard National Provider Identifier (NPI) credential search. Dr. Rogers worked with the medical director and our prior authorization review team to develop a solution that would facilitate access to these medications for our Enrollees. As a result, prescribers now provide attestation for their training and receive prior authorization approval for prescribing these medications.
- *Pharmacy Management Dashboard.* The workgroup collaborated on the development of a pharmacy management dashboard that contains a set of consistent metrics used to compare trends across the pharmacy program.
- *Streamlined Policy Communications.* Understanding that it can sometimes be difficult for local pharmacists to understand and implement new policies, the workgroup met to develop a standardized communication approach to educate pharmacists about the new cost share requirements. This issue was brought to our attention by a WellCare of Kentucky Enrollee who needed their medication but did not have the ability to meet the costs of the associated co-payment. As a result, the communication letter that we used to address this issue with our pharmacy network was brought to DMS and approved for use by all MCOs regarding filling medications for Medicaid beneficiaries at or below the Federal Poverty Level (FPL).

Applying Experience to Future Meetings. As our Kentucky leadership team meets regularly to discuss the success of such workgroups, we realize that several clinical areas have not received as much attention or have suffered from a lack of consistency through no fault of the MCOs, DMS, or other stakeholders. Moving forward, we are eager to model our approach to ongoing meetings to meet the renewed expectations of the contract and dedicate our health plan directors and their teams to attend consistent meetings with DMS and our MCO peers. Through these meetings, we believe that enhanced, bi-directional communication with DMS will help our health plan tailor our strategic pursuits, innovations, and solutions to the goals and priorities of DMS.

In addition, we also recommend the implementation or expansion of smaller workgroups, such as the Uniform Policy Workgroup to include other clinical disciplines that can address broader issues. By creating cross-functional, integrated teams or workgroups, we would engage behavioral health, medical, and quality directors, as well as the provider community, to develop solutions that address whole-person care and take into consideration all aspects of health. Lastly, we would use this experience to implement dedicated timelines and establish accountability at each meeting to ensure that our collective initiatives move forward toward their ultimate goals.

Most recently, we have contacted DMS to begin working on an issue regarding cost outliers. Certain cost outliers identified through pharmacy reporting may be impacting pharmacy cost trends for the Fee-For-Service (FFS) program and the MCOs in the Commonwealth. Discussion includes evaluating less costly alternative medications to use instead of expensive pharmacy products that may be contributing to wasteful spending practices for the Medicaid benefit.

LESSONS LEARNED #2: THE IMPORTANCE OF TAKING THE INITIATIVE TO IDENTIFY INNOVATIVE SOLUTIONS TO COMPLEX PROBLEMS.

As WellCare of Kentucky and our MCO counterparts in the Commonwealth understand, serving the most vulnerable populations means continually building creative solutions to fix complex problems that are often made more difficult by a lack of resources or funding. Through our experience collaborating with DMS, we have learned that new ideas are always encouraged and although some may fail, the process of innovation allows us to keep striving toward the development of better programs to improve the quality of life and sustain healthy outcomes for our Enrollees. Many of the programs developed by WellCare of Kentucky, and collaborated on with DMS, have evolved into national initiatives, which WellCare implemented at our affiliate Medicaid health plans across the country.

For example, following the success of the Kentucky One Provider-One Pharmacy program (formerly known as the lock-in program), We began implementing lock-in through enhanced care coordination services and increased access to MAT across all the Commonwealth's health plans. **In 2018, WellCare of Kentucky saw a 27% drop in opioid utilization, with a 47% increase in MAT services, a 25% increase in maintenance medications, and a 33% decrease in emergency department utilization.**

Today, the One Provider-One Pharmacy program has evolved into WellCare's national ACT for Opioids Program, which is responsible for an entirely new, comprehensive suite of integrated services that help us prevent and treat opioid conditions for our Enrollees. Moving forward, WellCare of Kentucky has plans in place for implementing components of this program in Kentucky, including alternative pain management solutions, expanded access to the One Provider-One Pharmacy Program with referral to care coordination, specialized care management for low back pain, and earlier identification of Enrollees at-risk for opioid use or dependency through predictive analytics.

Knowing that the status quo is never enough, our Kentucky leadership team continuously discusses and brainstorms new ideas to help our most vulnerable Enrollees. For example, our team, led by Provider Relations Liaison for Foster Care, LeAnn Magre, realized that we needed to develop enhanced support processes and community linkages for children in the foster care system with autism. Often, children in foster care with complex medical conditions experience difficulty finding a reliable support system and living arrangements. To address this, we approached DMS with an idea to help these children find a reliable and sustaining living arrangement where they could receive comprehensive support for all their needs. As a result of DMS' valuable feedback and eventual approval for the new pilot program, we developed services along with Key Assets Kentucky, a behavioral health and child caring company, which helped find a place for children with autism in the foster care system a reliable place to live. Most often, these children could not leave facility level care and transition back into the community. The following describes some of the key highlights of the initiative:

Key Assets Kentucky Collaboration

Beginning in 2013, WellCare of Kentucky partnered with Key Assets to help find sustainable living arrangements for Enrollees with autism in the foster care system. As a result of what came to be known as the James Project, the success of the program has led the Department to implement these services across all MCOs in the Commonwealth.

- *Process Development.* Our team established clinical components of the program, identified best practices, determined the services descriptions and corresponding CPT codes, developed an appropriate reimbursement process, and addressed Enrollee-specific needs.
- *Program Implementation.* We educated DMS and our state partners on the expectations and goals of the program. In 2014, the first Enrollee successfully transitioned from a facility level of care into a foster home. From that day on, the program became known as The James Project.
- *Program Outcomes.* Together, WellCare of Kentucky, DCBS, and Key Assets presented our project outcomes at a national conference called The Family Focused Treatment Association (FFTA). In total, we covered benefits for ten Enrollees until 2018, when DMS took over responsibility for treatment costs. Today, eight WellCare of Kentucky enrollees remain in the program.
- *Program Expansion.* Upon taking over the responsibility of the treatment costs, DMS had an opportunity to learn in depth about the services provided and the ongoing costs involved. Realizing not only the success but the importance of the James Project, DMS is standardizing the services and transitioning responsibility back to the MCOs in the Commonwealth. To prepare for the transition, we have initiated meetings with Key Assets to proactively identify the applicable services, service codes, and the utilization management process for service approval, discharge planning, and quality reviews.

Applying Experience to Future Meetings. Moving forward, we will leverage our workgroup meetings with DMS and our peers as a forum to bring new ideas and initiatives to the table for discussion. Through ongoing collaboration and enhanced bi-directional communication with DMS, we hope to learn about the major goals and pain points that DMS would like to address in the near and long-term future.

LESSON LEARNED #3: LEARNING TO LEVERAGE EXISTING TECHNOLOGIES AT WELLCARE HEALTH PLANS TO ASSIST THE DEPARTMENT AND OTHER MCOS IN THE COMMONWEALTH.

We promote the importance and use of data analytics and regulatory reporting across our entire operations to access already established and proven resources from other WellCare health plans. During our time in Kentucky, we have provided leadership and guidance to enhance reporting capabilities through the ongoing assessment and adjustment of standard reporting features used by DMS. For example, WellCare of Kentucky has provided leadership and expertise in the realm of behavioral health reporting by working hand-in-hand with DMS and DHBDID to share our advice and recommendations. Through this collaboration, we have emphasized the significant role of reporting across managed care plans, which when done well, provides valuable insight on all areas of health services and supports, including successes, gaps in care, and areas for improvement.

To streamline this process, we realized that DMS could benefit from the guidance of a reporting subject matter expert to assist them with complex reporting processes. To help, we leveraged an IT reporting specialist from the corporate office to assist DMS with accomplishing their reporting goals. We also assessed the reporting process across other WellCare Medicaid managed care plans similar to our Kentucky health plan in both size and scope. From there, we pulled together a standardized regulatory reporting package and presented it to DMS for evaluation and possible implementation at the state level. DMS was able to streamline the reports required by the MCOs, relieving administrative burden and making the current reporting package more impactful.

Applying Experience to Future Meetings. Although we have made great progress toward an enhanced and standardized approach to reporting in the Commonwealth, we would like to apply this experience and continue to work collaboratively with DMS and other MCOs to develop a uniform reporting process. The goal would be to improve operational reporting structures for utilization management, claims, call centers, and other functional areas and ensure that MCOs are providing data in a consistent and comparable format. In adherence to Section 37.0 Contractor Reporting Requirements, we support DMS' initiative and request of the MCOs to leverage existing technologies and reporting capabilities to develop a comprehensive reporting package through the collaborative process. For more information, we have described our proposed reports, templates, and MCO-collaboration process to ensure consistent and comparable reporting in Section C.27 Contractor Reporting Requirements for the comprehensive, DMS-accepted reporting package.

3. Capitation Payments

4. Financial Security Obligations

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C.4. FINANCIAL SECURITY OBLIGATIONS

a. Describe how the Vendor will comply with net worth, solvency, and surplus requirements.

b. Provide documentation of lines of credit that are available, including maximum credit amounts and available credit amount.

c. Describe any risk arrangements the Vendor proposes to have with providers for contracted services and describe oversight of such arrangements.

C.4. FINANCIAL SECURITY OBLIGATIONS

OVERSIGHT

Through our Kentucky-based **Provider Engagement Model (PEM)**, our Provider Relations Representatives (PR Reps) manage the provider relationships, making in-person visits to review care needs in collaboration with Quality Practice Advisors (QPAs) and engaging providers and practice managers in Joint Operating Committee (JOC) meetings. Our QPAs collaborate with physicians and office staff through in-person visits in closing care needs, which in turn help our providers succeed in their PIP arrangements. Our Patient Care Advocates (PCAs) are co-located in select high-volume provider offices and assist in scheduling appointments for targeted Enrollees with identified care needs. As care needs are closed, providers become more successful under their PIP arrangements. Our Care Managers support Enrollees following discharges from the hospital to prevent readmissions, which would adversely impact a provider's performance under a shared savings contract.

As part of our PEM, we assign a **Practice Transformation Specialist (PTS)** to supply providers with enhanced tools and information, such as our AccuReports and our Enterprise Provider Dashboard (EPD) described in detail below. This information helps providers understand their earnings opportunities relative to care needs and allows providers to focus on delivering better care to Enrollees. The PTS further assists providers in achieving high quality practice status through support of care coordination and enhance data analytics that help providers migrate to higher levels across our continuum of risk arrangements available to them. The PTS performs root cause analysis to understand both positive and negative outcomes against goals and benchmarks, taking into consideration PIP opportunities, provider participation rates, Enrollee/PCP engagement, provider feedback, quality measurements such as HEDIS, reductions in potentially preventable events and total cost of care, adjusting the individual PIP program accordingly. The PTS also continuously performs reassessments, using our formal PIP assessment tool described below.

Providing Data and Reporting Tools to Help Drive Behavior Change

At the core of our PIP is a dedicated DataMart platform integrated with our production environment that captures medical claims, pharmacy claims, vendor encounters, enrollment, accounts payable system and provider data. Provider groups under a PIP arrangement can securely access a front end interface that displays detailed data feeds or aggregate reporting to monitor performance. With the goal of improving Enrollee health and assuring that services are occurring at the right time, in the correct location, and for the appropriate duration, it is critical that providers have access to data and information to help them succeed. WellCare developed a suite of reports to help support providers in PIP arrangements. Examples of these reports include:

AccuReports: Our proprietary AccuReports system was specifically designed for providers who have entered into a value-based purchasing shared savings / shared risk arrangement with quality incentive payments. It gives providers insight into performance and patient data. AccuReports is available to providers via a secure site provided by WellCare. It provides information on Enrollees who have been readmitted within less than 30 days, Enrollees incurring high costs, and Enrollee pharmacy utilization.

P4Q Portal Reports: Our P4Q portal reports including web portal and drill down capabilities, which QPAs and PR Reps provide to WellCare of Kentucky providers monthly, provide a snapshot of the care needs for their Enrollees tied to performance payments, allowing them to prioritize those measures that will result in the most improved Enrollee health outcomes.

Performance Scorecards: Custom monthly scorecards monitor provider performance and calculate performance-based payments based on a specific set of quality measures tailored to the provider.

Members without PCP Visits for 16 Months: Included with the respective Enrollee PCP information, this is a detailed list of WellCare of Kentucky Enrollees who have not had a PCP visit with the last 16 months. It is the PCP that is the driver or the hub for the Enrollee's preventive and primary care initiatives. Routine PCP visits contribute to healthier Enrollees, and conversely lower cost. This report is distributed monthly via in-person PR Rep visits, email and/or secure FTP.

ER High Utilizer Report: For the last 12 rolling months, this report reflects the Enrollees who are assigned to the respective provider group and/or IPA who have utilized the Emergency Room (ER); how many visits they have had; which hospital they have utilized; when the last ER visit was; what their most frequent diagnosis was during all of their visits; and how much WellCare of Kentucky has paid for the Enrollee's ER utilization during the respective number of ER visits. This report helps the PCP to address any non-emergent conditions the Enrollee may have, educating the Enrollee on the cost benefits of coming to the PCP office for non-emergent conditions. This helps the PCP develop a long term care plan to help improve the Enrollee's health. This report is distributed monthly via in-person PR Rep visits, email and/or secure FTP.

30-Day Readmission Report: This report reflects Enrollees who have been readmitted to the hospital as inpatient within the last 30-days. It reflects detailed information regarding both admission and re-admission including the facilities of both admissions, diagnoses, DRGs, and respective amounts paid. This report gives the PCP insight into any unresolved health issues that may contribute to poorer quality outcomes and higher costs. This report is distributed monthly via in-person PR Rep visits, email and/or secure FTP.

High Cost Member Report: This report reflects Enrollees who have claims over $50,000 (catastrophic claims) for the last 12 months. It includes any claim with the amount paid over $50,000—inpatient hospital, outpatient/ER hospital, physician office, or pharmacy. This report allows the provider group/IPA to see which Enrollees are the more expensive (and, conversely have a greater impact on their Value-Base Contractual arrangement), and how better can the Enrollee's care be tailored to help improve quality outcomes while helping to mitigate cost. This report is distributed monthly via in-person PR Rep visits, email and/or secure FTP.

Care Needs Reports: The Care Needs Report shows which outstanding Care Needs exists on which specific Enrollee, allowing the provider to address the outstanding Care Needs to help improve quality outcomes. This report is distributed monthly via in-person QPA visits.

Pharmacy Utilization Reports: These reports reflect a provider's generic dispensing rate (which helps mitigate cost), 90-day fills (also helps mitigate cost and improves Enrollee compliance) and breaks down the provider group's/IPAs individual prescriber profiles, which helps address

any therapeutic equivalent recommendations and ensure the Enrollee receives exactly the same care but at a much less cost. These reports are distributed to providers through monthly meetings with our pharmacy leadership and via secure email and FTP sites.

Enterprise Provider Dashboard (EPD): The EPD provides a single place for providers to access cost effectiveness, quality scorecards/care needs, utilization, Enrollee demographics (risk score), and other population health data for managing total cost of care and outcomes. EPD is a living dashboard that updates on a weekly basis as new information is available.

OPUS Specialty Provider Dashboard: WellCare of Kentucky leverages episodic grouper logic to assess the cost efficiency of specialists in Orthopedics, Cardiology, Neurology, Podiatry, Pulmonology, and OB/GYN using the OPUS Specialty Provider Dashboard. By comparing actual costs against expected costs for a specific episode, WellCare of Kentucky is able to identify efficient specialists and can share that insight with PCPs with the goal of reducing the overall cost of care. In addition, it allows WellCare of Kentucky to compare specialists against their peers within the same specialty by grouping treatment and services into risk-adjusted medical condition-based episodes. This level of analytics, in combination with traditional utilization metrics (ER/1000, IP/1000, MWOV), helps create a complete and holistic picture of healthcare costs for the PCP and in turn, allows us to create efficiencies that benefit our Enrollees. New claims data is provided quarterly through this system.

Example of a Full Risk Arrangement and Supporting Oversight

JenCare is an advanced partner in other states that was recruited to come to Kentucky to serve our Medicare and Dual Eligible Enrollees. We entered into a full-risk arrangement with JenCare, adopting best practices they had implemented with their successful Medicare VBP arrangements, and sharing these with our Medicaid practices.

Oversight

JenCare had a large amount of Enrollees for whom we did not have updated contact information, creating a challenge in completing recommended preventive care visits and keeping accurate medical records. This was adversely affecting providers' ability to close care needs and improve quality. To address this, and to ensure JenCare's success, **WellCare PR Relations staff and QPAs** have worked closely with the practices to review their quality metrics and make suggestion for improvement. We created a welcome letter for JenCare to introduce new Enrollees to the practice and to encourage them to make an appointment with a JenCare physicians. In addition, we used our new **Unable to Contact (UTC) Reach program** to locate Enrollees for whom we did not have updated contact information. **WellCare Health Coaches** also outreach to Enrollees who have been unable to contact to assist them with making appointments. WellCare developed the **suite of reports** mentioned in section a. above to address JenCare's need for clinical, utilization and financial data.

Measurable outcomes

As a result of the efforts listed above, JenCare has achieved an MBR of 78.7% while still improving overall quality.

Lessons learned

By working with JenCare, we learned that access to data is key. This is why we share the suite of reports, discussed above, with all of our large Medicaid practices and IPAs that are participating in a shared savings VBP. We also learned the importance of assisting providers in locating Enrollees that have been unable to contact in order to successfully engage with and provide care to these Enrollees. This includes monitoring claims activities to validate if an Enrollee has engaged in care with another PCP and should therefore be reassigned to another practice.

C.4 Financial Security Obligations

- Attachment C.04.b Centene Lines of Credit Agreement (Provided Electronically)

5. Third Party Resources

C.5. THIRD PARTY RESOURCES

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 14 Third Party Resources of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

As an experienced managed care partner with a strong TPL process established in 11 other Medicaid states, our approach to meeting DMS' expectations and requirements starts with taking full responsibility for identifying and pursuing Third-Party Liability (TPL) for our Medicaid Membership. We make every reasonable effort to identify and coordinate both cost avoidance and recovery with all third parties with whom Members may have a claim for payment or reimbursement for services. Third parties may include Medicare, any other group health insurance, any coverage under governmental programs, and any coverage required to be provided for by state law. In cases of accident-related subrogation, WellCare also pays and chases casualty and liability insurance carriers. We perform cost avoidance and TPL identification activities under our well-defined, highly audited policy, TPL Avoidance and Recovery WHP CR20R006-PR-011 and procedure WHP C6PI-006-PR-001 that conform to all federal and state requirements. This policy is available for review and approval by DMS.

THIRD-PARTY LIABILITY AND COORDINATION OF BENEFITS

In 2019, the WellCare COB team cost avoided over **$241 million** for the Kentucky market. The 2019 KY TPL Avoidance goal was $220 million.

Properly coordinating benefits and Third-Party Liability (TPL) is a critical step in ensuring there are no erroneous, wasteful, and duplicate payments. WellCare recognizes that Medicaid is the "payer of last resort" and has built detailed processes for ensuring TPL payment information is captured and used appropriately. Our coordination of benefits (COB) process begins with identifying sources of TPL by various means. We collect other health insurance information through a variety of sources including:

- State eligibility files (834 HIPAA transactions)
- State TPL files
- Provider claims with an explanation of payment (EOP) attachment
- The Member himself/herself as part of initial enrollment activities
- Member involvement in routine follow-up questions by telephone

We validate all other sources of TPL information via 270 electronic eligibility inquiry transactions or outbound phone call to the other insurance carrier. This validation allows us to verify the information we received as well as collect additional information such as effective and term date of policy, policy number, policyholder's name, group policy number, group policy name, Member relationship to policyholder, and whether the policyholder is the non-custodial parent.

If a provider or member disagrees with our TPL information they have an opportunity to request a validation via our customer service department. TPL tickets are created by the

Customer Service team and routed to the TPL team for validation Tickets are logged in our tracking system. The TPL team validates coverage within 48 hours for urgent requests and within three business days for routine/non-urgent requests. When the validation is complete, an email is auto sent to the member or provider advising them of our findings.

Using Industry-Leading Resources for TPL Identification

In addition to internal leads related to other insurance coverage, WellCare of Kentucky partners with industry-leading TPL identification partners, for other insurance leads. WellCare of Kentucky sends daily/weekly/monthly HIPAA-compliant claims and eligibility data feeds to our TPL identification partners to evaluate and determine if any Members have other coverage through a governmental or commercial source. To identify Medicaid Members with other coverage, WellCare of Kentucky partners with the following organizations:

Health Management Systems (HMS): a national vendor that specializes in coordination of benefits and TPL collections for Medicaid and other government-sponsored health plans. Through its data sharing agreements with commercial insurers, HMS helps to identify Medicaid Members with other coverage.

Council for Affordable Quality Healthcare (CAQH): to identify other commercial and Medicare coverage across the United States. CAQH offers a TPL identification product referred to as "COB Smart". Commercial and Medicare Health Plans across the United States directly contribute to a registry of coverage information that helps all participating health plans and providers correctly identify which Members have benefits that should be coordinated in order for corresponding claims to be processed correctly the first time. Each week, participating health plans supply coverage information to the CAQH COB Smart registry, where it is compared with information from other participating health plans to identify Enrollees with more than one form of coverage. Standard primacy rules are then applied to determine the correct order of benefits and the information is returned to the applicable health plans.

Syrtis Solutions: assists with identifying enrollees with other pharmacy coverage. We send daily HIPAA-compliant claims data feeds from all of our WellCare programs to Syrtis who then sends batch files to an e-prescribing vendor who houses real-time eligibility information for almost all pharmacy benefit managers and carriers within the U.S. to search for enrollees that have other primary pharmacy coverage. Syrtis will also take the pharmacy other coverage information and make an outbound call to the primary pharmacy carrier to inquire about any corresponding medical coverage for the Enrollee.

Our TPL identification partners return a data feed containing other insurance information in a date-sensitive and HIPAA compliant format used to update the Member's COB history tables in the WellCare of Kentucky Claim System.

Machine Learning Capabilities

WellCare of Kentucky has also recently begun expanding their use of Machine Learning capabilities to use care manager case notes as an opportunity to identify TPL information earlier and/or find additional potential opportunities to research other coverage opportunities.

By training a machine learning model that reviews care manager notes, our machine learning model is able to determine whether the case note is likely to be indicative of other coverage. This information is used by our recovery team to research these indicators and take the appropriate follow up action.

COORDINATION OF BENEFITS AND COST AVOIDANCE

All other insurance segments are added to the Member's record in the WellCare of Kentucky claims system. Other insurance information is accessible for claims processing and viewable by care management, Member, and provider services associates and to providers on our portal.

We avoided over $1 billion in claim payments and recovered over $43 million in overpayments for our entire Medicaid membership, due to the existence of third party coverage. The overall 2019 TPL Avoidance goal was $987 million.

When WellCare of Kentucky is not the primary insurer, our claims system evaluates the claim for COB. If the other carriers' explanation of payment is attached to the claim, WellCare coordinates and processes the Medicaid secondary payment. If the primary carrier's payment information is not attached, WellCare denies the claim and notifies the provider of other coverage that exists for our Member. Cost avoidance amounts, including denials, are reported through our encounter process.

Recovering Overpayments Due to Third-Party Liability

If other primary insurance information is loaded into the claim system after claim payment, then we review previously paid claims systematically for overpayments. We uses two methods for recouping erroneous overpaid claims: Direct Provider Recovery and Carrier Billing.

Direct Provider Recovery

For members whose primary coverage is under Medicare, we utilize direct provider recovery for identified overpaid medical claim(s) that have a date of service within the last 10 months. Ten months allows providers enough time to bill the other carrier without the administrative burden of an upfront timely filing denial. Internal recovery efforts begin with a letter to the provider advising them that Medicare was responsible for the claim payment and that a refund or recoupment is necessary to satisfy the overpayment. The letter provides the necessary other insurance information required for the provider to re-bill the claim to Medicare.

Carrier Billing

WellCare of Kentucky uses an outside vendor to submit bills to health insurance carriers when commercial is primary to WellCare. The WellCare subcontracted recovery vendor, HMS, receives monthly HIPAA-compliant claim data feeds to evaluate for overpayment recovery. HMS adheres to the billing requirements of each commercial insurance carrier and exercises reasonable efforts to provide medical records to the other carrier within thirty (30) calendar days of becoming aware records are needed for payment. On a monthly basis, primary carriers refund recoveries to WellCare of Kentucky and add them to the Member's claim history.

Subrogation

WellCare of Kentucky recognizes there are situations where our Members are involved in incidents where a third party is liable for all or part of expenses related to the accident. WellCare of Kentucky uses a subrogation vendor, Equian, to identify claims with accident related diagnoses for the purpose of investigating potential TPL and making retrospective post payment recoveries. Typical accident-related treatments are sprains, fractures, head and back injuries. Additionally, Equian attempts to identify treatment for incidents such as car accidents, injuries on someone else's property, injuries while working, dog bites, and other accidents. Additionally, WellCare of Kentucky also sends referrals to Equian when we believe the Member may have been involved in an accident. This includes the analysis of the State motor vehicle accident report file and a third-party liability accident information report form from the Member's attorney.

Tracking the Process

WellCare's Third Party Liability module (refer to **Figure C.5-1** and **Figure C.5-2**) is utilized to track the identification of each individual claim (separately or as part of a group), track the process of recovery from initiation through recovery from the other carriers, and maintains an audit trail tracking and follow-up capability for post payment recovery actions (including those that apply to health insurance, casualty insurance, and all other types of recoveries). When recovery is completed, paid claims are adjusted to properly reflect the payment status and financial responsibility under the Medicaid contract.

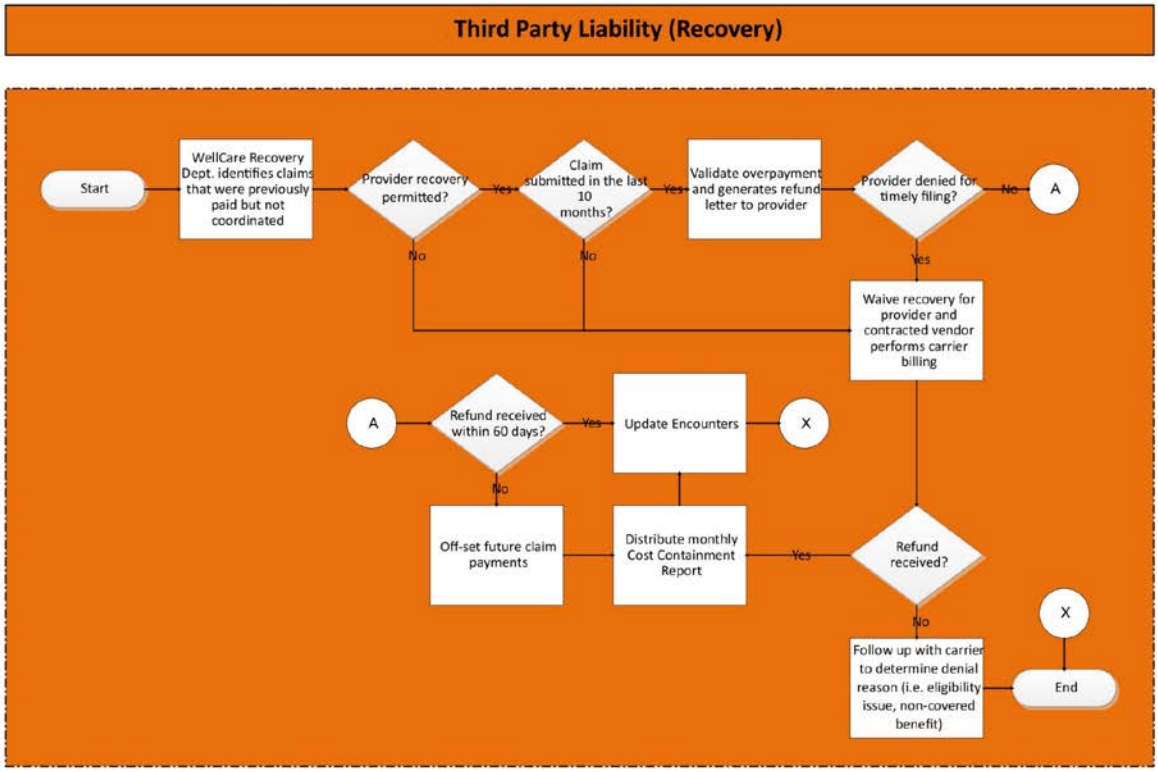

Figure C.5-1: TPL Avoidance

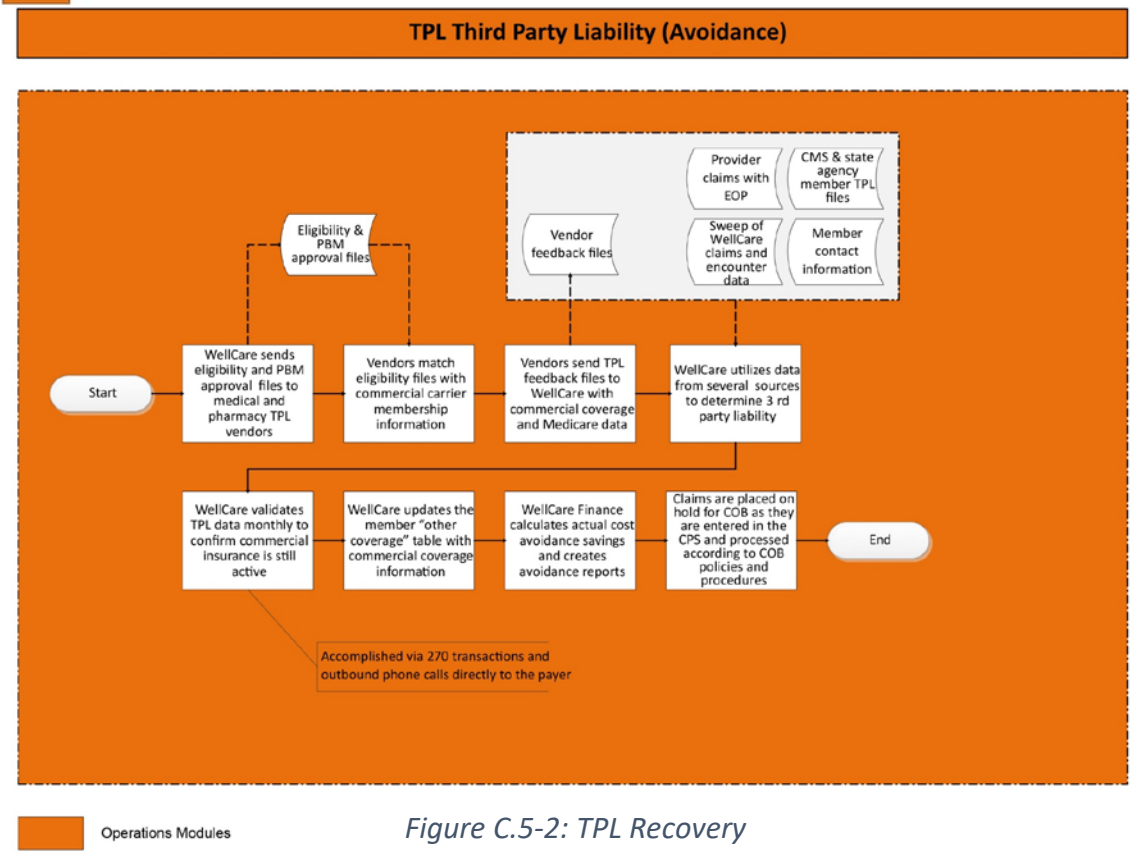

Figure C.5-2: TPL Recovery

6. Management Information System

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C.6. MANAGEMENT INFORMATION SYSTEM

a. Provide a detailed description, diagrams and flowcharts of the Management Information System (MIS) the Vendor will use to support all aspects of Kentucky's Medicaid managed care program including the following subsystems:

   i. Enrollee Subsystem
   ii. Third Party Liability (TPL)
   iii. Provider Subsystem
   iv. Reference Subsystem
   v. Claims Referencing Subsystem (to include Encounter Data)
   vi. Financial Subsystem
   vii. Utilization Data/Quality Improvement
   viii. Surveillance Utilization Review Subsystem

As part of the response, include information about the following:

   i. Required interfaces, how the system will share and receive information with the Department, how the Vendor's system will use files provided by the Department, Subcontractors, providers, and other supporting entities.

   ii. Capability to store and use large amounts of data, to support data analyses, and to create standard and ad hoc reports.

   iii. Extent to which these systems are currently implemented and integrated with other systems, internal and external, and the Vendor's approach for assuring systems that are not fully implemented and integrated will be ready to begin operations on required timeframes.

Diagrams and flowcharts should show each component of the MIS and the interfacing support systems used to ensure compliance with Contract requirements.

b. Provide a description for and list of potential risks and mitigation strategies for implementing new information systems and changes to existing systems to support the Kentucky Medicaid managed care program.

c. Describe the Vendor's current and planned use and support of new and existing technology in health information exchange (HIE), electronic health records (EHR), and personal health records (PHR).

d. Describe the Vendor's approach to assessing integrity, accuracy, and completeness of data submitted by providers and Subcontractors.

e. Provide a description of the Vendor's data security approach and how the Vendor will comply with Health Insurance Portability and Accountability Act (HIPAA) standards including the protection of data in motion and at rest, staff training and security audits.

f. Describe any proposed system changes or enhancements that the Vendor is contemplating making during the anticipated Contract Term, including subcontracting all or part of the system. Describe how the Vendor will ensure operations are not disrupted.

C.6. MANAGEMENT INFORMATION SYSTEM

a. Provide a detailed description, diagrams and flowcharts of the Management Information System (MIS) the Vendor will use to support all aspects of Kentucky's Medicaid managed care program including the following subsystems:

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 17 Management Information System and Appendix G Management Information System Requirements and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare of Kentucky recognizes the value that our single integrated management information system (IMIS) brings to ensuring visibility into an Enrollee's complete clinical picture. We leverage ours and our affiliates' more than 30 years of experience serving Medicaid populations across the country to develop, maintain and deploy our MIS, which aligns with our organizational focus on enhancing Enrollee outcomes and quality of life. Through our experience, we have gained a strong understanding of the needs of our state partners and recognize that if our systems do not function properly we risk our Enrollees not receiving needed care and our providers not getting paid timely and accurately. **This is evident from our recent increase in the systems availability metrics from 99.98% in 2017 to 99.99% in 2018.**

Our corporate commitment to government sponsored health programs is reflected in our use of industry leading solutions, our active participation in government healthcare IT initiatives, and in particular, directly in the design, development, and implementation of our custom IT systems. Examples of how this focus drives our IT solutions include:

- Actively participating in CMS-lead Interoperability initiatives, including being the first (only) Healthcare Payer to have become a Medicaid Information Technology Architecture (MITA) board member
- Implementing a new, mobile, and highly functional case management solution (CareCentral) to enhance care manager's ability to comprehensively address complex care plan scenarios when the market did not appear to have viable, functional solutions
- Developing Community Connections, our Social Services Provider Resource and Referral management platform that supports our aggressive activities in addressing social determinants of health, including during the care management process in support of innovative methods to improve Enrollee outcomes
- Developing Robotics, Artificial Intelligence (AI) and Machine Learning to enhance Enrollee outcomes and reduce overall cost. Examples include:
    - Developing and deploying Bots that automate complex claims adjudication scenarios with the results of improved accuracy, reduced costs, and enhance disaster failover capabilities
    - Developing a Machine Learning model to recognize sources of other Primary Coverage (TPL) in care nurse notes not found in enrollment or claims data. For 2018, the TPL determination model identified $4,912,480 in cases that were predicted as related to

Motor Vehicle Accidents, **including a single actual recovery of $81,013 that traditional TPL methods did not identify.**

- Using AI and Machine Learning techniques and non-clinical data to improve Risk, Identification, and Stratification of Enrollees into care management programs they will participate in and respond to most effectively
- Implementing a natural-language, benefit lookup solution that allows for searches and explanations in common, easy to understand language

DETAILED DESCRIPTION OF OUR MANAGEMENT INFORMATION SYSTEM (MIS)

Our IMIS is built to support all functions of our operational processes. We are certified as compliant with Health Information Trust Alliance (HITRUST) security standards, which are more restrictive than Health Insurance Portability and Accountability Act (HIPAA). It has been designed to interface with other data feeds and to serve as an interoperable platform. Our MIS has applications and processes that:

- Execute core functions efficiently and effectively, including Enrollee, Third Party Liability, provider, reference, Encounter/Claims processing, financial, utilization data/ Quality Improvement and Surveillance Utilization Review Subsystem.
- Ensure prompt payment of all provider claims and minimize provider claim denials.
- Complies with 42 C.F.R. 438.242. and supports confidentiality of medical information at all times through security protocols including:
  - least-privilege role based access templates
  - encryption at rest through the use or disc-level encryption
  - encryption in motion through the use of https: and secure FTP sites for external data exchanges
- Support a seamless Enterprise Information Management (EIM) solution that captures all clinical and transactional data, assembles necessary data and provide it in formats and files that are consistent with DMS' functional subsystems
- Place the Enrollee at the center of every application and process to promote and improve Enrollee health outcomes and satisfaction in everything we do.

The key features of our IMIS include scalability, integration, reliability, and security. From the ground up, we have invested in our single integrated MIS to specifically support government-sponsored healthcare programs and to address our enrollees' full spectrum of needs – physical health, behavioral health, pharmacy and social services supports. All WellCare of Kentucky applications are developed within the context of our overall technical architecture as well as our Architectural Principles, Guidelines, and Standards. The result is that all applications leverage best practices in Security & Privacy, as supported by a stable and robust infrastructure, and use common interaction functions to fully integrate with each other.

The MIS is an integrated delivery of three key technology and four major application components, as seen in **Figure C.6-1 MIS Overview.**

Security and Privacy Services: This broad set of technologies is interwoven into the design of our entire operating environment, including functions such as encryption, end point security on

physical and mobile devices, role-based security models, two-factor authentication, firewalls, intrusion detection services, data loss prevention services and automated remote wiping capabilities. We supplement these technologies, which directly support HIPAA privacy and security requirements, through internal policies and ongoing training and education for all our staff. Our security and privacy capabilities are further demonstrated by our 2018 HITrust certification.

Infrastructure and Operations: Engineered to ensure that they meet or exceed expectations, WellCare's Data Center Services, Network and Telecom Engineering (including our cloud-based Interactive Voice Response and automated call routing solutions), Servers, Storage, Database Administration, and end-user devices are all selected and implemented to ensure scalability and reliability. Our Architecture Review Board ensures all technology selections meet our specifications and are continuously monitored by our 24/7 Enterprise Service Operations Center. Our tested and validated Data Center and Business Continuity plans use redundancy and fail-over locations to ensure our operational viability (systems, Customer Service centers, and other operations) at all times, especially in scenarios where our enrollees and providers need us most.

Interoperability and Electronic Data Interchange (EDI) Integration: WellCare of Kentucky's applications are developed with a target architecture based on an Event-Driven, Publish and Subscribe, Service-Oriented Architecture, including clear separation between the User Interface, Business Logic and Data Access Layers. These services and EDI Integration tools support those goals through the provision of common services, direct support for industry standard EDI data exchanges (including HIPAA-compliant formats such as ANSI, clinical data formats including HL7 and FHIR, as well proprietary formats when required) and are consistent with the CMS Interoperability initiatives.

Figure C.6-1 MIS Overview

APPLICATION SUBSYSTEMS

Our subsystems satisfy the requirements of Section 15 Management Information System and is compliant with the subsystem concept. Our systems have the capacity to capture necessary data and provide it in formats and files that are consistent with DMS' functional subsystems.

i. Enrollee/Member Subsystem

WellCare of Kentucky's Membership subsystem supports the Inputs, Processing Requirements, Reports, On-Line Inquiry screens, and interfaces identified in Appendix G, Membership items a. through e.

WellCare is successfully processing enrollment and disenrollment transactions from daily and monthly 834 files from Medicaid programs across the nation. WellCare of Kentucky securely processed approximately 22 million enrollment transactions for Kentucky Medicaid in 2018. Our Member subsystem is explicitly designed to recognize DMS as the authoritative source of Enrollee data and eligibility by accurately processing and reconciling to Department-supplied 834 files. However, the application also maintains our Enrollee-first focus, ensuring that Enrollee preferences and provider selections are fully enabled to provide the most effective enrollee experience.

Our Member subsystem supports multiple edits and validation on the incoming 834 data during the processing stages including comparisons to existing records using names, Medicaid or other IDs, and date of birth to prevent loading duplicate records. Because the subsystem performs all validations (including potential duplicates), tracks each enrollee separately, and requires manual confirmations prior to loading, WellCare of Kentucky is not only able to ensure accurate system updates but also support notification and interaction with DMS for duplicate or other potential enrollee data issues.

Key functional attributes of this application include:

- Automated receipt and validation of DMS-supplied 834 files through secure FTP sites
- Processing rules for daily transactional and monthly verification eligibility files
- Validating data and executing required updates to WellCare of Kentucky's eligibility files
- Automated triggering of critical enrollees materials such as handbooks and ID Cards to the Correspondence and Communications Module
- Automated distribution of enrollment and eligibility updates to our PBM, dental, vision, transportation and other delegated partners
- Complete audit and verification of all received transactions and updates
- PCP auto-assignment in the absence of Enrollee choice
- Ongoing support for Enrollee updates to addresses, communication preferences, and provider choices through multiple channels
- Independent reconciliation functions to provide additional controls, specifically including a function dedicated to reconciling Department Capitation payments (received via 820 transactions) to membership to ensure payment integrity

WellCare of Kentucky's Member subsystem (refer **to Figure C.6-2**) becomes the source of truth for Enrollee demographics, eligibility, primary care provider (PCP) selection and assignment, third party coverages, and all subsequent processes including Enrollee services, utilization management, claims processing, tracking EPSDT preventative services, inclusion in HEDIS measure calculations, and all other functions requiring membership data.

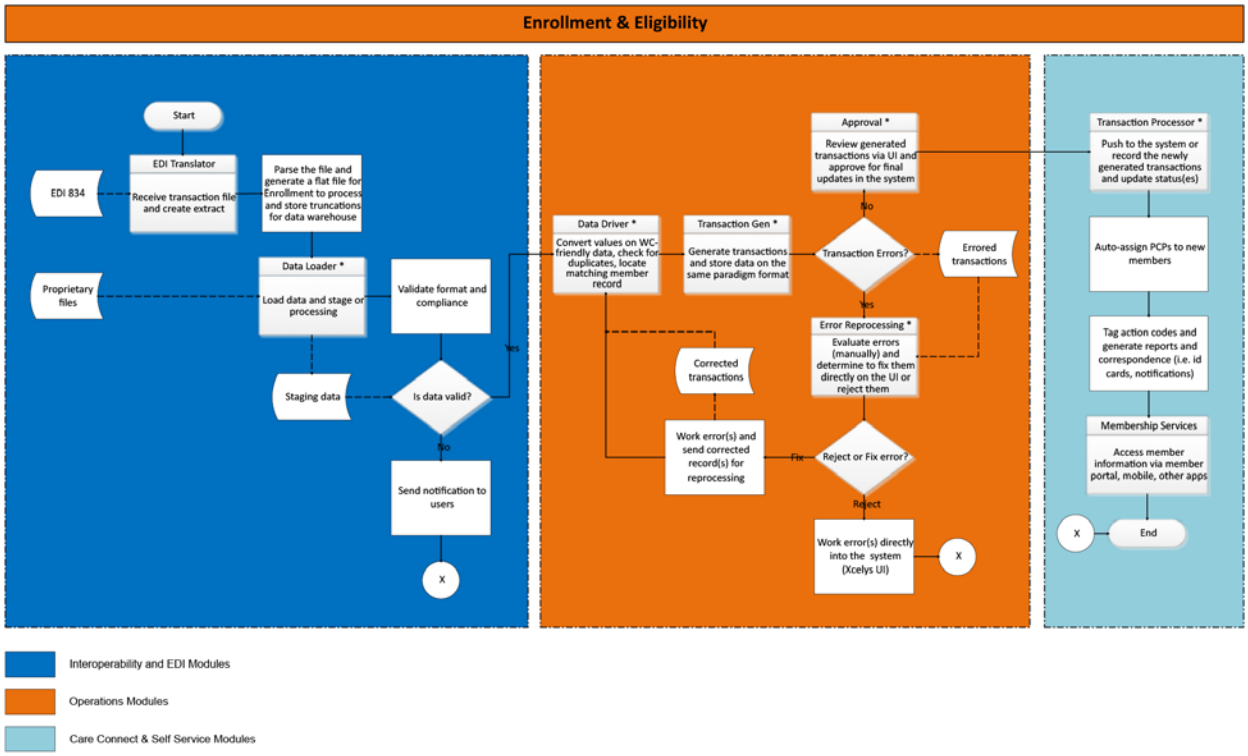


Figure C.6-2 Enrollment Eligibility System

ii. Third Party Liability (TPL)

WellCare's Membership and Claims Processing (including the Third Party Liability module) subsystems support the Third Party Liability Inputs, Processing Requirements, Reports and Online Inquiry requirements identified in Appendix G, Third Party Liability, items a. through d.

To ensure that federal third party liability requirements are met and to maximize savings from available Third Party Resources, identification and recovery of new Third Party Resources, WellCare of Kentucky will ensure that a joint effort is implemented between DMS and our Recovery team.

WellCare of Kentucky's Membership subsystem supports Third Party liability (TPL) by associating and tracking other coverage information received from all sources including DMS' supplied information (including Medicare effective dates) and other third-party resources available to enrollees. WellCare contracts with HMS to obtain additional sources of third party liability information (including commercial carries, Medicare, Workers Comp, Auto and other potential coverages) and updates the Membership subsystem with this information to ensure that Medicaid is the payer of last resort. The membership system is able to track each occurrence of other coverage individually, with unique effective date ranges, to ensure all applicable coverages are tracked and applied in a time-sensitive manner.

Our coordination of benefits (COB) process begins by identifying sources of TPL through various means. Other health insurance information is collected through a variety of sources including:

- State eligibility files (834 HIPAA transactions)
- State TPL files
- Provider claims with an explanation of payment (EOP) attachment
- The Enrollee himself/herself as part of initial enrollment activities
- Enrollee involvement in routine follow-up questions by telephone

All other sources of TPL information mentioned above are validated via 270 electronic eligibility inquiry transactions or outbound phone call to the other insurance carrier. This validation allows us to verify the information we received as well as collect additional information such as effective and term date of policy, policy number, policyholder's name, group policy number, group policy name, Enrollee relationship to policy holder and whether the policy holder is the non-custodial parent.

WellCare of Kentucky's Claims Processing subsystem will utilize data received on the claim (including diagnosis, procedures, and provider-submitted TPL indicators) and other coverage information in the Membership subsystem (including Medicare, Commercial, Accident and other sources) during the adjudication process to ensure that other coverages which are in effect have been utilized first. In addition to this cost-avoidance practice post-adjudication WellCare of Kentucky also searches for and identifies post-payment recovery processes when it is determined later that other coverages may have been in effect.

USING INDUSTRY-LEADING RESOURCES FOR TPL IDENTIFICATION

In addition to internal leads related to other insurance coverage, WellCare also partners with industry leading TPL identification partners, for other insurance leads. WellCare of Kentucky sends daily/weekly/monthly HIPAA-compliant claims and eligibility data feeds to our TPL identification partners to evaluate and determine if any enrollees have other coverage through a governmental or commercial source. To identify Medicaid Enrollees with other coverage, WellCare of Kentucky partners with the following organizations:

- Health Management Systems (HMS) is a national vendor that specializes in coordination of benefits and TPL collections for Medicaid and other government-sponsored health plans. Through its data sharing agreements with commercial insurers, HMS helps to identify Medicaid Enrollees with other coverage.
- Council for Affordable Quality Healthcare (CAQH) to identify other commercial and Medicare coverage across the United States. CAQH offers a TPL identification product referred to as "COB Smart". Commercial and Medicare health plans across the United States directly contribute to a registry of coverage information that helps all participating health plans and providers correctly identify which Enrollees have benefits that should be coordinated in order for corresponding claims to be processed correctly the first time. Each week, participating health plans supply coverage information to the CAQH COB Smart registry, where it is compared with information from other participating health plans to identify Enrollees with more than one form of coverage. Standard primacy rules are then applied to determine the correct order of benefits and the information is returned to the applicable health plans.

- Syrtis Solutions assists with identifying Enrollees with other pharmacy coverage. We send daily HIPAA-compliant claims data feeds from all of our WellCare programs to Syrtis who then sends batch files to an e-prescribing vendor who houses real-time eligibility information for almost all pharmacy benefit managers (PBMs) and carriers within the United States to search for Enrollees that have other primary pharmacy coverage. Syrtis will also take the pharmacy other coverage information and make an outbound call to the primary pharmacy carrier to inquire about any corresponding medical coverage for the Enrollee.

Our TPL identification partners return a data feed containing other insurance information in a date-sensitive and HIPAA-compliant format used to update the Enrollee's COB history tables in the WellCare of Kentucky claim system.

WellCare's Third Party Liability module (refer to **Figure C.6-3 and Figure C.6-4**) is utilized to track the identification of each individual claim (separately or as part of a group), track the process of recovery from initiation through recovery from the other carriers, and maintains an audit trail tracking and follow-up capability for post payment recovery actions (including those that apply to health insurance, casualty insurance, and all other types of recoveries). When recovery is completed, paid claims are adjusted to properly reflect the payment status and financial responsibility under the Medicaid contract.

WellCare of Kentucky has also recently begun expanding their use of Machine Learning capabilities to use care manager case notes as an opportunity to identify TPL information earlier and/or find additional potential opportunities to research other coverage opportunities. By training a machine learning model that reviews care manager notes, our machine learning model is able to determine whether the case note is likely to be indicative of other coverage. This information is used by our recovery team to research these indicators and take the appropriate follow up action.

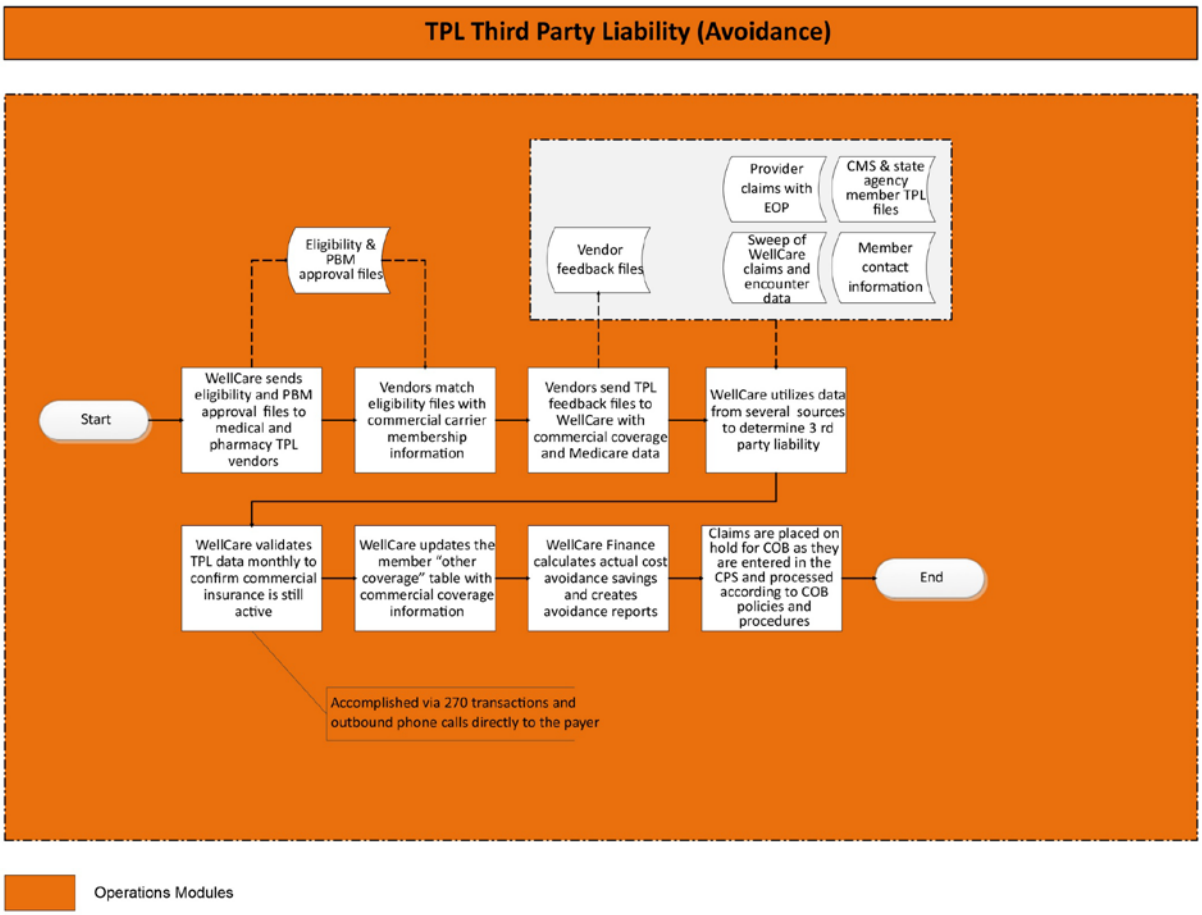


Figure C.6-3 TPL Avoidance

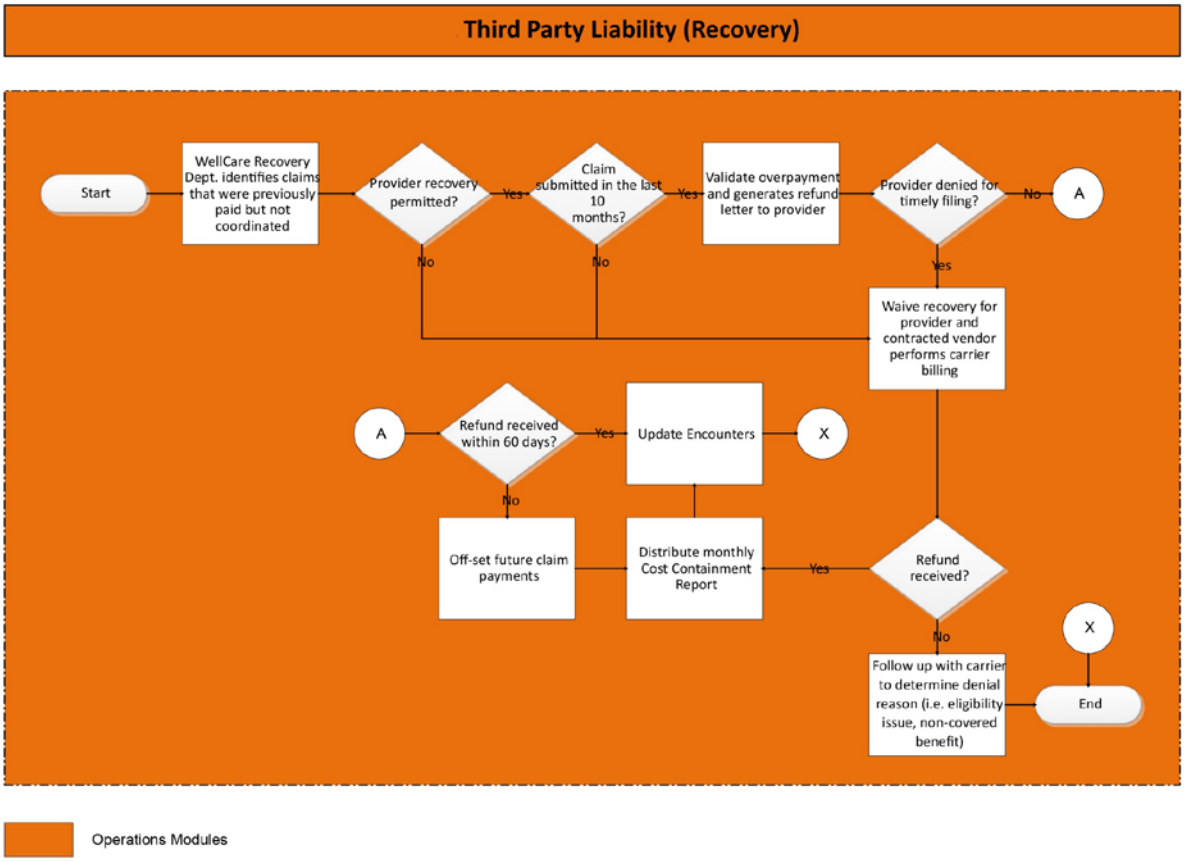


Figure C.6-4 TPL Recovery

iii. Provider Subsystem

WellCare of Kentucky's Provider Management subsystem accepts and maintains comprehensive, current and historical information about providers eligible to participate in the our network and is used to support the Inputs, Processing, Online Inquiry, and Interface requirements identified in Appendix G, items a. through d., including the requirement to electronically transmit provider enrollment information to DMS on a monthly basis, by the first Friday of the month following the month reported.

WellCare is successfully maintaining a provider network consisting of over 315,000 active contracted providers and hospitals over 100,000 delegated specialty providers (Dental, Vision, Pharmacy, Transportation, etc.), and more than 160,000 community providers to support the physical, behavioral, and social services needs of our Enrollees.

The primary aim of this solution is to ensure that a consistent, validated, comprehensive provider directory is available at all users at all times. Direct integration with the CareConnect and Self-Service applications, Claims and Encounter Processing, and Quality and CareCentral, our clinical applications ensure that Enrollees, providers, and our staff have access to the same validated information on an adequate, quality provider network.

The validation of provider data, oversight of provider performance, and maintenance of productive relationships with the provider community is an ongoing need that is reflected in the continuous processes and validations performed by this module.

Key functional attributes of this application include:

- Recruiting of providers to meet current and future network needs
  - Acceptance of applications and referrals from multiple channels
  - Targeted identification based on specialty, geography, and predictive gaps
- Contracting of providers of all types leveraging electronic contract management capabilities where possible to facilitate rapid negotiations and data validation
- Continuous Network Validation to ensure Enrollee access to needed services
  - Geo Access processes to confirm WellCare of Kentucky is meeting DMS' network adequacy and capacity requirements
  - Continuous execution cycles to identify predictive gaps in advance of Enrollee demands
- Ongoing Provider Verification to ensure that only qualified providers are accepted include in our network
  - All new providers are credentialed before joining the network
  - Utilization of a broad array of sources to identify providers that may be excluded from providing services. Includes validating non-participating providers before paying claims or authorizing services
  - Integration with Fraud, Waste, and Abuse in the validation process
- Relationship Oversight functions facilitate ongoing interactions with our entire provider network
  - Ongoing training and education is provided by customer service representatives for issues such as care needs and quality scores to improve Enrollee health outcomes
  - Audits and site visits of contracted and delegated providers to ensure accurate and comprehensive data is being provided
  - Profiling of provider performance to provide feedback and collaborate on opportunities to improve Enrollee health outcomes
- Data Maintenance capabilities focus efforts on maintaining accurate information on providers of all types. Update capabilities are provided through multiple channels, and changes in data are automatically reviewed and updated for impacts on network adequacy, provider verification, and provider directory updates. Each change in provider participation, contractual relationship, reimbursement rates and methods, and specialty, among other data elements, is maintained in a date-effective historical record.

WellCare of Kentucky also utilizes a variety of external data sources including the NPPES registry, Death Master File, List of Exclude Individuals and Entities, CMS SAM system and other sources to ensure that not only accurate data is maintained but that no excluded providers are able to participate in our network or be paid for services. Our provider subsystem is able track

and maintain a history of a variety of provider identifiers including NPI/Taxonomy, SSN, FEIN, and CLIA numbers.

Our Financial Subsystem utilized data from the claims, capitation, and other payment systems, combined with the appropriate data from the Provider Subsytem to calculate, maintain and produce accurate 1099 forms (including associated payment data by FEIN number for providers with changes of ownership, based upon effective dates).

iv. Reference subsystem

WellCare of Kentucky's Operations Management application, including the Provider Management, Membership, Claims and Encounters, Financial and Issues Management subsystems maintain current and comprehensive Reference data needed to support the Inputs, Processing, Online Inquiry, and Interface requirements identified in Appendix G, items a. through d.

Each type of reference data is captured and managed by one application and is utilized consistently as the source of truth for that type of information across all modules and functions, including Claims and encounter processing, TPL processing and utilization/quality reporting functions.

Claims, encounter, and authorization reference data maintained includes pricing files for procedures and drugs, general reference information such as diagnoses, edit/audit criteria, edit dispositions and reimbursement parameters/modifiers. This scope includes maintenance of procedure codes (NDC, HCPCS, CPT4, and Revenue codes), ICD-10 diagnosis codes, modifier codes (multiples are allowed on a claim), ADA codes and identification of pricing files, maintenance of edit and audit criteria. Each reference data set includes the ability to track the code set information by effective and termination dates. The complete history of reference data is maintained, exceeding the required 36 months of history.

The Third Party Liability (TPL) module supports the maintenance of reference data for Indication of TPL actions, such as Cost Avoidance, Benefit Recovery or Pay, by procedure code and other information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage and allowed amounts.

The maintenance of this reference data affords WellCare of Kentucky the ability to accommodate multiple reimbursement methodologies, including but not limited to fee-for-service, capitation and carve-outs from capitated or other "all inclusive" rate systems, and DRG reimbursement for inpatient hospital care.

While many of these code sets are maintained through interfaces by obtaining the reference data from the affiliated governing body, On-line Inquiry Screens are available for all reference data showing the code, the description, effective and termination dates, and any other relevant data and information for that code.

v. Claims Referencing Subsystem (to include Encounter Data)

WellCare's Claims and Encounter subsystem are utilized to support the Claims Control and Entry, Edit/Audit Processing, Claims Pricing, and Claims Operations Management requirements outlined in Appendix G. This includes meeting the requirement that all claims are captured at the earliest possible time and in an accurate manner, and that they are adjudicated within the parameters of Prompt Pay standards set by CMS and the American Recovery and Reinvestment Act (ARRA).

The primary function of the claims component of this application is the timely and accurate adjudication of Fee-for-Service (FFS) claims submitted by providers. The FFS functions apply benefits, clinical edits, provider contract and pricing, data validations and service code verifications (including NCCI edits), and authorization rules to claims in a real-time processing environment. This capability allows WellCare of Kentucky to meet or exceed the timeliness and accuracy standards identified in the RFP.

Encounter submissions, including claims (medical, pharmacy and ancillary) from delegated vendors are all processed through the Encounter Processing System (EPS) which ensures completeness through validation against Cash Disbursement Journals, as well as compliance with state companion guides for encounter submissions, and management and resubmission of any submission rejections. Our experience and focus in government programs has led WellCare to understand that DMS' definition of an acceptable encounter submission is the entry-level set of quality edits that must be applied to all submissions to WellCare of Kentucky. As a result of this philosophy, we successfully transmit encounter data in 13 versions of Encounter formats (837I/P/D, NCPDP, PACDR, APAC, etc.) for 22 lines of business. All services, regardless of the method or provider remuneration are submitted as encounters to DMS.

Key functional attributes of this application include:

- Acceptance Edits ensure that WellCare of Kentucky only accepts valid submissions from all sources as inputs :
    - Strategic National Implementation Process (SNIP) edits Level 1 and 2 as defined be the Workgroup for Electronic Data Interchange (WEDI) are applied to ensure a submission meets minimum formatting requirements
    - Data Quality Validation edits to identify data submission and quality issues earlier in the process and expedite rejection and return to providers
    - Capturing and validating the use of standard codes (e.g. HCPCS, ICD9-CM/ICD-10 CM/PCS diagnosis and procedure code, Revenue Codes, ADA Dental Codes and NDCs)
    - SNIP Level 3 – 7 edits, based on DMS' submission edits, are applied to ensure that any data quality issues are identified prior to acceptance
    - The basic editing necessary to pass the claims onto subsequent processing as identified in Appendix G (Basic Edits 1 through 21)
    - Tracking, monitoring, and ensuring compliance with response timelines
- Enrollee and provider edits ensure that both the enrollee and provider information on the claim or encounter are properly identified. Primary functional components include:

  - Automated matching of Enrollee information to Enrollment and Eligibility System information
  - Automated matching of provider information to Provider Network system information
  - Manual workflow to support identification of Enrollees and providers in an effort to reduce system-wide administrative expense from resubmissions
  - Validation of excluded entities including Enrollee and provider to avoid payments to unauthorized individuals
  - Tracking, monitoring, and ensuring compliance with response timelines

- Adjudication of Fee-for-Service claim submissions to ensure correct coding and clinical protocols were applied. Key components include:
  - Coding edits, including but not limited to National Correct Coding Initiative edits, are applied to validate the accurate reporting of services provided
  - Clinical edits are applied to ensure appropriate treatment and prior authorization expectations have been met
  - Pricing of services according to provider contracts or other payment methodologies which take into account contractual allowed amounts, TPL payments, Medicare payments, Enrollee age, prior authorized amounts, and any co-payment requirements
  - Workflow functions are directly integrated into the adjudication functions to effectively manage claims processing workload
  - Automated re-adjudication functions for items such as retroactive Enrollee eligibility changes in an effort to reduce system-wide administrative expense from resubmissions
  - Tracking, monitoring, and ensuring compliance with response timelines
- Provider Notification processes are implemented to ensure prompt and timely awareness to submitters about the status of transaction. Key features include:
  - Notification of acceptance of a claim or encounter submission
  - Early notification of any rejection of a submission for any of the validation edit processes
  - Support for standard notification and status transactions such as the 277U format to improve automation and reduce system-wide administrative expense
  - Tracking, monitoring, and ensuring compliance with response timelines
- Submission Edits are applied to all service transactions to ensure quality encounter submissions to DMS. Key characteristics include:
  - Validation of encounter data against DMS' submission guidelines and edits
  - Validation of completeness based on the Cash Disbursements journals of the adjudicator of the services, whether WellCare, a vendor partner, or a delegated entity
  - Tracking, monitoring, and ensuring compliance with response timelines
- Encounter submission to DMS utilizing WellCare of Kentucky's standard EDI services ensure consistency and validation of acceptance. Key features include:
  - Leverages standard EDI toolsets and formats to automate application of submission edits based on DMS' submission guidelines

  - Workflow functions to track the submission and acceptance or rejection of any encounter submission, including the resolution and resubmission of any rejected encounter
  - Tracking, monitoring, and ensuring compliance with response timelines

- Integration with WellCare's Customer Service and Self-Service functions assist the provider community in supporting timely and accurate encounter submissions. Key features include:
  - The ability to check the status and outcome of Fee-for-Service claims, regardless of the method of submission (paper or EDI)
  - Support for small practices and other providers without automated systems by enabling direct data entry of FFS claims or encounters. Manual entry is directly integrated with the edit validations in a real-time fashion to eliminate downstream rejections and resubmissions
  - The ability to correct on-line an FFS claim or encounter submission which is directly integrated with the edit validations in a real-time fashion to eliminate downstream rejections and resubmissions

WellCare of Kentucky's Claims and Encounters processing module maintains complete audit trails, including Claim history at the level of service line detail, adjudication history, payment history, and a complete audit record of all data submitted or created (such as paid amounts) throughout the entire lifecycle of the service record.

Our Claims and Encounter Module, coupled with the use or our Enterprise Information Management (EIM) solution enables robust inventory tracking and reporting and visibility at all times. Ongoing monitoring of claims operations, depicted in **Figure C.6-5**, enabled through innovative technical solutions and dashboard reporting ensure continuous oversight of open inventory, rapid identification and resolution of operational issues, and strict accountability for and adherence to processing SLAs.

In addition, these solutions provide the reporting capabilities necessary to support a wide variety of applications, including the ability to product the following reports on the claims processing function 15 days after the end of each month:

- Number of claims received, paid, denied, and suspended for the previous month by provider type with a reason for the denied or suspended claim.
- Number and type of services that are prior-authorized (PA) for the previous month (approved and denied).
- Amount paid to providers for the previous month by provider type.
- Number of claims by provider type for the previous month, which exceed processing timelines standards defined by DMS.
- Claim Prompt Pay reports as defined by ARRA

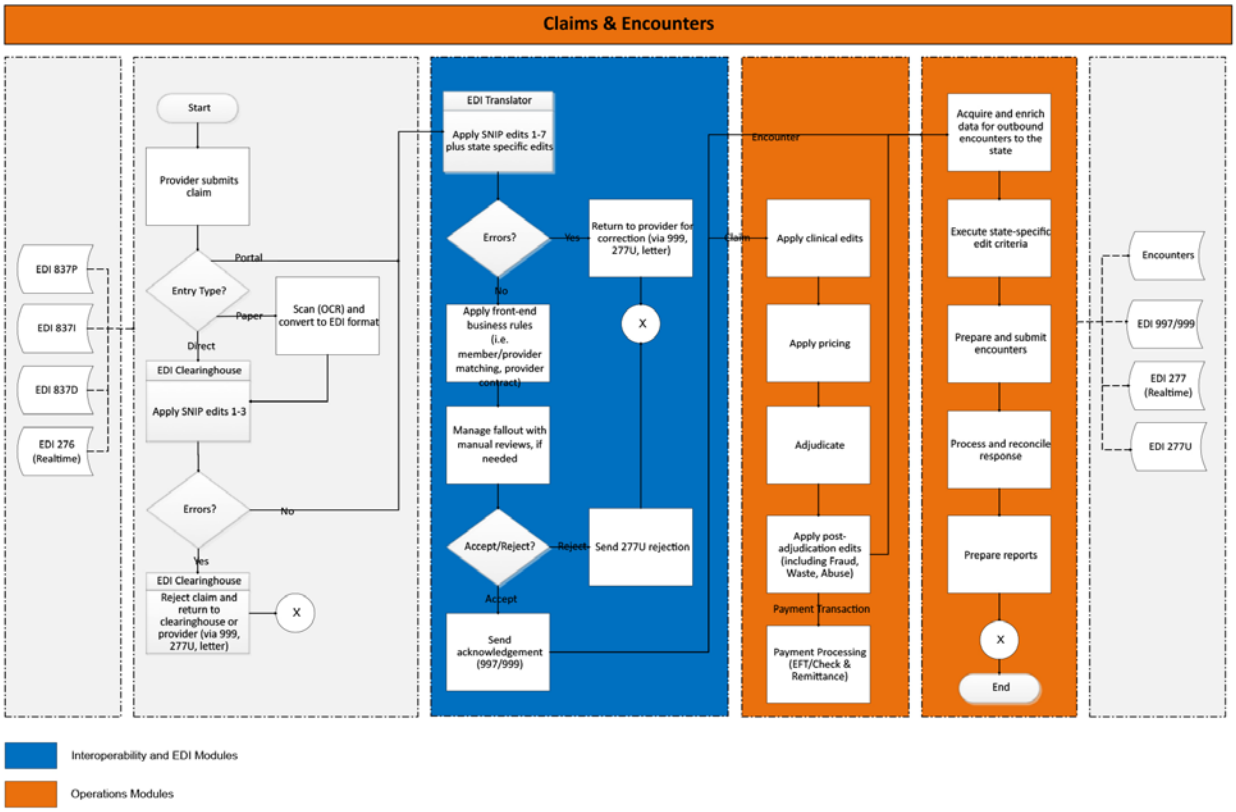


Figure C.6-5 Claims and Encounters Process

vi. Financial subsystem

WellCare of Kentucky's Financial subsystem supports claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing is used to support the Inputs, Processing Requirements, Payment Processing, Adjustment Processing, Other Financial Processing, and Report requirements identified in Appendix G, items a. through f., including the requirement to electronically transmit provider enrollment information to DMS on a monthly basis, by the first Friday of the month following the month reported.

WellCare of Kentucky's suite of financially oriented applications provide solutions for calculating payments to providers for optional payment methodologies (those not based on Fee-For-Service claims payments) including value-based arrangement, traditional Enrollee and provider incentive programs based on participation and activities, standard financial functions, secure execution of payments and incentives, and a separate reconciliation with DMS data sources to ensure accounting integrity. These financial systems are deliberately designed to support the auditability, separation of duties, and additional compliance requirements that are consistent with industry best practices.

The key applications and functions of Financial Payment and Reconciliation include:

- Enrollee incentives are defined in accordance with Department's guidelines and are integrated with our focus on health outcomes. Primary functions include:
  - Based on program design, identifying enrollees that are eligible for the incentives and notifying them of the opportunities for awards
  - Integration with the CareConnect & Self-Service applications and the Corporate Correspondence Module to support increased notification
  - Tracking of enrollee activities associated with award programs
  - Determining and making available award information for integration with the Payment Execution module
- Value-based payments are based on provider contracts that are separate from fee-for-service claim payments and are designed to promote health outcomes and improved efficiency in the health care system. This module tracks multiple payment methodology components and includes as key features:
  - The calculation of Enrollee-based payment methodologies such as age/gender based capitation payments to providers and delegated entities
  - The calculation of 'Revenue' and fund amounts for risk-based arrangements, to be used in the settlement process
  - Tracking of service amounts and other health outcomes and activities to be offset against fund amounts as part of contractual settlements
  - Determining and making available value-based payments and award information for integration with the Payment Execution module
- Provider Incentives are separate programs intended to influence provider activities that support health outcomes and improved efficiency in the health care system. This module tracks multiple payment methodology components and includes as key features:
  - Based on program design, identifying providers that are eligible for the incentives and notifying them of the opportunities for awards. These include standard Pay-4-Performance and Pay-4-Quality initiatives as well as targeted provider behaviors
  - Integration with the Customer Service & Self-Service, Provider Network Management, and Corporate Correspondence modules to support increased notification and awareness
  - Tracking of provider activities associated with award programs
  - Determining and making available award information for integration with the Payment Execution module
- Payment Execution is completed through separate and distinct solutions to ensure separation of duties in accounting functions and to support increased compliance requirements. Key features include
  - PCI-compliant provider payment modules supporting electronic payment and remittances for all payment types (Capitation, FFS Claims, incentives) - includes support for voids, reissues, recoupment and manual adjustments
  - Support for secure paper-based transactions (payments, remittances) for providers that lack the capability to utilize electronic transactions

- Support for Enrollee Award programs through separate applications allowing for enrollee redemption of awards in compliance with DMS' standard
- Integration with the Enrollee incentive, provider incentive, and value-based payment modules to ensure payment completion
- Maintains a complete audit trail and history of payments, adjustments, overpayments and recoupment activities with the ability to trace each payment at a claim level

- Financial Accounting modules support the basic internal and corporate finance activities. Key capabilities include:
  - Accounts Payable processing, including operational and internal-operations functions (such as purchase orders and vendor payments) and the interface into general ledger activities
  - Accounts Receivable processing based on DMS' payments to WellCare of Kentucky, including the interface into general ledger activities
  - General Ledger capabilities, with inputs and interfaces to multiple systems, to compile and generate WellCare financial statements in accordance with GAAP and applicable State and Federal guidelines

WellCare of Kentucky's Financial Subsystem utilized data from the Claims, Capitation, and other payment systems, combined with the appropriate data from the Provider Subsytem to calculate, maintain and produce accurate 1099 forms (including associated payment data by FEIN number for providers with changes of ownership, based upon effective dates).

vii. Utilization Management/Quality Improvement

WellCare of Kentucky's **Quality systems (referred to collectively as CareCentral)** leverages the breadth of data and comprehensive reporting solutions of our Enterprise Information Management (EIM) solution combines data from other subsystems and external systems, to provide the capability to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and underutilization of services, and the development of user-defined reporting criteria and standards.

Examples of the capabilities supported include (and depicted in **Figure C.6-6**):

- *The Assessment subsystem* allows for the rapid development and deployment of Enrollee health assessments
- *The Utilization Management (UM) subsystem* supports the request, evaluation and monitoring of referral activities, including in-patient and outpatient care, emergency room use, outpatient drug therapy, and out-of-area services. Pharmacy UM services include support for electronic Prior Authorization (ePA) processing
- *The Care Planning subsystem* uses best practices and patient-specific modifications to ensure comprehensive care plan are developed for each individual. This mobile, digital application supports field-based care managers and supports tracking an individual Enrollee and its family's health status, participation and adherence to care plans and medication schedules and the ability to compare individual experience to population norms

- Enrollee 360 views combine administrative data and transaction, clinical data and transactions, and social determinants information to provide comprehensive, holistic views to consider the whole patient and provide the most effective individual-specific outcome management capabilities
- Social Determinants and Services are tracked for each Enrollee and provide both access and referrals to Community providers that can help Enrollees meet these needs
- *The Measures subsystem* provides the generation and ongoing publication of HEDIS results as a primary means of effectiveness (based on currently published, standard measure definitions)
- Our proprietary risk identification and stratification uses data from all sources (administrative, clinical, and social) and incorporates AI and Machine learning in addition to traditional methodologies to most efficiently identify Enrollee needs and the most effective means of engaging them in their health
- Tracking care needs, publishing to Enrollees, providers, care givers and care managers to assist in completing these vital preventative health activities including EPSDT
- Generation and communication of provider profiles to identify opportunities to collaborate with and educate providers on opportunities to improve Enrollee health outcomes
- Monitoring service delivery of critical services through Electronic Visit Verification (EVV) technologies, when applicable

WellCare's ability to utilize standard functions of modules such as the EDI & Interoperability module and our EIM solution allows CareCentral to support and directly incorporate our Clinical Data repository into all aspects of operations and care management. Key features and capabilities of the Clinical Data Repository include:

- Receipt (batch and real-time) of ADT transactions, including real time notification to care managers and affiliated providers
- Ability to receive clinical data from all participants (including providers, hospitals, and HIEs) in both standard formats (CCD-A, FHIR, lab ORU and other HL7) as well as support non-standard clinical information capture
- Establishment and management of EMR connections and data interchanges interchange
- Capture of Transition and Historical service information from DMS or other MCOs and directly incorporating this data into ID/Stratification and care management functions
- Integration of clinical data and transactions into care manager 360 views as well as provider quality dashboards with the primary focus of improving provider quality performance and the associated Enrollee health outcome improvements

WellCare’s **Issue Management subsystem** includes support for the requirements related to occurrence reporting, including adverse incidents and complications, monitoring and evaluation studies, as well as enrollees and providers aggregate Grievances and Appeals. Key functions of this tracked and supported by this module include:

- Identification and proper classification of Issues, Complaints, and Grievances including the active monitoring of language and tone of customer service calls to initiate immediate action on satisfaction issues

- Receipt and acknowledgement of Issues, Complaints, and Grievances from all available communication channels including customer service agents and web portal submissions
- Monitoring of social media activity to identify potential issues, Complaints and Grievances and initiate cases based on this information
- Receipt and acknowledgement of provider disputes from providers and internal provider representatives
- Identification and classification of Critical Incidents
- Recording and communication of the decision to Enrollees and providers
- Tracking, monitoring, and ensuring compliance with response timelines

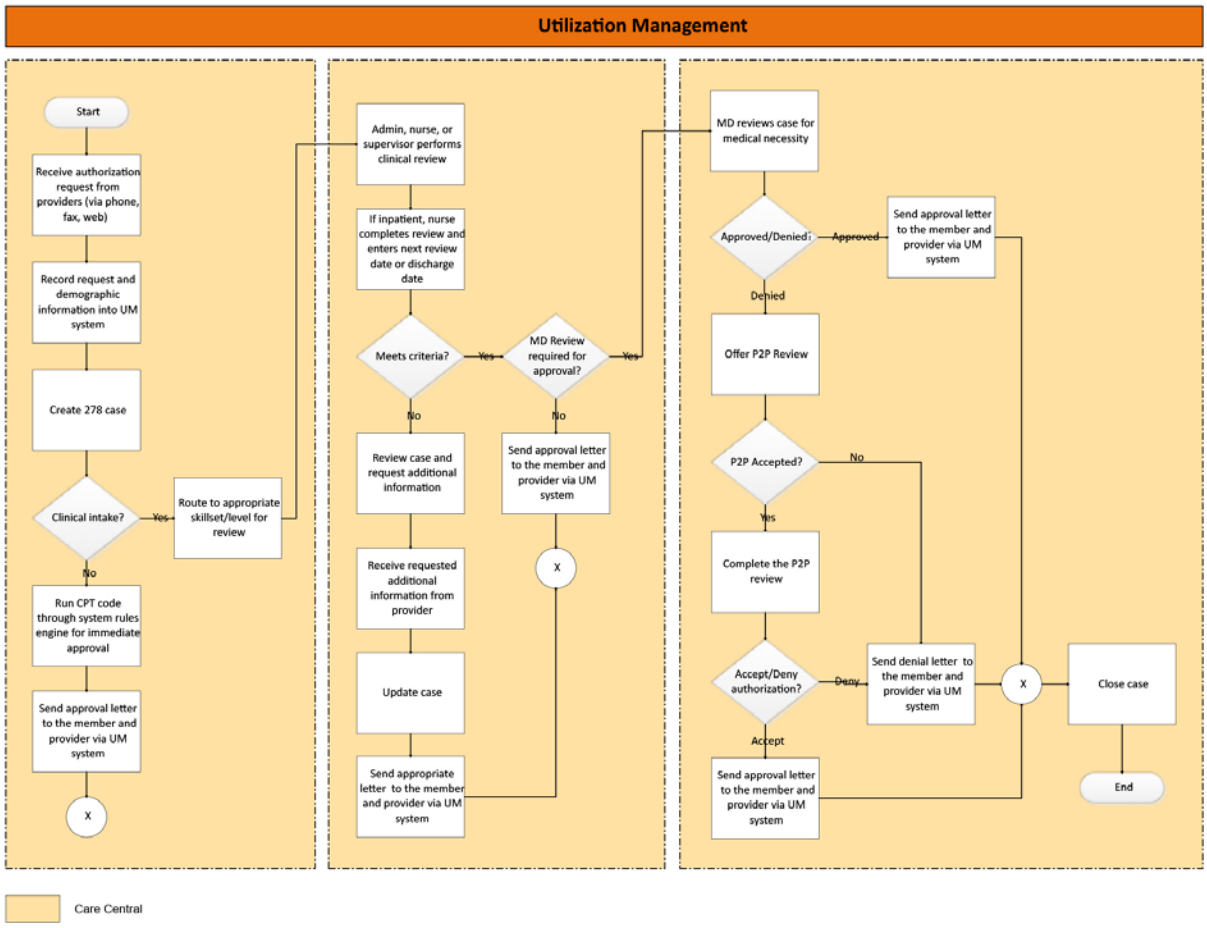


Figure C.6-6 Utilization Management Process

viii. Surveillance Utilization Review Subsystem (SURS)

Multiple WellCare of Kentucky subsystems, operating in a seamlessly-integrated fashion, provide the SURS functionality outlined in Appendix G.

WellCare of Kentucky's Claims and Encounter Processing subsystem includes modules such as Fraud/Waste/Abuse, Adjudication and Clinical Edits, and TPL support contain features and capabilities including the application of analytical algorithms to service data to identify and detect patterns of fraud, waste, or abuse by Enrollees and providers.

The Adjudication module of our Claims Application automatically applies Clinical Edits, pricing groupers, and Fraud/Waste/Abuse edits on a real time fashion. In addition, WellCare of Kentucky contracts with both Optum and Cotiviti to review claims for indications of abuse and abnormal utilization patterns in order to ensure multiple methods of utilization oversight are applied. All of these solutions, both pre-payment and post payment will identify and report on enrollee and provider fraud.

WellCare of Kentucky's Quality subsystem, leveraging the breadth of data and comprehensive reporting solutions of our EIM solution combines data from other subsystems and external systems, to provide the capability to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and under-utilization of services, and the development of user-defined reporting criteria and standards. The subsystem provides information directly to the provider using dashboards and portals to inform them of outcome measurement performance using HEDIS and state specified quality indicator with ability to show areas of opportunity to improve outcome measures. The subsystem manages provider credential review processes to evaluate the credibility of the provider and any associated owners of the provider group.

WellCare of Kentucky's Issue Management subsystem includes support for the requirements related to occurrence reporting, including adverse incidents and complications, monitoring and evaluation studies, as well as enrollees and providers aggregate Grievances and Appeals. Key functions of this tracked and supported by this module include:

- Identification and proper classification of Issues, Complaints, and Grievances including the active monitoring of language and tone of customer service calls to initiate immediate action on satisfaction issues
- Receipt and acknowledgement of Issues, Complaints, and Grievances from all available communication channels including customer service agents and web portal submissions
- Monitoring of social media activity to identify potential issues, Complaints and Grievances and initiate cases based on this information
- Receipt and acknowledgement of provider disputes from providers and internal provider representatives
- Identification and classification of Critical Incidents
- Recording and communication of the decision to Enrollees and providers
- Tracking, monitoring, and ensuring compliance with response timelines

REPORTING

As a part of WellCare's Enterprise Architecture, we are constantly investing in the enhancement of our formal Enterprise Information Management (EIM) solution that supports all of our data needs, including application processing, regulatory reporting, and ad hoc reporting. This comprehensive EIM solution ensures that all data sources are captured and catalogued, fully integrated into and accessible by transactional processing systems, and enables robust reporting capabilities in support of regulatory, operational, and analytic capabilities.

WellCare of Kentucky's EIM solution ensures that data collected from external sources, generated from internal sources, and exported to external parties is captured and made

available in a useful manner. Some key examples of data sources that are incorporated in the EIM include:

- Raw data source receipts such as 834s and 837s received from the State and delegated vendors
- Systems of record including enrollee and provider data
- Transactional systems including claims, utilization and other medical record data
- Quality data including HEDIS® outcomes, EPSDT, vaccination and care need information
- Care management and utilization data, including authorizations
- Submissions to external entities such as encounters (including all pharmacy, dental and ancillary claim data)

All of the data that is pooled into our EIM is available for use in generating regulatory reports, fulfilling ad hoc requests, and meeting operational and analytics needs. Data is collected and incorporated into the Data Marts on a continuous basis.

WellCare of Kentucky employs a set of validation, cleansing and aggregation activities to make sure all data marts are populated with clean, accurate, and useful information. Data Marts include all data types and combine similar data sets from multiple source systems in order to meet the specific needs of the organization as efficiently as possible. Data Marts are typically constructed based on the intended use and can generally be classified as an Application Support, Reporting or Analytic Data Mart.

Application Data Marts are a key method of integrating data from all sources into our applications. Just as the application data stores (such as claims, enrollment and provider transactions themselves), these data marts are accessed by applications through the data services layers. Reporting and Analysis Data Marts often come from the same sources of data but are structured to be used by our Reporting tools (such as Cognos), Analytics tools (such as SAS), and Visualization tools (such as Tableau®). In turn, these tools make data readily available to our users. **Figure C.6-7** depicts our reporting and analytics sources and integration

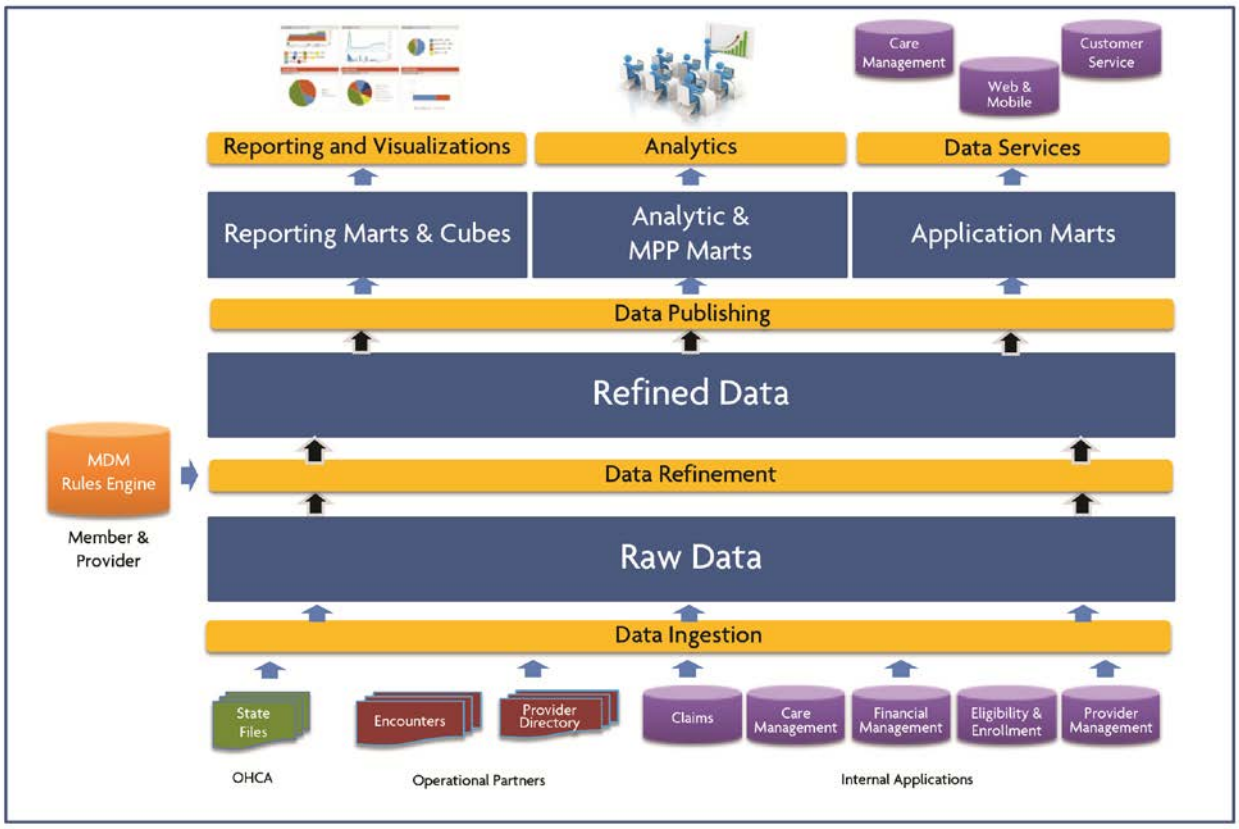


Figure C.6-7 EIM - Our reporting capabilities

TESTING

Testing is an embedded and engrained function in our software development and implementation project activities for both waterfall and agile software development models. Testing activities involve both system tests and user acceptance tests. System tests focuses on functional and non-functional tests, validates all business, functional and technical requirements are met by the system, and that the system functions per the business driven design specification. User Acceptance tests (UAT) are performed by business users and focuses on validating business requirements to confirm that system is fulfilling its intended business purpose.

During the development of reports and applications, performance testing is completed as development is occurring, and is validated independently during the QA process. In addition, we have established and is continually improving our Scalability Testing function, which utilizes a dedicated test environment and independent tests to measure and predict application and report performance in our production environment.

Quality assurance (QA) team has well-defined testing process to ensure that all functional areas are thoroughly tested for the defined functional requirements and meet necessary exit criteria. Specific to software tests for Provider configuration of benefits/pricing, Quality assurance team conducts following activities during testing phase.

- QA Team thoroughly reviews functional requirements specific to configuration updates impacting benefits / pricing and identifies the impacted claim scenarios to be tested. The test scenarios and corresponding test cases are written to validate the tests in line with requirements. Requirement traceability matrix (RTM) is established to ensure 100% test coverage.
- QA team identifies the specific Lines of Business (LOBs), Claim types, scenarios, provider types, enrollee types to be tested against. QA Test data management (TDM) team then prepares / identifies test data to be used for validating all identified business / test scenarios
- QA team then creates the claims to validate all impacted business rules and critical regression business rules / configurations to validate accuracy of test claims results for following aspects
    - Validation of key parameters such as copay, coinsurance, deductibles, Out-Of-Pocket (OOP) Maximum limits based on business rules against the benefit configuration rules.
    - In-network / out-network provider based claims processing
    - Price based validations
- QA team validates specific scenarios in provider portals to ensure provider configuration reflects accurately in provider view and other provider specific IT applications such as Enterprise provider directories
- QA team identifies and reports any discrepancies in Benefits calculations based on provider configuration and reports the discrepancies thereby assisting with accurate claims adjudication

WellCare has developed a Testing Center of Excellence (TCOE) to enable faster-time-to-market through streamlined and effective QA processes/functions. The processes are enabled by a strong automation approach and critical techno-functional skilled people. These areas of focus have **resulted in 99.9% system availability and stability for our enrollees and providers.**

The Quality Assurance (QA) team operating in a Center of Excellence model, is able to achieve business value while mastering speed, quality and productivity. The overview of the QA areas are outlined in **Figure C.6-8**. Over the past four years, QA has achieved the following key outcomes:

- *Governance and Operating Model*: Our strong leadership team drives strategic initiatives with a global network of resources providing 24/5 support coverage for speed to market delivery.
- *Process Discipline*: We have made rapid maturity advances across our Quality Assurance team. In 2018 the team reached the industry recognized Testing Maturity Model (TMMI) level 3.3. **This level was assessed by Gartner, a 3rd party independent assessor. The achieved maturity level translates into an improvement of 2.24 on a 5 point scale between 2015-2018.**
- *Automation:* Automation of test scripts is a key success factor as the TCOE focuses on repeatability and cost reduction. WellCare has consistently delivered UAT leakage to production at an industry beating rate of 1 – 2%.

- *Continuous Improvement:* The team executes proactive root cause analysis activities to review processes with a focus on increasing standards of quality. Metrics have shown identification of 95% of the defects in system testing before User Acceptance Test (UAT) every month.
- *Innovation:* WellCare has utilized various software tools and approaches to steadily increase its speed- to-market delivery of business requirements, technical environment and regulatory changes to production. **QA change order productivity has increased by 21% while cost per change order decreased by 12%.**

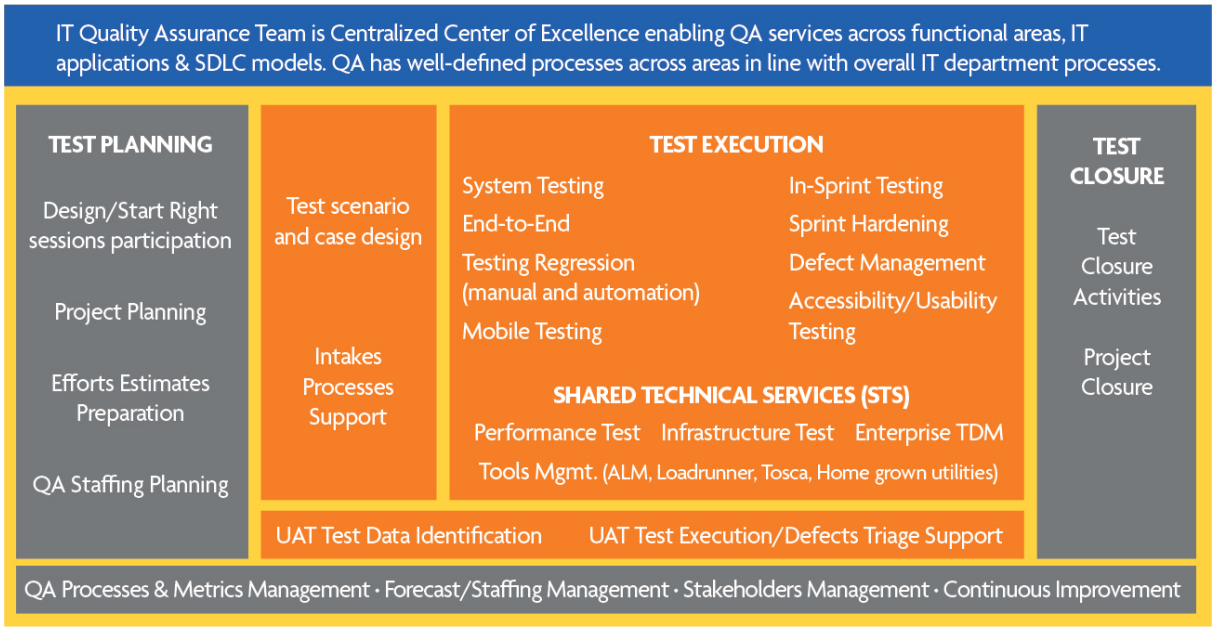


Figure C.6-8 Overview of QA areas

As part of the response, include information about the following:

i. Required interfaces, how the system will share and receive information with the Department, how the Vendor's system will use files provided by the Department, Subcontractors, providers, and other supporting entities.

WellCare of Kentucky's Interoperability and Integration Services is specifically designed to provide the means to interact and conduct electronic transactions with all health system participants, including DMS, subcontractors, providers, and other supporting entities. Specifically, these capabilities include support for incoming and outgoing data from other organizations, such as allowing us to maintain enrollee enrollment information and Enrollee-related information based on data exchanges. These functional and technical components highly leverage industry standards for EDI while directly incorporating MITA and CMS Interoperability concepts to maximize integration capabilities, reduce health system operating costs, ensure the inclusion of specific security and privacy measures in all data exchanges in adherence to HIPAA and other privacy provisions in order to ensure protection of sensitive Enrollee information, and advance government initiatives.

Data exchanges are completed utilizing pre-established secure File Transfer Protocol (sFTP) transfers that implement encryption and role-based security, ensure each incoming file is scanned for viruses, trojans, malware and other threats, catalogued and archived before being delivered to the appropriate processing application in another secure, application directory.

The primary method of data sharing currently in use in government sponsored programs remains the exchange of data files. WellCare of Kentucky's Interoperability and Integration services support the receipt of data files (using secure FTP and other encrypted transmission methods), validation of the structure of the data files to ensure compliance with defined data elements, formats, and file layouts (for example, 834 format and associated SNIP Edits), and delivery of the data files to the appropriate processing applications (such as our Enrollment module). Incoming data file FTP sites are monitored continuously, and after validation data files are delivered directly to the processing application. Outbound data files WellCare is required to generate are initiated through an automated scheduler. Automatic monitoring of job execution for both inbound and outbound file processing is built into the job applications and any failure automatically generates a service desk ticket and requires resolution. The failure queue is monitored 24 hours a day by our Enterprise Service Desk Operations.

Key functional attributes of this Enterprise technical component include:

- Receipt of all incoming transactions
    - Standard EDI trading partner management functions
    - Standard EDI file Strategic National Implementation Process (SNIP) edits and validations
- Support for receipt of batch Data File or real time transactions
- Delivery of transactions to operational systems through:
    - Flat file delivery to batch oriented applications such as enrollment processes
    - Event publishing of individual transactions to real-time applications such as claims intake (including when received in batch files)
    - Recording and Retention of all incoming transactions in raw receipt form
- Support of audits and independent verification of processing accuracy
- Support for transaction timeliness , completion, and reconciliation activities
- Support of record retention requirements that meet/exceed State and Federal retention requirements

A primary feature of WellCare of Kentucky’s Interoperability and EDI integration platform is support for industry standard transactions and formats. WellCare complies with the transaction standards rule 45 CFR Part 162 [CMS-0009-F] published on January 16, 2009. This rule mandates the use of the Accredited Standards Committee X12 (X12) version 5010 for health care, supporting the X12 version 5010 for health care transaction standards in the following **Table C.6-1**:

Table C.6-1 Healthcare Transaction Standards

Healthcare Transaction Standards	
Claims and Encounters 837P – Professional 837I – Institutional 837D – Dental NCPDP D.0 Pharmacy Claims	Claims Status 276 – Claims Status Inquiry 277 – Claims Status Response 277U – Unsolicited Claims Status
Remittance Advice 835 Remittance	Premium 820 – Premium Payment
Eligibility Inquiry and Response 270 – Eligibility Inquiry 271 – Eligibility Response	Transaction 997 – Functional Acknowledgement 999 – Implementation Acknowledgement
Enrollment 834 Benefit Enrollment and Maintenance	Authorization Requests 278 Authorization Request

REQUIRED INTERFACES

Provider

The primary aim of the Provider module is to ensure that a consistent, validated, comprehensive provider directory is available at all users at all times. All WellCare of Kentucky applications are developed to integrate directly with the Provider module as the single source of truth. In compliance to the requirement outlined in Appendix G, Provider subsystem, our Provider function accommodates an external interface with:

- DMS; and
- Other governmental agencies to receive licensure information

WellCare Kentucky utilizes the functionality of our Interoperability and Integration Services to integrate external data transfers with our Provider and Credentialing applications, which leverages our Cactus Application suite to manage the provider credentialing life cycle. These applications support the integrations necessary to receive and utilize licensure information from a variety of sources. These interfaces are able to import these data sources in a variety of data format and utilize them to ensure that only licensed, non-excluded providers are included in our directors or paid for services and include interfaces such as CAQH, CMS SAM, Lexus-Nexus, List of Excluded Individuals and Entities, CMS Death Master, and State Roster Files.

State Roster files are also utilized to ensure that proper identifiers are submitted and available for the receipt of claims and the submission of encounters.

WellCare of Kentucky has pre-developed interfaces which utilize our Interoperability and Integration Services to extract provider data to create outbound extracts of data, in the required formats including active providers in the last six months in the format specified by Provider Master Extract File Layout for MCOs in Attachment C, as well as the CMS Machine readable format). These data files are delivered via secure FTP transfer sites

Enrollment

WellCare Kentucky utilizes the functionality of our Interoperability and Integration Services to integrate external data transfers with our Enrollment module, which is explicitly designed to recognize DMS' 834s as the authoritative source of Enrollee data and eligibility by accurately processing and reconciling to Department-supplied 834 files. In compliance to Appendix G – Member Subsystem WellCare of Kentucky accommodates an external electronic interface (HIPAA ASC X12 834, both 4010A1 and 5010 after January 1, 2012) with DMS.

WellCare of Kentucky's Member and Enrollment application currently supports DMS' specified 834 file specifications for daily and monthly eligibility files. The applications apply multiple edits and validation on the incoming 834 data during the processing stages including comparisons to existing records using names, Medicaid or other IDs, and date of birth to prevent loading duplicate records. Because the Enrollment module performs all validations (including potential duplicates), tracks each Enrollee separately, and requires manual confirmations prior to loading, WellCare of Kentucky is not only able to ensure accurate system updates but also support notification and interaction with the State for duplicate or other potential Enrollee data issues.

All WellCare of Kentucky applications are developed to integrate directly with the Provider module as the single source of truth.

Encounters

WellCare of Kentucky utilizes the functionality of our Interoperability and Integration Services, integrated with our Claims & Encounters application which specifically designed and developed to submit complete, accurate, and timely Encounter Data to DMS within 30 days of claim adjudication. This includes all paid and denied claims, corrected claims, adjusted claims, voided claims, and zero dollars ($0) paid claims processed by us or by our subcontractors.

WellCare of Kentucky's Encounter Submission processes currently supports DMS' specified, Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 transaction 837 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version 2.2. Example transactions include the following:

- 837I – Instructional Transactions
- 837P – Professional Transactions
- 837D – Dental Transactions
- 278 – Prior Authorization Transactions
- 835 – Remittance Advice
- 834 – Enrollment/Disenrollment
- 820 – Capitation
- 276/277 Claims Status Transactions
- 270/271 Eligibility Transactions
- 999 – Functional Acknowledgement
- NCPDP 2.2

All Encounter Data (paid, denied, voided, etc.) will be submitted to DMS according to the agreed upon schedule (as frequently as daily). Encounter submission to DMS utilizing WellCare Kentucky's standard EDI Services ensure consistency and validation of acceptance.

Key features include:

- Leveraging standard EDI toolsets and formats to automate application of submission edits based on Kentucky's submission guidelines
- Workflow and Work distribution functions to, track the submission and acceptance or rejection of any encounter submission, including the resolution and resubmission of any rejected encounter
- Tracking, monitoring, and ensuring compliance with response timelines

Capitation interface

WellCare of Kentucky utilizes the functionality of our Interoperability and Integration Services to integrate with the Enrollment and the Finance modules to generate the Report 230 and Report 250 data files, using the format specified in Appendix O, and submit this payment and roster information to DMS. The process validates the data and information generated to ensure compliance with the formatting requirements and deliver the data file to DMS securely using a secure FTP data transfer site

WellCare of Kentucky receives and validates, from a secure FTP data site, the inbound Reports, applies validation edits to the data received, and generates variance reports that will be utilized to fully reconcile all Capitation payments against our records. When appropriate, accounting adjustments will be made in the financial system to ensure accurate financial statements and records are kept.

HOW THE SYSTEM WILL SHARE AND RECEIVE INFORMATION WITH DMS

WellCare of Kentucky implements automated processes to facilitate the exchanges of data with our external partners, whether they are State agencies or our provider and delegated partners (such as CVS, our PBM) to exchange data. Our automated scheduler initiates the generation, execution, and delivery of this data through secure FTP (sFTP) services in the defined frequency without human intervention. Any job failure automatically initiates an alert which is delivered to our EDI Operations teams creating an intake ticket. All tickets are resolved and the queue is monitored by both EDI Operations staff and the management.

WellCare of Kentucky's sFTP sites for incoming data are constantly monitored for the arrival of new data files and all subsequent processing is initiated automatically. All data files are scanned for viruses, trojans, malware, and other threats, catalogued and archived before being delivered to internal, access-restricted (based on application or user role) directories for further processing. Incoming secure FTP sites will be monitored daily for any received but unprocessed files.

USING FILES PROVIDED BY DMS, SUBCONTRACTORS, PROVIDERS, AND OTHER SUPPORTING FUNCTIONS LIKE ENROLLMENT, PROVIDER, OTHERS

At WellCare of Kentucky, the utilization of files provided by DMS, subcontractors, providers and other supporting functions is determined based on the following criteria:

- Where specified by DMS (such as the Enrollment 834, Provider Data, and Reference Data as outlined in Appendix G), WellCare uses these data exchanges for the express purpose described by DMS (maintaining accurate enrollment files, maintaining accurate provider network data, and ensuring accurate reference data for use in other functions). This would extend to the receipt of files such as the 820 payment file, which is utilized for the reconciliation of payments and independently as a validation of the accuracy of our membership information
- Where industry standard specifications outline an intended use, the data exchanges are used according to the guidelines of that specifications. Examples include the receipt of 837 Claim files which are used specifically to accept the submission of claims from providers, 278 Authorization Request and Authorization Notification processes, and HL7 transaction such as the ADT records to maintain an accurate clinical record and provide notifications to care managers and providers of admissions, and other industry standard guidelines.
- Other proprietary data exchanges are supported and used for the reasons outlined in the agreement(s) that govern the exchange of data

In addition, as a general rule, WellCare will utilize all data sources available to support research, analytics, and analysis to gain unique insights into methods of improving operations or Enrollee health outcomes. Further, whenever available, WellCare will use all data exchanges as a means of identifying actionable events. As an example, either an ADT or a Hospital Admission claim are indicators to alert care managers to the fact that a enrollee was admitted and may be in need of discharge planning or other follow up activity.

Specific examples of how WellCare will utilize data exchanges with DMS, Subcontractors, providers, and other supporting functions like enrollment and provider include:

Data and Files from DMS

- Eligibility information is utilized to ensure accurate eligibility in our operational systems. This data is also utilized to identify third party liability opportunities as well as the Enrollee risk stratification process
- Payment files are utilized not only to validate payments but are reconciled to ensure that Enrollee eligibility information was properly processed and the category or eligibility codes are utilized to further enhance our risk stratification and care planning processes

Data and Files from Subcontractors

- Validated encounters and the subcontractor's cash disbursements journal are utilized to ensure complete and accurate submission of encounter data
- Lab test results, in addition to lab claims, are received and the lab results are integrated into our Clinical Data repository. This data is then used to identify Enrollee health conditions to address in service plans and support HEDIS and other quality measure evaluations and included in the care manager's Enrollee 360 view

Data and Files from Providers

- Chart data (including CPT-II codes) is incorporated into the Clinical Data repository and utilized to enhance the risk and stratification process, support HEDIS and Care Gap calculations, and is incorporated into the care manager's Enrollee 360 view
- ADT information received is utilized to alert Care Managers to the fact that an Enrollee was admitted and may be in need of discharge planning or other follow up activity. Notification can also be made to the Enrollee's PCP

Data from supporting Functions

All WellCare application modules as directly integrated with each other and able to share information.

- Care needs identified during the HEDIS quality calculations are accessible by and displayed on the Enrollee portal, the Enrollee mobile applications, to PCPs on the provider portal (for their assigned Enrollees), to care managers in care planning, and alerts to customer service agents
- Enrollee data updates from both DMS and other operational activities are automatically acted upon. As an example, an Enrollee's change in PCP selection can be used to notify DMS, KHIE, care managers and physicians (both the prior and new PCP) of the enrollees change in election
- Encounter data is automatically integrated into our Fraud, Waste, and Abuse edits for claims processing to help ensure comprehensive programs to identify Enrollee and provider fraud

Data from other sources

- WellCare has interacted with HIEs, EHRs, and other clearinghouses to collect ADT and Clinical Data (even if only available through Direct Secure Messaging) on Enrollees and incorporates this data into HEDIS measure calculations and care managers leverage this data in the care planning process
- Externally validated Clinical Guideline data is obtained and directly integrated into our Utilization Management applications to assist UM staff in ensuring that authorization requests are validated against industry best practices in treatment plans
- Clinical guidelines are also obtained and directly integrated into our claims adjudication process to identify services for which reduced payments or payment denials should be applied

WellCare's Operations and Care Management systems, leveraging our EDI & Interoperability and Enterprise Information Management technical solutions, as capable of supporting all interface needs, including the Required Interfaces identified by DMS.

ii. Capability to store and use large amounts of data, to support data analyses, and to create standard and ad hoc reports.

WellCare of Kentucky views having the ability to process and support large amounts of data, analytics and reporting as a foundational element of a top-performing health plan. To excel in

this area, our Enterprise Information Management (EIM) strategy and approach are based on both maximizing the capture of timely, accurate, and complete data, as well as converting that data into value-added information and insights that can be used to diagnose areas of opportunity and design and execute initiatives and programs to better serve our Enrollees and providers.

As described in (testing section above) WellCare of Kentucky also implements multiple levels of independent test verifications into our processes to ensure the ability to scale. During the development of reports and applications, performance testing is completed as development is occurring, and is validated independently during the QA process. In addition, we have established and is continually improving our Scalability Testing function, which utilizes a dedicated test environment and independent tests to measure and predict application and report performance in our production environment.

To that effect, we designed our EIM which is the central repository of all our data which facilitates data integrity and self-service analytics. Developed using industry leading solutions such as Oracle, Hadoop, and Greenplum our technology stack is built on foundational technologies capable of scaling to volumes in excess of the demands required to meet our obligations to DMS.

Our EIM solution begins with the implementation process that describes cataloging and collecting any and all available data for use in subsequent processes. This ensures that data collected from external sources, generated from internal sources, and exported to external parties is captured and made available in a useful manner. Some key examples of data sources that are incorporated in the EIM include:

- Raw data source receipts such as 834s and 837s received from the State and delegated vendors
- Systems of record including Enrollee and provider data
- Transactional systems including claims, utilization and other medical record data
- Quality data including HEDIS® outcomes, EPSDT, vaccination and care gap information
- Care management and utilization data, including authorizations
- Submissions to external entities such as encounters (including all pharmacy, dental and ancillary claim data)

All of the data that is pooled into our EIM is available for use in generating regulatory reports, fulfilling ad hoc requests, and meeting operational and analytics needs. Data is collected and incorporated into the Data Marts on a continuous basis. EIM leverages innovative solutions and technologies for storage and processing, high performing data exchange and integration tools, data visualization tools for reporting and analytics in conjunction with predictive modelling capabilities to process, analyze and report on very large amounts of data rapidly. The EIM is also directly integrated to support application functions such as the quality management reports, Part C&D reports, Risk adjustment process submissions, FWA reports, providing service coordinators with Enrollee 360 views, and as the source of stratification and provider profiling outcomes. The EIM also supports ongoing initiatives to onboard clinical data in industry format from providers for effective population health management and reduce gaps in care.

SUPPORTING DATA ANALYSIS

With the capability of EIM (as discussed above), we have the full capability to support data analysis. Using data from our transactional and EIM applications, and leveraging tools such as Tableau, Cognos, and SAS, WellCare has both the technical tools and the experience needed to support analytic functions.

WellCare of Kentucky's support for analytics extends from support for casual business users, to experienced experts, and now includes data scientists utilizing machine learning techniques.

In addition to basic tools such as Excel or Access, WellCare of Kentucky has developed a series of drill down dashboards that are accessible to casual business users. These intuitive, Tableau-bases, self-navigating dashboards are accessed through a main landing page and incorporate standard data elements in views. User are able to utilize these dashboards to refine the information in the view through clickable drop down selections, enabling them to gain new and useful insights. A sample dashboard is depicted in **Figure C.6-9**.

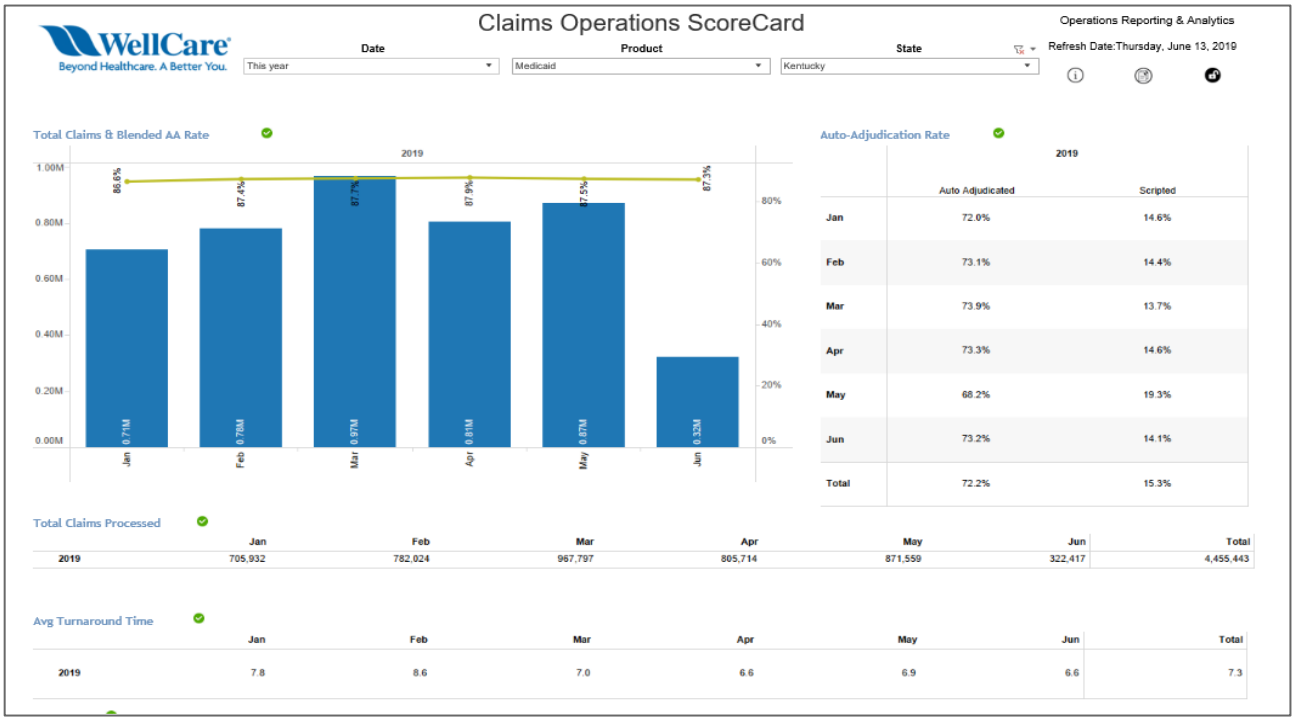


Figure C.6-9 Sample Dashboard

For more experienced experts, the EIMs data warehouse and published data marts provide a wealth or pre-validated data in easily accessible format for use with more robust and capable tools such as SAS. Used in combination these tools allow our experienced users to include and combine data in any desired manner and run advanced analytics and statistical models on all data sets.

WellCare of Kentucky's dedicated team of experts AI and Machine Learning, in collaboration with the appropriate business partners, have been able to leverage highly advanced statistical techniques to approach analytics from new and productive perspectives. A key example of the

application of the tools, knowledge, and skill sets has been our set of Population Segmentation activities. **Population segmentation and modeling have proven useful for a variety of applications. Some of these include, but are not limited to: identifying populations for specialized/tailored health interventions, selecting different care and utilization management strategies, factors leading to disenrollment, and the effectiveness of enrollee retention practices.**

See **Figure C.6-10** and **Figure C.6-11** for Population Segmentation and Modeling Samples.

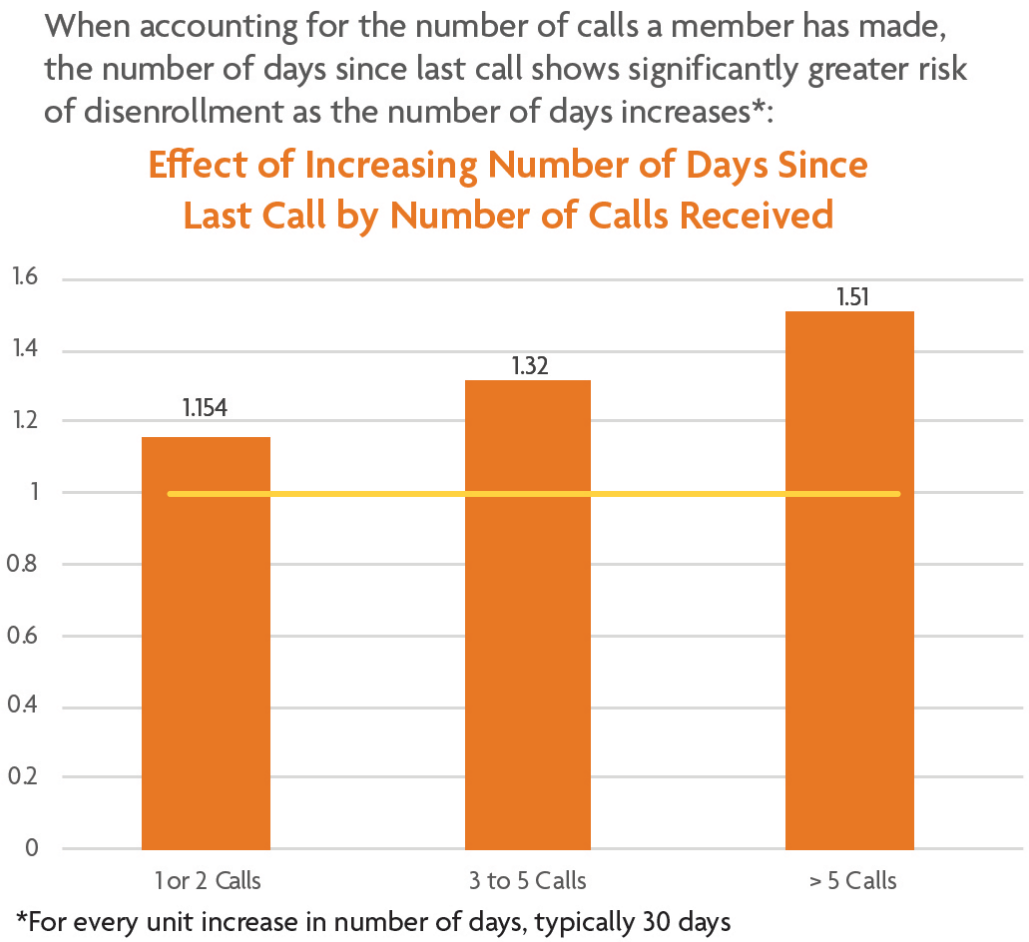


Figure C.6-10 Population Segmentation and Modeling

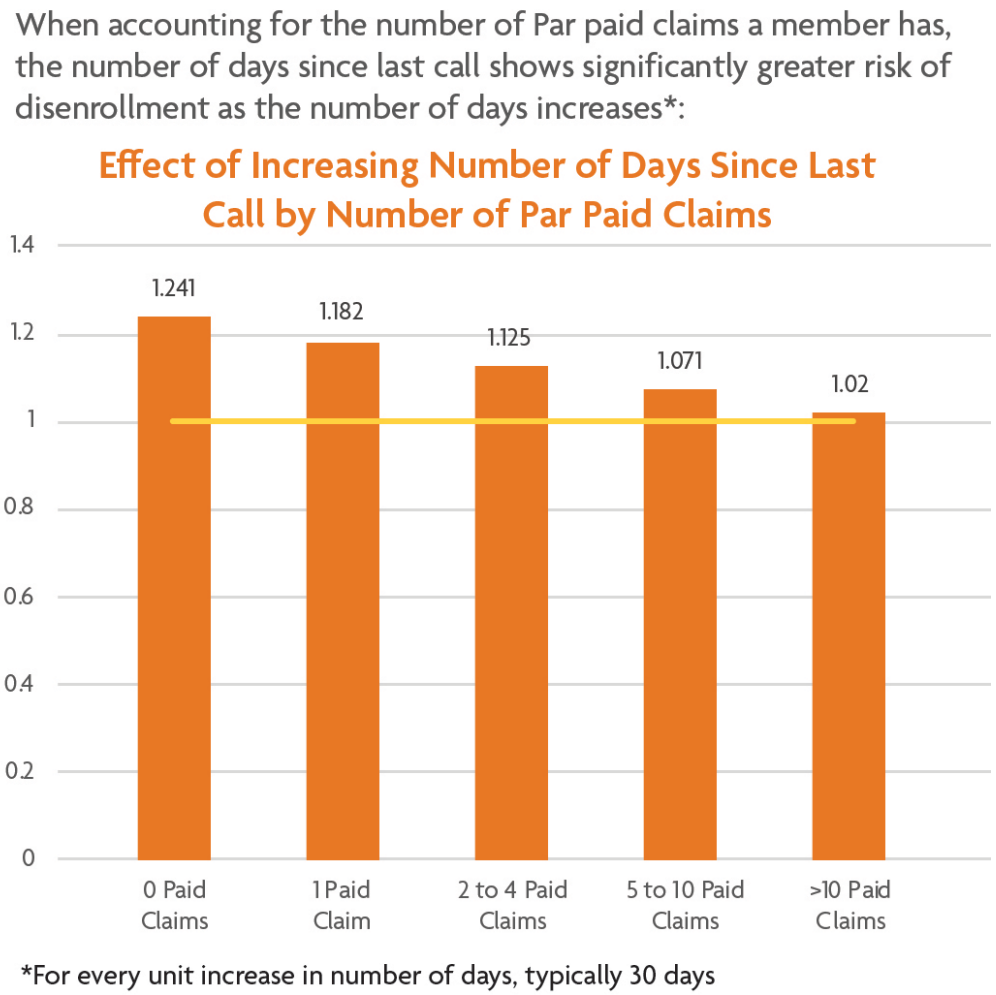


Figure C.6-11 Population Segmentation and Modeling

CREATE STANDARD AND AD HOC REPORTS

With the capability of EIM (as discussed above), we have a formal process to develop and revise regulatory reports, and ad hoc reports which is designed to support the development of accurate, timely and automated regulatory submissions.

Our Kentucky Regulatory Affairs team receives a variety of requests from DMS, and has a well-defined process for ensuring timely response to ad hoc requests. First, the team analyzes the request and the turnaround time immediately engaging the appropriate functional business owners. If the request requires an immediate response, in-market data analysts leverage self-service reporting tools (such as SAS, Cognos, and Tableau) to complete the report. If a longer turnaround time has been offered, or the reporting requirement needs to be ongoing, the Kentucky Regulatory Affairs brings in WellCare's IT Regulatory Affairs team to build and run the report in the same manner as described above. By leveraging our EIM solution, WellCare of Kentucky is able to ensure this team has access to comprehensive, validated data without regard to the type of service (physical, behavioral, pharmacy, dental, vision) or the source (WellCare, WellCare partners, WellCare subcontractors, government partners, former insurers

and health information exchanges). Additional data sets from our transactional systems and delegated partners are available to support these requests as well. Similar to the process described above, our team continues validating accuracy, tracking completion, analyzing for trends, storage of the completed report and final submission to DMS. Additionally, the Kentucky team sends a weekly validation report to DMS' account manager to ensure no reports or requests are missed.

In addition to the above, we **also offer a Government Partner Portal for our state partners to access their own reports with drill down capabilities, and we have it available for DMS.** Our portal is internet-accessible based on login credentials that are approved by Department Administrator(s). Consistent with our other portals, it is available 24/7 with the exception of pre-published and approved maintenance and enhancement windows. Our government partner portal is capable of providing multiple functions to DMS, including:

- Delivery of standard required reports
- Delivery of ad hoc report and data requests
- On-line access to dashboard reports using visual tools and providing drill-down capabilities
- On-line ability to submit service desk tickets for IT or portal issues
- Publishing of materials, manuals and documentation (including portal user guide)

However, to the extent that DMS identifies additional or different reporting requests, we are able to commit experienced personnel to new Dashboard development. In addition, in the event DMS wishes to receive our dashboards via a different mechanism than our government partner portal, we are able to accommodate that approach as well. For example, the reports we currently submit to DMS are primarily delivered via SFTP. We certify the accuracy of our regulatory reports.

iii. Extent to which these systems are currently implemented and integrated with other systems, internal and external, and the Vendor's approach for assuring systems that are not fully implemented and integrated will be ready to begin operations on required timeframes.

WellCare has successfully completed and passed 100% of all readiness reviews for the Medicaid new markets, expansions, and rebid awards

As an incumbent in Kentucky since 2011, we have been using in production a fully tested and operational deployment of our single integrated platform, which is deliberately built and constructed for the purpose of supporting programs such as DMS. WellCare of Kentucky develops, tests and deploys this platform as a comprehensive, fully-integrated solution, ensuring that all subsystems are pre-integrated and validated before. As a result, we have the significant advantage of being able to leverage our existing production deployment, including all the existing and functioning integrations with external systems, to enhance go-live readiness demonstrations.

One of the most critical aspects of our readiness process is the identification of new Information Systems functions and requirements. At the time of this submission, our Enterprise Architecture team has already completed a comprehensive analysis of the RFP, model contract,

and all attachments. Our Enterprise Architecture team members are experienced not only with DMS' program, but also with multiple state Medicaid program requirements across the country. Based on their experience with DMS (including our experience of being prepared to fully implement the Kentucky Waiver program, including Enrollee billing premium requirements)and with other similar populations, they were able to analyze the requirements, identify which needs could be fulfilled with current system capabilities, and determine needs for enhancements to our IT systems. WellCare of Kentucky also recognizes that while we do not need to build program components and systems functionality from scratch, either as a result of Department-specific requirements or our own ongoing improvement programs, we will be obligated to enhance our MIS platform to ensure compliance with DMS' requirements and expectations.

Highly Configurable System

Our copay configuration system allowed WellCare of Kentucky to implement copay requirements based on enrollee demographics, place of service, and at the code level with minimal turn-around time. For the 1/1/2019 implementation of copays we made enrollee-based copay changes that were required by DMS 20 days before the implementation. WellCare of Kentucky also successfully modified its copay configuration multiple times since implementation based on modified DMS requirements.

WellCare's Kentucky-based staff will be aided by WellCare's corporate Enterprise Project Management Office (ePMO) to ensure both local and corporate operations have been adapted to the requirements of the new contract. Our team is also well-versed in standard Software Development Lifecycles (SDLC) such as Waterfall and Agile methodologies. Our PMP-certified, professional project managers leverage ePMO-developed, best-practice "playbooks" that reflect years of industry experience and aggregate lessons learned across numerous contract implementations. The ePMO works hand-in-hand with the state market leaders, government partners, other corporate business functions and subject matter experts, corporate IT, and ancillary vendors to ensure a compliant, operationally-sound Medicaid implementation that seamlessly transitions new enrollees and providers into our health plan. The individuals assisting the Kentucky staff in Kentucky are subject matter experts who have been successful in the implementation of multiple programs in these states: Nebraska, Kentucky, Georgia, Florida, Missouri and New York.

Diagrams and flowcharts should show each component of the MIS and the interfacing support systems used to ensure compliance with Contract requirements.

In addition to the above diagrams, **Figure C.6-12** provides a high level view of our Care Management flowchart and **Figure C.6-13** shows our Identification and Assessment process.

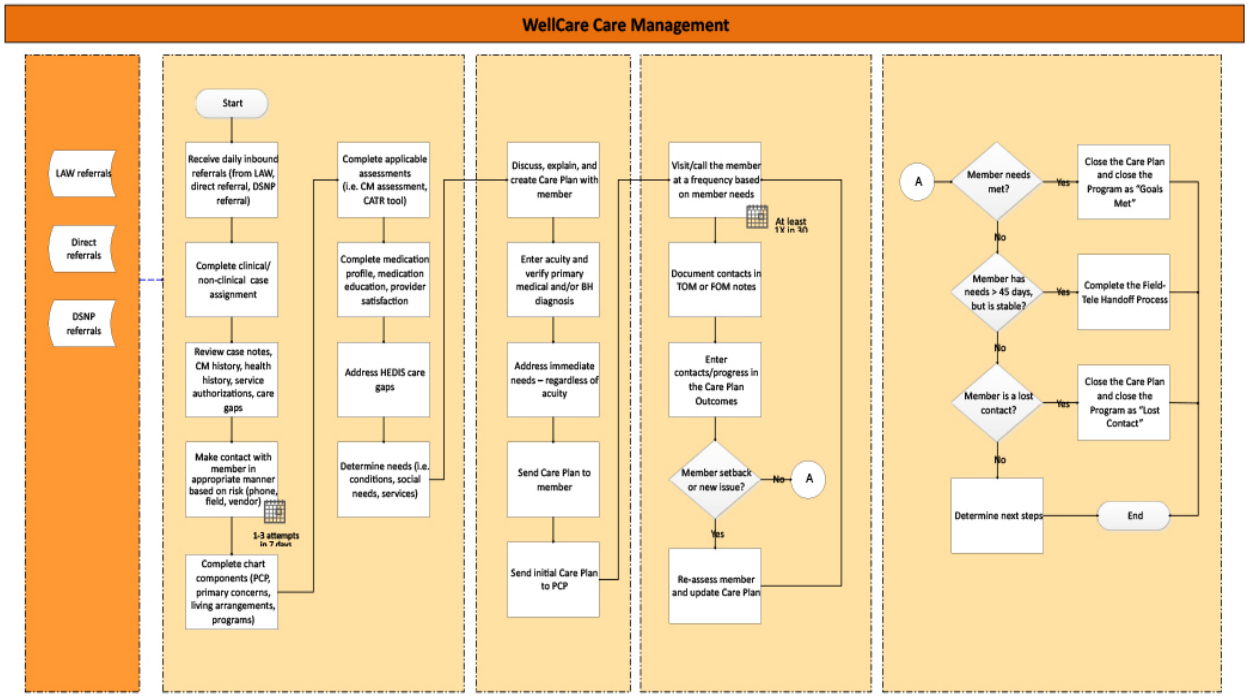


Figure C.6-12 Care Management Flowchart

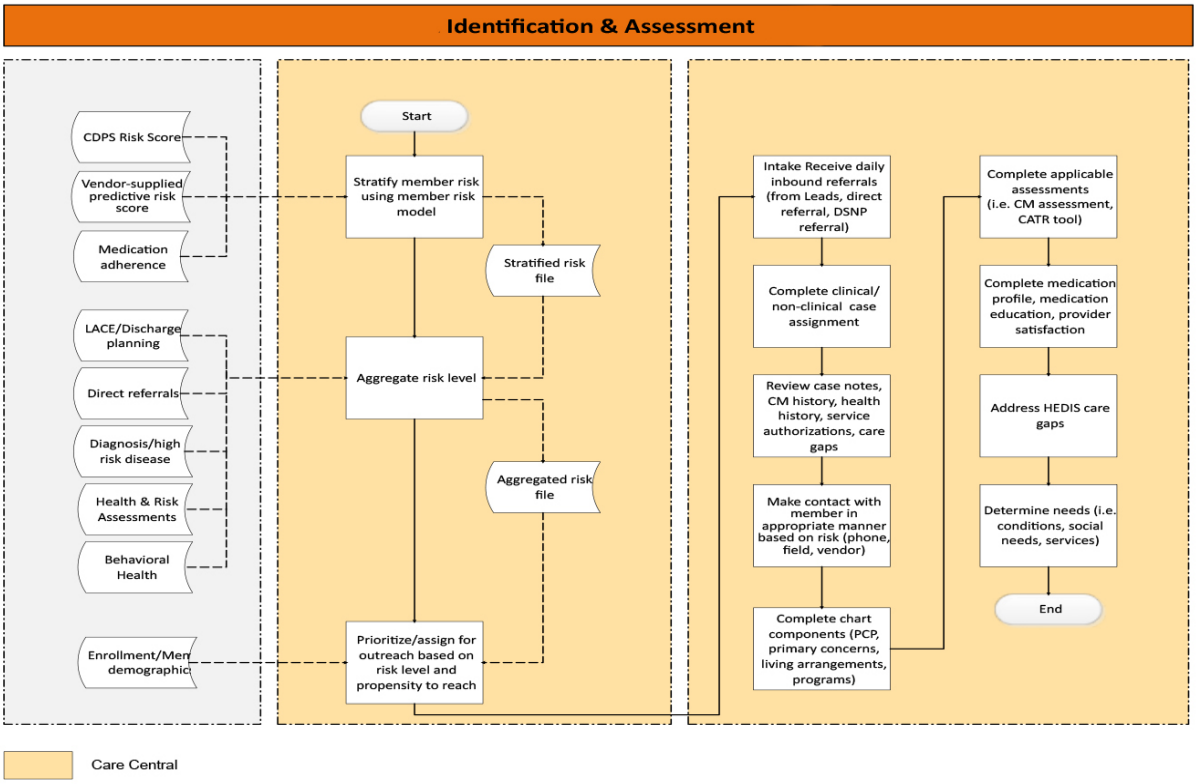


Figure C.6-13 Identification and Assessment process

b. Provide a description for and list of potential risks and mitigation strategies for implementing new information systems and changes to existing systems to support the Kentucky Medicaid managed care program.

Effective Risk Management and Mitigation is a primary focus of our enterprise Project Management Office (ePMO) and is built directly into our project management lifecycle. While WellCare of Kentucky has already implemented the systems and operations needed to effectively support Kentucky Medicaid, we aggressively view each new contract implementation as an opportunity to identify and manage risk. As part of our comprehensive project planning start-up, we have identified an initial set of potential risks and mitigation strategies depicted in **Table C.6-2**. As we move forward, we monitor and update these risks to ensure tracking and mitigation.

Table C.6-2 Potential Risk and Mitigation Strategies

Potential Risk	Mitigation Strategies
Implementation activities associated with a new information system	WellCare of Kentucky has an existing implementation that meets current requirements and will be leveraged for new contract
Bandwidth for new program adds and new enrollees	The Architecture team completed a review and impact assessment as part of our RFP response ePMO is accountable for the implementation. They create a list of commitments and requirements from the RFP and contract, an assessment of whether currently met or not, and ensures both Business and IT plans are in place and executed to meet obligations Our Scalability capability will be used to validate growth and expansion requirements, including investing in, implementing, and validating any infrastructure needs prior to go-live
Additional regulatory reporting requirements	Dedicated regulatory reporting process to ensure accurate submissions, including internal ownership and attestation of all report submissions by WellCare staff before delivery to DMS Ability to leverage our Enterprise Information Management (EIM) solution to meet requirements. EIM ensures that all data from all sources (internal systems and external sources) is available (and has quality validations) to ensure ability to support reporting requirements
Changes in Federal or State regulatory requirements (post go-live)	Local (Kentucky) and federal (corporate) regulatory departments continually monitor guidance and legislation for any new requirements Our single integrated solution allows leverage from all other books of business and ensures federal guidance changes and requirements are monitored and incorporated Ability to leverage Kentucky SUD Waiver and other changes as needed for additional enhancements
New or Additional Functional requirements and Interfaces	The Architecture team completed a review and impact assessment as part of our RFP response. Funding and approval for these changes will

Potential Risk	Mitigation Strategies
needed to support the new contract	be available immediately upon award Initial solution designs for any notable changes have been started and will be completed prior to award Our robust software development lifecycle ensures that accurate data are captured and used for test validation

c. Describe the Vendor's current and planned use and support of new and existing technology in health information exchange (HIE), electronic health records (EHR), and personal health records (PHR).

HEALTH INFORMATION EXCHANGE (HIE) - OUR CURRENT AND PLANNED USE

As part of our commitment to government sponsored health care initiatives, WellCare of Kentucky has been actively engaged in working with our State partners on a Healthcare Information Technology (HIT) strategy since 2012. WellCare continues to track the activities of all HIEs in states where we operate. We have attended and actively participated in the Strategic Health Information Exchange Collaborative (SHIEC) conferences since the initial meeting in 2015. WellCare was the first MCO to attend and the first to have its care managers attend and present on the value potential of HIE interactions to improve the care management process. WellCare has long believed that understanding the perspective of the HIE community is key to establishing effective HIE partnerships and gaining the greatest value for our enrollees.

WellCare actively participates with a large number of HIEs to facilitate the use and exchange of clinical data. Examples include:

- In Georgia, WellCare joined GaHIN in 2015 and has been an active partner. As part of the planning activities for implementing MCO-MCO transition of care, WellCare encouraged the use of the HIE as the facilitator of information transfer between MCOs and this approach was adopted and put into use.
- In Nebraska, WellCare formed a relationship with NEHII which predated the contract award in Nebraska. This approach allowed a smooth transition to WellCare membership upon contract award and has become WellCare's standard approach to new state business.
- In North Carolina, WellCare established an early relationship with the NCHIE long before contract award to ensure another smooth onboarding process. WellCare presented the MCO viewpoint in many meetings with NCHIEA and other stakeholders. WellCare's goal was and is to provide the best care to our Enrollees and access by MCOs to the HIE is a key component of this.
- Our care managers in Missouri have used CyberAccess for many years to review the state pharmacy database and view Enrollee's medical records and claim history during the care planning process.
- WellCare has multiple years of participation in the Florida, the FLHIE who provides ADT feeds to WellCare, which are subsequently utilized to notify care managers and providers to increase the coordination of care and improve discharge planning.

WellCare of Kentucky is not a primary source of clinical data in the traditional sense. However as a MCO, WellCare has data to offer including care plans, condition information, care needs (addressed and unaddressed) and prescription and claims history. Additionally, in discussions with other HIEs, we have found that our ability to provide Enrollee-PCP relationships can enable HIEs to serve as an additional method of distributing ADTs to providers when appropriate. As standards emerge for the sharing this information we will increasingly do so, but today the sharing is defined on a state-by-state basis. WellCare of Kentucky will participate in any data sharing required by Kentucky Medicaid, and encourages that it be done in a standard way. In addition, any clinical data that we receive is available for delivery to KHIE, should it be desirable to do so. Planning to implement a clinical Data Mart that will include information we are able to obtain from HIEs and also to submit to HIEs in accordance with HIE protocols. We have the ability to submit any received ADTs to the KHIE as required, regardless of the source of the ADT.

WellCare of Kentucky will continue to utilize interactions with HIEs whenever possible to facilitate the transition of care process between health plans, leverage the receipt of ADT transactions to improve care coordination and discharge planning functions (which is facilitated automatically through our CareCentral application), improve the information available to care managers during the care planning process, and incorporate clinical data into our risk stratification and other analytic processes.

EHR- OUR CURRENT AND PLANNED USE

We also recognize the need to use all opportunities to connect with our network providers who have EHR capability. In 2014, we piloted a program in Florida that allowed providers to submit EHR files containing clinical data, and our care coordinators used this data to close care gaps by outreaching Enrollees. The provider practices participating in the pilot demonstrated an increase in the results of the HEDIS measure, weight assessment and counseling for nutrition and exercise, through our use of the EHR data. Since this initial pilot project, we have continued to aggressively pursue direct data feeds from physician practice EHR systems as we develop efficiencies and improve effectiveness in our ability to consume clinical data. We prioritize data integration with EHR systems, state HIEs, and other clinical data aggregators and are developing a holistic view of the Enrollee to reduce gaps in care and improve Enrollee health outcomes. Where provider organizations and systems are limited in integration solutions, WellCare often works with the provider organization to gain direct access to their EHR to aid in clinical information capture and prior authorization processes. **In 2018, we captured 1,470,437 services for 132,615 unique Enrollees through CPT 2 or clinical data feeds.**

PHR: OUR CURRENT AND PLANNED USE

WellCare supports the efforts of CMS and the ONC to promote the delivery of health information to the patient. We agree that this approach will enhance the flow of information and improve care. Moving information to the patient provides them with a Personal Health Record that they control.

As an illustration of this support WellCare will implement the Blue Button 2.0 API this year to make benefit and claim information available to our Enrollees. This standards based API approach is central to WellCare's IT architecture strategy and we will expand API usage as new

standards are adopted. As a sign of our commitment, our mobile application will be adapted to use these APIs.

d. Describe the Vendor's approach to assessing integrity, accuracy, and completeness of data submitted by providers and Subcontractors.

WellCare of Kentucky's approach to ensuring the timeliness and validity of data from providers and subcontractors is based on our assumption of responsibility for all data associated with our contract with DMS, whether that data is internally generated or provided by providers or subcontractors. During our regulatory report submission attestation process, if data from subcontractors is included in the report, this fact is recorded and the appropriate internal subcontractor representative is attesting to the accuracy of the data.

WellCare of Kentucky also ensures that all data from subcontractors is submitted to the appropriate validation edits based on DMS' guidelines. As an example, for claims and encounters WellCare of Kentucky applies DMS' encounter SNIP edits and will reject submissions back to the subcontractor for resolution if the edits are not met. Our encounters team actively tracks the quality, timeliness, and volumes of subcontractor's submissions to ensure we are receiving timely, accurate encounter data for inclusion in our submission process.

WellCare implements completeness checks against data received from subcontractors in addition to standard edits, as part of every process. As an example, WellCare requires the submission of a Cash Disbursements journal in addition to Encounters from delegated adjudication entities. This allows us to ensure the subcontractor has provided all required encounter information.

In similar fashion, WellCare executes edits against clinical data submissions and cross reference the closure of care needs data with the clinical and administrative data to ensure data quality and accuracy.

In addition, all data received from subcontractors is included in our Enterprise Information Management (EIM) solution that supports all of our data needs, including application processing, regulatory reporting, and ad hoc reporting. This comprehensive EIM solution ensures that all data sources, including data from subcontractors, are captured and catalogued, fully integrated into and accessible by transactional processing systems, and enables robust reporting capabilities in support of regulatory, operational, and analytic capabilities.

WellCare of Kentucky employs a set of validation, cleansing and aggregation activities to make sure all Data Marts are populated with clean, accurate, and useful information. In cases where data is submitted to us by a subcontractor and it fails to meet the data quality and accuracy requirements or our EIM, the submission is rejected to the subcontractor for remediation and resubmission.

e. Provide a description of the Vendor's data security approach and how the Vendor will comply with Health Insurance Portability and Accountability Act (HIPAA) standards including the protection of data in motion and at rest, staff training and security audits.

Our Security and Privacy team recognizes the impact of identity theft and medical fraud on enrollees and works to protect them in practical and effective ways. These include training for associates, clear and descriptive policies, modern technical security solutions, and incorporating security and privacy into our daily operations versus adding it after the fact. Our approach to meeting DMS' expectations and requirements centers in our core design objective for our systems architecture which is grounded in Security and Privacy services. This high-level depiction of our enterprise architecture provides an overview of our MIS and specifically depicts how our Security and Privacy services encapsulates and protects our systems (as depicted the graphic beside) and builds these concepts into our solution at the foundational level. We employ multiple physical and electronic security technologies as part of our privacy and security services and infrastructure services into every layer of our operational environment. Our principle of maintaining and enforcing a set of information security policies and standards is reflected throughout the enterprise via adoption of the HITRUST Common Security Framework. These standards are overseen by our Information Security Group and implemented by our Infrastructure Security Group, with clear segregation of duties throughout the process. Our servers, workstations, and network are continuously monitored using industry-standard intrusion protection technologies, advanced persistent threat monitoring, and data loss protection.

The HITRUST Common Security Framework allows us to demonstrate compliance with DMS' requirements via a set of security and privacy controls in direct support of HIPAA, NIST 800-53, NIST Common Security Framework, PCI-DSS, and other industry frameworks. Our Chief Security and Privacy Officer is responsible for monitoring and auditing ongoing compliance including risk assessments based upon NIST 800-30, HITRUST compliance, application security testing, wireless testing, and penetration testing. WellCare leverages a 3rd party firm that specializes in information security to conduct a comprehensive penetration test once a year. The results of all these tests are reviewed by our IT infrastructure management and by the Information Security team, and enhancements are made accordingly. The test results and progress tracking on enhancements and resolution are also presented to WellCare's senior leadership and the Board of Directors' audit, finance, and regulatory compliance committee.

WellCare was assessed and successfully obtained HiTrust certification in 2018.

OUR DATA SECURITY APPROACH - ENROLLEE DATA PROTECTION

WellCare of KY invests heavily in the Information Security and Privacy programs in order to reduce risk of a data loss event. The HITRUST program and the implementation of the HITRUST Common Security Framework focuses on minimizing the risk of a breach while efficiently providing services to enrollees. We employ multiple physical and electronic security controls as part of our privacy and security services and infrastructure services into every layer of our operational environment. Our environment is continuously monitored by our 24/7 Enterprise Service Operations Center (ESOC). Examples of our existing comprehensive security features include:

- Encryption of hard drives, including all desktops and laptops
- Multifactor authentication for all remote access
- Monitoring of laptops, desktops, and the network through automated virus scanning solutions, data loss prevention, and advanced persistent threat technologies
- Blocking of ability to save data to portable (thumb drive), disc media (CDs), webmail, and cloud file sharing.
- Built in "Automated Wiping" for desktops and laptops in the event of loss or theft
- Encrypted storage solutions (including medical records)
- Secure decommissioning including full magnetic erasure of disc drives
- Email controls (e.g., scans for spam, malware, and viruses; user-elected and automated email encryption; Transport Layer Security (TLS) email exchanges)
- Role-based security features based on least-privilege (e.g., two-factor authentication, automated provisioning) with annual certification
- Implementation of a diverse set of Firewalls, Intrusion Detection Systems, virus scanning, data loss prevention, and advanced persistent threat prevention, monitoring and detection technologies
- Recurring vulnerability testing, web application testing, and penetration test and with remediation of any identified vulnerabilities and enhancement opportunities
- The use of encrypted file transfers with government partners and subcontractors primarily through the use of Secure File Transfer Protocol (SFTP) (which will include Department provided FTP site)
- Application designs and controls (e.g., detailed audit logs; access to display last change date, time, and user; inability to alter finalized transactions)
- Physical controls (e.g., restricted access building requiring appropriate credentials to enter; separate, highly restricted areas, like Data Center facilities)

WELLCARE'S SECURITY STRATEGIES FOR DATA INTEGRITY AND ACCESS

Access to any WellCare system requires a valid user ID and password, the sharing of which is strictly prohibited. The User ID process begins at the time of hire through our user provisioning process. Provisioning occurs via role based access associated with role and job title. The user access request includes a complete description of the access needed including network drives, applications, and templates. Requests for access to in-scope applications are approved based on the individual's need to view, add, change, or delete data. "Least Privilege" access is driven by the use of templates specific to the system functions and information that the unique user requires. Once a user receives his or her ID, access attempts are monitored. WellCare's Active Directory domain policy restricts unsuccessful login attempts and can be programmed to fit DMS-specific requirements.

WellCare desktops and laptops are protected at the host level by an Enterprise Anti-Virus and End-Point Firewall solution. Password complexity is established and enforced at the domain level and administrator user privileges are limited to support staff exclusively. A mature patch management process ensures that these devices receive scheduled vendor updates, and compliance is tracked via an enterprise distribution package. Laptops are further protected by the use of a full-disk encryption solution with full DOD level remote wipe capability.

As part of the data integrity program, WellCare maintains a formal Corporate Compliance program to manage and respond to external audit requests from state and federal agencies. The program leverages resources from WellCare's Corporate Compliance, Internal Audit, HS-Quality Improvement, and IT Compliance to respond to audit requests. We also maintain regularly audited preventive and detective controls to sustain system integrity and consistency. Controls are testing no less than annually. Scheduled reviews of user access are performed to detect inappropriate access at least quarterly.

In addition to the electronic and physical architecture components, our Information Security Group defines security policies and our IT security group defines practices and provides testing and manages an independent, 24/7 external Managed Security Services provider to ensure enterprise-wide compliance with policies. WellCare has developed a robust, flexible, and standards-based Interface Subsystem to provide integration across all internal functions and systems, and to support interfaces with external organizations including State MMIS systems, EQRO, security management functions, and other contractors. Our Interface Subsystem supports service-based interfaces across our applications with many services available to DMS, other contractors, and our subcontractors.

COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Security and Privacy policies and procedures enterprise-wide are authored by the Information Security department, including for topics such as records retention. The purpose of this department is to manage privacy and security in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as modified by the Health Information Technology for Economic and Clinical Health (HITECH) Act set forth by the United States Department of Health and Human Services (HHS). To provide additional oversight for this vital function of information security management, we have established an Information Security and Privacy Officer. Our ability to comply with the HIPAA Privacy rule is a primary function of the Security and Privacy module of our single integrated platform. This broad set of technologies is interwoven into the design of our entire operating environment including functions such as encryption, end point security on physical and mobile devices, role-based security models, two factor authentication, firewalls, intrusion detection services, data loss prevention services and automated remote wiping capabilities. These technologies, which directly support HIPAA privacy and security requirements, are supplemented by a focus on our people through policies and aggressive training and education. Our architecture department researches CMS Medicaid Information Technology Architecture (MITA), interoperability, and other relevant guidance and legislation. We maintain and enforce a set of information security policies and standards throughout the enterprise. These standards are overseen by our information security group and enforced by our infrastructure security group, with clear segregation of duties throughout the process. WellCare is investing in a multi-year program to further enhance our security processes and attain HITRUST certification by the end of 2018, well in advance of the implementation go live date.

Our Corporate Chief Compliance Officer oversees implementation and compliance with all current and future HIPAA standards. The COO manages the corporate compliance department, which is responsible for WellCare's privacy, information security, records management, and

information management programs. The COO reports to our Corporate CEO and independently reports to the Board of Directors' audit, finance, and regulatory compliance committee.

WellCare actively promotes compliance with the requirements of this section through multiple ongoing activities which include:

- Maintaining policies and procedures describing the types of information to be safeguarded and the proper release of protected health information (PHI). These policies, including HIPAA Privacy, HIPAA Transactions and Information Security Policies defined and document our commitment to understanding and enforcing these standards.
- All new hires are also required to complete this training within their first 30 days of hire. Our corporate training department independently executes the administration and completion compliance of this training.
- Requiring the completion of annual training on security, privacy, fraud waste and abuse, and HIPAA compliance by all associates as a condition of continued employment.
- Associates also attend general compliance training designed to instill our core values and ethics. We maintain corporate policies that address system access management and information accessibility at the corporate level. In addition to the aforementioned programs, our information security council meets regularly with key leaders to communicate and govern the information security risks throughout the organization.

We also adhere to Section 1104 of the Patient Protection and Affordable Care Act operating rules that complement the HIPAA mandated standards and health plan certification of compliance, federally required Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) Operating Rule Sets, (including but not limited to 45 CFR Parts 160 and 162 of CMS–0032–IFC), Administrative Simplification Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions and 45 CFR Parts 160 and 162 (CMS-0024-IFC), 45 CFR Part 164 Security and Privacy (including the ePHI standards, breach notification, and Individually Identifiable Information provision) Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice.

WellCare supports the specific intent and accessibility requirements. Our website meets the accessibility requirements defined in Section 508 Compliance. Additionally, through support of TDD/TTY capabilities, we make every attempt to accommodate our Enrollee and provider communication needs including use of our state-of-the-art video relay service.

STAFF TRAINING

Associates' vigilance and awareness play critical roles in protecting sensitive and confidential data requiring the entire organization's awareness of the role they play, ensuring the safety and privacy of our network and our Enrollees' PHI and medical record information. Continuous and current training is used to reinforce our corporate philosophy and our Employee Code of Ethics. Within 30 days of employment and annually thereafter, all our associates are required to satisfactorily complete 16 or more hours of mandatory training on subjects including Information Security, Information Governance, HIPAA Privacy and Security, Acceptable Use, Compliance Training, and Certification of Reports and Submissions to State and Federal

agencies. We also provide our employees trainings on social engineering, PCI compliance, and phishing. The satisfactory completion of appropriate training courses is considered a condition of employment and is continually tracked for compliance. Our associate and management staff receive ongoing reminders to complete trainings. Compliance with our commitment to integrity is included in all associates annual evaluations, and failure to adhere to training requirements can lead to individual discipline, including employment termination. Data Classification and the HIPAA handbook provide guidance to associates regarding treatment of data and individual responsibilities.

f. Describe any proposed system changes or enhancements that the Vendor is contemplating making during the anticipated Contract Term, including subcontracting all or part of the system. Describe how the Vendor will ensure operations are not disrupted.

Prior to implementation and go live of this contract, WellCare of Kentucky does not anticipate any changes to our existing use of subcontractors and will retain the primary sills and accountability for all of our applications, most of which are internally developed and supported. WellCare may consider an alternative Pharmacy Benefits Manager contract, though an open bid process, in 2021.

WellCare of Kentucky's thorough and detailed project management processes, application development lifecycle, and through Quality Assurance and testing processes (which include User Acceptance Testing) will aggressively ensure that new functionality is implemented accurately without disruption to existing processes.

Below, in **Table C.6-3**, are the known and anticipated changes associated with the proposed contract and Contract, as well as major initiatives related to Medicaid functionality that WellCare of Kentucky is anticipating.

Table C.6-3 Proposed System Changes or Enhancements

Features	Description
Appeals, Grievances, and Disputes	WellCare is in the process of enhancing and deploying a robust Issues management application (to include the scope or Appeals, Grievances, and Disputes) to streamline and more efficiently resolve Enrollee and provider concerns
Web	Government Partner Web Portal - the establishment of a Government Partner Portal specific to DMS for use in facilitating direct access to reports, data and documentation Mobile App and Portal suite - We are continually enhancing our mobile applications and portal suite to improve user experience, based on direct feedback and interaction with end users
Call Center	Call Center Scripts - Minor modifications to our CareConnect's call center scripts to address specific requirements are anticipated and included in our scope

Features	Description
Interfaces	Delegated Vendor Interfaces - Update existing standard interfaces with delegated vendors (such as our Pharmacy Benefits Manager [PBM] and dental contractors) to ensure they receive the appropriate membership information for Enrollees
Claims Processing	Artificial Intelligence (AI) and Robotics - Processing, ongoing exploration to enhance both our internal operations and our external Enrollees and providers
Provider Data	Configuration and Enhancements to collect data about provider participation in KHIE and HER capabilities
Care Management	Care Management Platform - Deployment and implementation of a new, more efficient care management platform, CareCentral to improve our ability to implement mobile person-centered care plans. This deployment is already planned for our existing Medicaid Contract and is in productive use in other Medicaid and Medicare markets
Correspondence	Anticipated minor changes and enhancements to our Enrollee and provider materials to align with new contractual requirements
Regulatory Reporting	In addition to planning for active participation in the pre-readiness review work group to collaborate on the development of a new Reporting Package, we are also planning for the likely changes and additions to comply with the outcome and newly-defined Reporting Package.

SYSTEM ENHANCEMENT FOR SKY CONTRACT

We identify the items in **Table C.6-4** as the known and anticipated changes associated with the proposed SKY Contract, as well as major initiatives related to Medicaid functionality that WellCare of Kentucky is anticipating.

Table C.6-4 Known and Anticipated Changes with SKY

Features	Description
Line of Business Setup	New line of business setup for the SKY Program. Includes branding of Enrollee application and Portals, line of business initialization.
Government Partner Web Portal	Government Partner Web Portal – specific to DMS for use in facilitating direct access to reports, data and documentation including any additional enhancements specific to the SKY Program
Agency Portal	Deploy Portal enhancements to allow specific agencies with access to relevant information, establishing a Caseworker Portal that the assigned DCBS/DJJ case worker can use to securely access information about the child.
Enrollee Portal	Enhancements to provide supporting materials and information for Foster Care or Juvenile Justice enrollee or their Enrollees and parents.
Provider Portal	Expected enhancements to consent gathering and tracking solution. Alerts and notification for Enrollees entering foster care and/or Juvenile Justice. Enhancements to provide Medical Passport functionality. Functionality to provide temper WellCare Card within 24 hours of SKY program enrollment. Enhancements to notifications and alerts for Enrollees that have experienced trauma.
Enrollment	Enhancements to Provider Alerting processes for Foster Care and Juvenile Justice Enrollees.
Correspondence	Anticipated minor changes and enhancements to our Enrollee and provider materials to align with new contractual requirements. Additional materials for foster care parents. Additional correspondence for the agencies involved in Enrollee foster care or Juvenile justice. Improved correlation between inbound and outbound letters supporting the foster care and Juvenile justice programs.
Enrollee Mobile App	Mobile App enhancements to better support Sky Enrollees (Clear Sky)
Call Center	Call Center Scripts - Minor modifications to our CAREConnect call center scripts to address specific requirements are anticipated and included in our scope
Regulatory Reporting	Reports for SKY program like the Assessment Timeliness Reports in addition to the reports called out in Appendix D “Reporting Requirements and Reporting Deliverables

ENSURING OUR OPERATIONS ARE NOT DISRUPTED

In order to ensure that these changes, or any changes to our systems and platforms, do not disrupt operations and specifically do not interrupt or adversely affect the delivery of care and services to our Enrollees, WellCare of Kentucky has developed formal processes to validate changes and ensure they are properly validated prior to any deployment. Our formal project management lifecycles, which are constantly refined to leverage our experiences but have been successfully utilized to implement and support DMS' programs, will be utilized to ensure impacts are identified and addressed early in the process. The project management lifecycle includes formal identification of risk and the mitigation strategy to ensure we avoid realization of those risks. Our processes also ensure that individuals and leadership at every level (including local market leadership up to Bill Jones, our Chief Executive Officer) have insight into the changes, the current status, and any risks that may exist in order to ensure our ability to escalate and remediate those risks. Our local leadership in conjunction with our Business experts will review and agree upon the requirements definition process to ensure we have a proper understanding of the business need and, as needed, are able to seek guidance and clarification from DMS. Our formal, well-established and independent Quality Assurance team will apply their validation practices to any change prior to deployments, including the User Acceptance testing from Market and Business experts.

In addition, with respect to these changes, WellCare of Kentucky will leverage the additional time available between RFP response submission, award date, and actual implementation to ensure we maximize our ability to mitigate risks. Consistent with that approach, the processes required to complete these changes have already started during the response process, and our Architecture department has completed a preliminary assessment of the solution, scope and design of modifications necessary to support these changes.

7. Encounter Data

C.7. ENCOUNTER DATA

a. **Provide a detailed description of the Vendor's processes for ensuring complete, accurate, and timely encounter data submissions to the Department, including procedures for working with providers and Subcontractors to correct errors.**

b. **Provide the Vendor's Encounter Data Processing policies and procedures.**

c. **Describe common challenges the Vendor has experienced in encounter data development and submission, and mitigation strategies and best practices the Vendor has implemented to ensure accurate and complete encounter data.**

d. **Describe educational approaches the Vendor will implement to support providers and Subcontractors that are identified as having ongoing challenges in submission of complete, accurate, and timely information.**

e. **Describe initiatives the Vendor proposes raising to the Encounter Technical Workgroup to enhance the data submission requirements and improve the accuracy, quality, and completeness of encounter submissions.**

C.7. ENCOUNTER DATA

a. Provide a detailed description of the Vendor's processes for ensuring complete, accurate, and timely encounter data submissions to the Department, including procedures for working with providers and Subcontractors to correct errors.

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 16 Encounter Data and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare of Kentucky has consistently demonstrated our ability to excel in our commitment to providing quality data to DMS. As an incumbent in the state of Kentucky since 2011 along with our combined experience and resources in other Medicaid programs across the country, we bring extensive knowledge and a proven commitment to continuous process improvement by working directly with DMS on enhancements, modifications, and data concerns. We also align encounters operations performance to state priorities. In accordance with the Contract requirements, our processes are designed to maximize compliance with submitting complete, accurate, and timely Encounter Data to DMS within 30 days of adjudication on a weekly basis. WellCare is poised for continued growth as **our current medical systems are capable of scaling to over 125 million encounters per year, or more than 10 million per month. WellCare of Kentucky currently submits to DMS about 1 million medical encounters per month (or 1.8 million total encounters) under our current Kentucky Medicaid contract.**

OUR ENCOUNTER DATA SUBMISSION PROCESS - ENSURING COMPLETE, ACCURATE, AND TIMELY ENCOUNTER DATA SUBMISSIONS

Medical Encounters

WellCare's record of submitting quality encounters data is the best among our peers in the state of Kentucky, with a 99.8% acceptance rate in 2019. Our success reflects a combination of experienced, highly disciplined, and dedicated staff, our leadership's close alignment and coordination with DMS, as well as our matured systems and processes. We are confident that our approach to continuous process improvement and system enhancement will enable us to remain a top performer in Kentucky for years to come.

Our established Kentucky Encounters Operations Team (EOT) has a total cumulative experience of over 40 years in encounters processing. This wealth of knowledge and experience has enabled a deep understanding of Kentucky-specific data; established a spirit of collaboration with our state partners; and provided continuity of excellence in service and data quality. WellCare has also developed a strong local market leadership who has been dedicated to improving processes and have delivered significant positive results in coordination with our Tampa data/systems experts over the past several years.

- Kentucky's Collaborative Encounters Team includes:
- Vice President of Encounters and Operations Strategy, Kiran Gadde
- Sr. Director of Encounters and Operations Strategy, Sean Fletcher
- Encounters Manager, Patrick Poland
- Kentucky Director of Strategic Market Analysis, Robin Rhea
- Sr. Project Manager, Johnie Akers
- Sr. Encounters Data Analyst, Fran Meadows
- Business Technical Analyst, James Richards

Robin Rhea, in particular, has been instrumental in assisting providers, resolving RHC/FQHC issues, and enrollment process issues attributed to the newly implemented Kentucky Benefind system.

Processing Medical Encounters

Our well-established encounters process can be broken out into multiple steps as shown in **Figure C.7-1**:

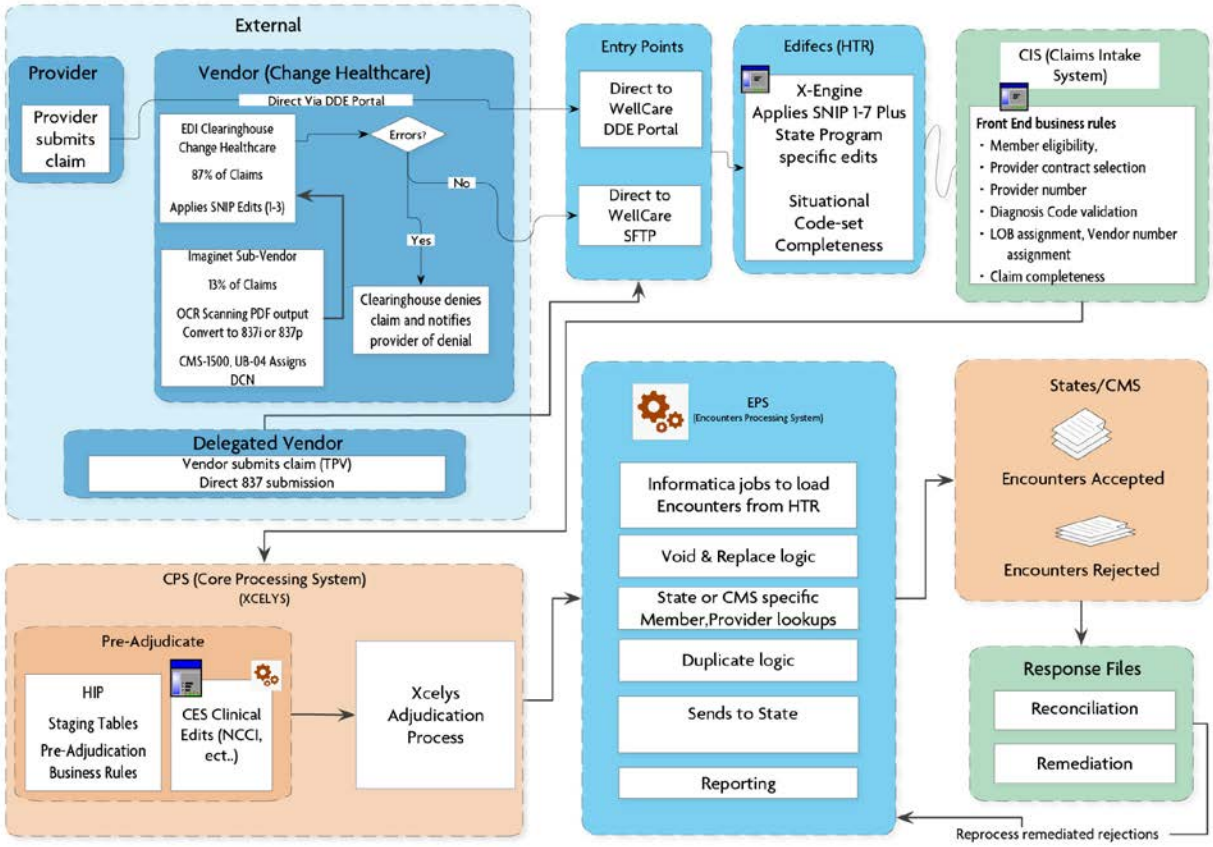


Figure C.7-1: Claims/Encounters Workflow

Intake - WellCare receives claims and encounters in both electronic and paper formats from a variety of submission avenues. We receive them directly from providers through our provider web portal, from clearinghouses, and directly from our subcontracted and atypical providers. We scan and convert paper claims immediately to an electronic format that can be loaded and processed quickly. For purposes of explaining our processes, "claims" refer to claims received from providers that have not yet been adjudicated, while "encounters" refer to adjudicated claims or capitated encounters.

- *Inbound Validation and Inbound Reconciliation:* Each claim or encounter is taken through a series of validations. Strategic National Implementation Process (SNIP) edits are applied to claims and encounters to identify issues related to the industry standard submission file layout, balanced field totals, record or segment counts, financial balancing of claims or remittance advice, balancing of summary fields, validating for numeric values in numeric data elements and presence of required fields based on type of service. Encounters not passing quality edits are immediately rejected and sent back to the submitter via an industry standard response file. The response file supplies information on rejections including descriptions to assist providers with resubmitting corrected data.
- *Claims Intake System (CIS):* WellCare's CIS is where pre-adjudication business rules are enforced to ensure key fields are populated and contain valid data. Kentucky provider validation and enrollee eligibility validation is performed, along with Kentucky-specific

business rules. Claims that fail CIS edits generate an automated letter with sufficient detail to assist providers with resubmitting corrected claims.

Core Processing System (CPS) - Claims that pass front end validations are sent to our Core Processing System which include the following processes:

- *Clinical Editing System (CES):* Prior to adjudication, the claim is sent through coding validation logic to ensure the procedures and diagnoses are appropriate for the age and gender of the enrollee. At this stage, a clean claim check is also performed to ensure all required fields are populated including: claim type, place of service, revenue code, diagnosis codes, and procedure code.
- *Adjudication System:* Xcelys is WellCare's claims adjudication system. Xcelys runs through benefit edits, determines FFS pricing based on contractual agreements and configuration, and performs the final adjudication and paid amount for each claim. The date appended for final adjudication is used for the 30-day timeliness contractual obligation to DMS. Claims are passed through final validations, including duplicate logic. Once determined to be complete, accurate, and valid, eligible claims are paid.

Encounters Processing Systems (EPS) - Adjudicated claims are seamlessly passed to the EPS, including paid, denied, and adjusted/voided claims. The EPS uses the extracted data from our claims adjudication system and extracted data from our subcontractor's encounter data to execute final validations and prepare encounters for submission.

- *Encounter Processing System (EPS) -* The EPS performs data quality validations to ensure the encounter meets the State requirements for submission, including but not limited to the addition of required Kentucky specific information. Adjusted encounters are submitted to update DMS' records with the correct version of an accepted encounter. Voided encounters are submitted to remove an accepted encounter from DMS'. Finally, EPS reconciles response files from DMS for remediation and reporting purposes.
- *Preparation and Batching -* Prior to submission of encounter data to DMS, WellCare validates that all data complies with our internal quality controls and corporate compliance procedures. We also apply Department-specific SNIP edits and batching rules as a final validation to ensure each encounter complies with DMS' companion guides. The batching process prepares the files and submits per Department's requirements.

PHARMACY ENCOUNTER DATA FROM THE PBM

WellCare's pharmacy encounters operations team includes experts in Kentucky Medicaid pharmacy data submissions. Our Pharmacy Encounters Operations Manager, Hardik Patel, provides oversight and management of results while our dedicated Encounters Data Analyst; Rashidat Majekodunmi, has close to four years' experience working with Kentucky data quality analysis and improvement efforts. Our Pharmacy Encounters Operations team works closely with the Pharmacy Department and our PBM to ensure timely, accurate, and complete submissions. Results speak for themselves with a pharmacy encounters acceptance rate of 99.99%.

Pharmacy Encounters Process

Our PBM adjudicates pharmacy claims at the point-of-sale (POS) per Kentucky state requirements and generates the NCPDP 2.2 files on a weekly basis. The PBM forwards the NCPDP files to WellCare via SFTP where WellCare has implemented a fully automated pass-thru process, which submits the files directly to the state. Upon receipt of response files, our automated pass-thru process forwards these files directly to the PBM for reconciliation and remediation. Our PBM generates a standard reporting package for WellCare, which includes reject details, reject summary, SLA reports, and accuracy measures. Bi-weekly meetings are held with WellCare's Pharmacy Encounters Operations Team, the Pharmacy, and our PBM to review results, coordinate remediation efforts, and identify any preventable root causes to initiate system or process improvements.

Drug Rebates

Pharmacists submit Medicaid claims with a clarification code to identify eligible rebateable drugs, or 340B claims. Our PBM provides guidance and education to pharmacies on how to properly submit 340B claims per Kentucky companion guide requirements, which are enforced through front end validations. Utilizing industry standard NCPDP requirements, our PBM identifies qualifying rebate transactions at the point of sale. As these encounters are processed through the end-to-end system, they are trackable to ensure timely submission. This process is followed for covered entities enrolled in the drug rebate program and placed in the Health Resources and Services Administration (HRSA) Medicaid Exclusion File where claims billed by the covered entity are 340B eligible. We have quality controls in place prior to submission to DMS, which includes a certification process requiring approvals from the Encounters, Claims, and Pharmacy departments.

Timeliness, Accuracy, and Completeness

Timeliness is determined by ensuring that the Encounter was transmitted to DMS within 30 calendar days after adjudication, although DMS tracks other timeliness measures as well. WellCare tracks the timeliness of each version of a claim using an SLA table which time-stamps the adjudication and submission date, as well as the date of any Department rejects and resubmission, enabling us to accurately monitor the percent of encounters submitted within the 30-day requirement. This SLA table and reporting will be modified to include voided and zero dollar paid claims, which is an additional requirement for the new contract. These new claim types will be closely monitored and outliers will be aggressively pursued to identify any system or process concerns that can be improved upon to ensure achievement of the 30-day requirement.

Accuracy is determined by evaluating whether or not the values in each field of the Encounter accurately represent the service that was provided, while completeness is determined by assessing whether the Encounter data transmitted includes each service that was provided. We follow DMS' requirement to submit an attestation showing that full file rejects were resubmitted in a timely manner, which has only occurred once within the past twelve months. Additionally, DMS has added a new comparison report to measure reported financials with encounters data. WellCare has experience with similar reporting requirements in other

Medicaid programs across the country and will work closely with DMS to design reporting to accurately reflect these requirements for monitoring and further identification of improvement opportunities.

DMS tracks multiple accuracy, timeliness and completeness measures and our success in achieving or exceeding requirements is reflected in the below **Table C.7-1**.

Table C.7-1: Accuracy, Timeliness and Completeness Results

Encounter Submission Results (Twelve Months Ending December 2019)				
Measure	**Requirement**	**Submitted**	**Met Requirement**	**Accuracy rate**
Accuracy	Each file submitted meets internal accuracy requirement	3,378 files	3,232	95.68%
Accuracy	Files submitted in appropriate format required by DMS	3,378 files	3,377	99.97%
Accuracy	New encounters are not duplicate of another encounter in MMIS	24,988,434 encounters	24,983,711	99.98%
Completeness	Resubmission and attestation of full file rejections	1 rejected file in time period requiring an attestation		
Timeliness	Submit encounter file within 5 days of scheduled submission dates	52 weeks	52	100.00%
Timeliness	Submit new encounters within 30 days of adjudication date	24,988,434 encounters	24,988,434	100.00%
Timeliness	Timely Resubmission of Erred Encounters within 60 days	53,629 encounters	53,562	99.88%

WellCare's success transcends Kentucky as we consistently perform well in other markets as well, as demonstrated below in **Figure C.7-2**

Accuracy	
State	Performance
New Jersey	99.29% for Medical and Pharmacy data combined
Missouri	99.40% for Medical and Pharmacy data combined
South Carolina	99.20% for Medical and Pharmacy data combined
Nebraska	98.00% for Medical and Pharmacy data combined

Completeness	
State	Performance
Georgia	99.69% for Medical and Pharmacy data combined
Medicare	99.61%for Medical
Nebraska	99.40% for Medical and Pharmacy data combined

Timeliness	
State	Performance
Florida	99.30% for Medical and Pharmacy data combined
New Jersey	99.80% for Medical and Pharmacy data combined
Georgia	99.90% for Medical and Pharmacy data combined
South Carolina	99.42% for Medical and Pharmacy data combined

Figure C.7-2: WellCare's Performance in Other States

PROCEDURES FOR WORKING WITH PROVIDERS AND SUBCONTRACTORS TO CORRECT ERRORS

To ensure seamless quality of care, we collaborate with our providers and subcontractors through our training and educational programs, offering a series of training modules through our provider portal and during scheduled monthly trainings. Through experience, we know that some providers may have technical challenges or a lack of understanding of required X12 format, which results in providers not submitting clean claims. To remediate, we have in-person and online trainings to educate providers on state requirements. These trainings consist of various topics including general encounter information and more specific topics presented by subject matter experts to answer provider questions or address concerns. We partner with providers and subcontractors, emphasizing communication, education, and collaboration. After trainings are completed, the materials remain online for providers to reference at their convenience. We also deploy a team of certified coding professionals each year to ensure accurate coding. Internal analytics target providers which direct coding professionals who work directly with providers to improve documentation and produce more accurate coding.

WellCare has extensive experience transitioning providers from FFS to managed care processes in Kentucky and Georgia with specific emphasis on electronic encounter submission. Our dedicated Encounters team include Robin, along with Johnie Akers, have conducted one-on-one training sessions, hosted webinars, and uploaded online training material accessible from the provider portal. **In 2018 alone, we conducted over 5,700 face-to-face meetings with providers and 30-40 of our Provider Representatives conducted webinars. These training efforts helped educate and ensure the accuracy, timeliness, and completeness of more than 20.9 million encounter submitted in Kentucky.**

Along with these trainings, our locally-based staff of Operations Account Representatives (OARs) provide “high-touch” service to providers. They conduct billing education, provide submission support, and are empowered to efficiently resolve issues, including on-site claims adjustments at provider offices. OARs monitor claim utilization, denial rates, encounter performance, and provide one-on-one training when issues are identified. They serve as a direct contact for the providers into the central operations team and ensure that we are aligned with Department's expectations while supporting provider and enrollee initiatives as necessary.

In February of 2018, all of the Rite-Aid pharmacies in Kentucky were acquired by Walgreens. In order to avoid disruption during the transition, the Department requested that the Rite-Aid pharmacies continue to use their previous NPI values until the provider roster could be updated. Several of the pharmacies began using their new NPI values, which resulted in the rejection of nearly 35,000 claims or $1.25 million in reimbursements due to invalid pharmacy NPI. WellCare presented the issue to the Department leadership team immediately, and they agreed to allow the pharmacies to continue submitting the new NPI ahead of roster changes. This resulted in a large scale manual effort on the part of both WellCare and our partners at CVS to ensure all of the encounters reflected the correct NPI. WellCare resubmitted the rejected encounters, resulting in 99.95% acceptance rate with no financial penalties incurred. Through guidance and partnership with the State, and collaboration with our pharmacy vendor, we were able to address the issue with minimal impact to the providers.

To resolve provider related rejections, our encounter associates gather data to offer assistance with provider registrations. We have designed an effective, streamlined process for new and existing providers to obtain a Kentucky Medicaid ID number. We make every effort to ensure that all of our contracted providers are registered in MMIS. Our team also works to minimize provider abrasion, working in collaboration with our vendors and the state to address rejections caused by routine changes to systems or requirements.

b. Provide the Vendor's Encounter Data Processing policies and procedures.

Please refer to **Attachment C.7.b Encounter Data Processing Policies and Procedures.**

c. Describe common challenges the Vendor has experienced in encounter data development and submission, and mitigation strategies and best practices the Vendor has implemented to ensure accurate and complete encounter data.

Having solid experience working with DMS and the providers in the state of Kentucky, as well as programs in other states, WellCare has experienced challenges in some areas of encounter data development and submission. **We were able to mitigate these challenges and improve our encounters acceptance rates to 99.8% in 2019 utilizing the methods described below.**

Incorrect submission by providers - The most common encounters challenge faced by WellCare of Kentucky is providers frequently submitting encounters in a manner that is not consistent with DMS' guidelines. Provider errors come in a variety of forms. They might use a clinically appropriate taxonomy, but not their Department registered taxonomy. They may use an NPI that is still registered with NPPES but has been terminated with DMS, or utilize a claim form that is not permitted by the MMIS submission guidelines. The variety of ways that providers deviate from Department submission guidelines is a constant challenge and requires continuous oversight with hands-on attention to quickly identify data issues and work with providers on solutions.

Our strategy for solving provider submission errors involve a 3-part remediation process that has been fully operational since 2016:

1. *Direct monitoring and analysis of rejected encounters* - No automated process can fully capture the potential issues providers will experience. We have weekly encounters sessions with our encounters team and market leadership to identify any new errors, their root causes, and potential solutions.
2. *Creation of new automated edits* - Our direct monitoring efforts help direct us to areas where our automated encounters edits can be strengthened and we continually re-evaluating and adding/modifying edits to address issues as they are discovered.
3. *Continuous provider education* - When new error trends are identified in encounter submissions, our analytical teams provide detailed, claim level error reports for our provider representatives to educate the affected providers. These error reports include, claim by claim, the nature of the error, an analysis of DMS' provider roster that supports our findings, and a solution which will allow the provider to begin billing correctly again. The solution may be to instruct the provider on DMS' requirements, but we have also frequently uncovered a need for the provider to address their licensing and registration issues with DMS.

Retroactive changes to encounter data elements - One particular aspect of encounters submission that is fairly unique to Kentucky is the frequency with which provider and enrollee eligibility will be changed in a retroactive manner. It is not uncommon for provider enrollment, enrollee eligibility, or even Medicare status to be altered retroactively on the enrollee eligibility or provider roster as much as several years in arrears. Because of these retroactive changes, situations frequently arise wherein a claim that was adjudicated and paid appropriately based on data available on the date of adjudication is no longer valid by the time the encounter is submitted.

In order to reduce state rejects caused by retroactive changes, WellCare has instituted a triple validation for provider and enrollee information.

1. Enrollment eligibility is validated upon receipt. In 2017, we also implemented front-end provider validation logic which has made a significant positive impact on state rejects by preventing ineligible providers' claims from being accepted into our system for processing.
2. During the adjudication process, the claims system performs a secondary validation on enrollee and provider eligibility.
3. Finally, before submission to the state, one final validation is performed. For our enrollees, we pay particular attention to retroactive changes in eligibility as a result of a recent incarceration or suspension, which might affect the validity of the claim. Encounters that fail this third validation are routed back to the claims team for potential recoupment.

This triple level of validation allows us every opportunity to identify those encounters failing validation before submission and begin an appropriate education, remediation, or recoupment processes, depending on the nature of the retroactive change. Provider validation is performed for every billing, rendering, ordering, attending, and referring provider, on every claim, in both our front-end and back-end processes.

Technical difficulties in the encounter submission process - Because the encounter submission and validation process is a complex technical process and we need to adjust quickly to changes in DMS' requirements, there will always be the need for ongoing collaboration with DMS to ensure that WellCare of Kentucky's submissions are perfectly aligned with both the policy intent and technical requirements. Over the years, our EOT has formed a close, collaborative working relationship with both DMS' policy makers that drive encounter submission policy and the Office of Administrative and Technology Services (OATS) staff that ensure those policy decisions are translated into technical submission requirements we can operationalize.

Our working relationship with DMS and the OATS staff includes not only the quarterly encounters one-on-one meetings and bi-weekly IT calls, but we frequently have email exchanges multiple times per week to seek clarification on technical issues. These interactions provide a constant feedback loop that help align our edits with DMS' expectations. Despite whatever specific encounter submission challenges arise in the coming years, it is this close working relationship with DMS that is going to ensure that we are able to adjust to Kentucky's changing environment and continue submitting encounters that meet or exceed DMS' expectations.

BEST PRACTICES TO ENSURE ACCURATE, TIMELY AND COMPLETE ENCOUNTER DATA SUBMISSION

The success of our encounters performance in Kentucky is driven by our matured process, configurable system, and 'one team' approach, where our management team and associates work in tandem to support end-to-end encounters processes in partnership with our providers. We implemented several best practices throughout the organization to support our encounter performance levels:

- *Partnership:* Functional encounters ownership is led by our Kentucky EOT with accountabilities across the organization including IT, Claims, Operations, Provider Relations, ePMO, Regulatory Affairs, driving cross-functional support and shared performance goals. This 'One-Team' approach ensures successful execution of the encounter process. We collaborate with our state partners to develop meaningful encounter submission requirements continually improving the process and quality of data. This manifests in our transparent process, comprehensive data sharing, and ready engagement.
- *We built several algorithms and data scrubbers* to screen, validate, and scrub encounters data to meet or exceed state specific quality requirements. Our fundamental goal is to provide DMS with the most accurate data on the first instance to reduce the remediation and reprocessing burden.
- *System Configurability:* Our EPS is built on a configuration model, which includes a rule based methodology, allowing us to modify processing rules throughout the lifecycle of the encounter customized by line of business. This configurable model adds flexibility and prompt turn-around in responding to certain changes designed to improve data quality.
- *Focus on Provider Education First:* WellCare focuses on provider impact before implementing changes that will impact provider. Upon receipt of incomplete data, our system allows for soft or hard front end rejects. Hard rejects are promptly communicated back to providers in the form of 999, 277U, 277CA response files, and/or automated letters

with detailed direction on how to resolve the root cause and resubmit. Soft rejects send a message to the provider but allows the claim to continue to process in our system. They are often used as a predecessor to implementing a new hard reject, allowing our Provider Representatives (PR) the opportunity to target providers requiring additional education on how to submit clean claims/encounters, minimizing provider impact upon implementing hard rejects. Additionally, our EPS validations enable reporting to PR for outreach/education as well, which improves the quality of the data sent to our state Medicaid partners.

- *Oversight:* We have developed a comprehensive suite of reports designed to track performance to Department requirements, providing a holistic accounting of encounters we receive, process, submit, and reconcile. Primary reports utilized include:
  - *SLA Performance Dashboard:* A table-driven report tracking every contractual SLA. It is produced monthly and is closely monitored by encounters management, market leadership and WellCare's executive leadership team (ELT).
  - *Inventory Aging Report:* Our end-to-end inventory monitoring and compliance oversight process provides transparency and early detection of encounter issues allowing timely remediation and submission to the Department. This process includes automatic alerts based on inventory thresholds set to each state's SLAs, with defined ownership for each fallout point.
  - *Standardized Work Plan Remediation:* We use a standardized remediation process including a standard work plan which is the primary driver for encounter remediation. The work plan provides a holistic view of open items, issues, and challenges for DMS enabling the encounters team to remediate quickly. Work plans are refreshed weekly and are reported to management and leadership teams. With this capability, we can track all Erred Encounter Records and provide a report detailing transmission reconciliation of each failed transaction or file within 30 Days of the transaction or file error. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) pose a unique challenge because a portion of their revenue is dependent upon accurate encounters submission and their providers records are subject to issues not faced by other providers. Their ability to receive supplemental payments can be terminated without their enrollment actually being end-dated. For these reasons, we pay particular attention to all encounters rejections encountered by these provider types and specifically address them individually in all of our encounters remediation sessions. We keep open lines of communication with the providers themselves and manually create provider-specific solutions where necessary.
  - *Encounter Completeness Reporting:* Our encounters team and cost reporting team collaborate with states to develop reconciliation reports of encounters to financials. The report provides visibility to any gaps existing between finance actuals and the representative encounters submitted to the state to ensure overall completeness. As our new contract in Kentucky includes a new comparison report, we will be working with DMS and our Finance team to develop reporting and processes for monitoring.
  - *Cross-functional Focus Groups:* When a data issue is identified that requires a deep dive data/system/process analysis and cross-functional solution, our Kentucky Encounters

Operations Team initiates a focus group. Focus groups bring together subject matter experts from multiple departments to analyze data, identify root cause(s), strategize on innovative solutions and execute on improvements needed. Each meeting includes at least one SME from Encounters Operations, Development, EDI Operations, and QA. For example, from September 2016 through February 2017, a focus group was established to deep dive into encounters failing Kentucky validation in EPS. This team identified over 17 opportunities for system/process improvements and laid the groundwork for at least a dozen future improvement initiatives. We continuously seek opportunities to improve on our processes through these types of collaborative efforts.

- The collaboration and education activities with our provider community is critical to driving data quality improvements within encounter submissions. A critical component of our encounters functional model is our local-based staff of Operations Account Representatives (OAR) s who work closely with Provider Representatives (PR) s and Quality Practice Advisors (QPA) s to implement our multilevel outreach and education processes engaging our providers to ensure quality, timeliness and complete data. Our process also includes the necessary feedback loops to enable providers to engage with us as needed. We also deploy a team of certified coding professionals to ensure accurate coding. Internal analytics target providers, which direct coding professionals who work directly with providers to improve documentation and produce more accurate coding.
- *Front End validation*: Along with educating providers, WellCare's success in driving quality data is significantly impacted by our well-established early detection process. We apply strong front end validations to prevent invalid data from even entering our system and work closely with providers to submit clean data. With every change in DMS' requirements, we continuously re-evaluate these edits seeking opportunities for prevention and provider education.

d. Describe educational approaches the Vendor will implement to support providers and Subcontractors that are identified as having ongoing challenges in submission of complete, accurate, and timely information.

As an incumbent in the state of Kentucky for almost eight years, we have developed trainings and educational programs to support our providers and subcontractors with their ongoing challenges in submission of complete, accurate, and timely information. Under the leadership of our Kentucky Encounters Director of Strategic Market Analysis, Robin Rhea; and Sr. Project Manager, Johnie Akers, our team includes over 30 Provider Representatives working closely with Kentucky providers and conducting webinars and trainings. **Our commitment to provider education is evident by the 6,000 face-to-face meetings conducted in 2018 with providers. These training efforts helped educate and ensure the accuracy, timeliness, and completeness of the 20.9 million encounters submitted in Kentucky.** We offer training modules and communications for our providers through our provider portal and during scheduled monthly trainings. Training material remains online for providers to reference at their convenience. Monthly trainings consist of various topics to include general encounter information, details on populating required/key fields on submission file (including how subcontractors are to populate the paid amount), and more specific topics presented by SMEs who can answer provider questions or address concerns.

In 2017, CMS required all state Medicaid entities to institute provider edits for ordering, attending, referring, and prescribing providers. These new edits affected a large number of our Medicaid providers. To ease the transition, WellCare of Kentucky embarked upon an extended period of testing and education prior to implementation. In early 2017, we tested historical encounters against the new standards to identify providers who were currently deficient on the new guidelines. Our OARs performed individual outreach to those providers and coached them on proper submission requirements. A technical presentation on the new submission requirements was included during our statewide series of provider summits. Since implementation, we have continued to educate our providers and help them conform to DMS' billing requirements. The chart below **Figure C.7-3** demonstrates that our total **rejects have decreased 51% year over year,** largely attributed to provider education and front end edits.

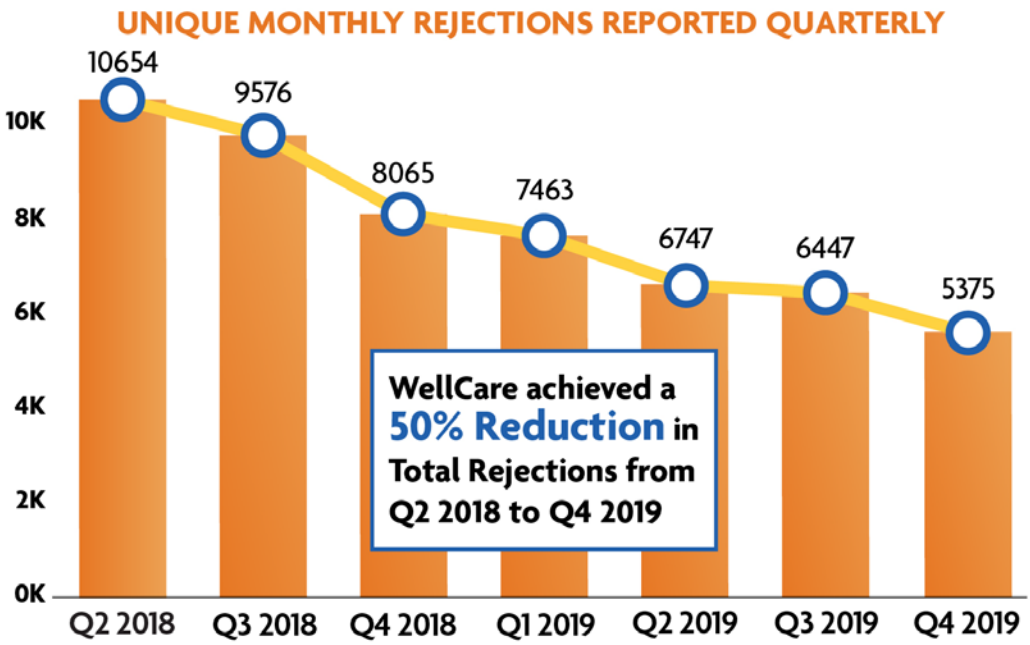


Figure C.7-3: Reduction in Rejection Rates

Processes/Tools used to support providers and subcontractors: Our EOT utilizes the tools/initiatives below to ensure timely resolution and resubmission of errors:

- Provider Scorecard: The Provider Scorecard tracks submission frequency and volume, compliance and accuracy of provider submissions. It reports the number of encounters submitted by the contractor by month, the number passing our front-end quality edits, and the number accepted by the Medicaid agency. These reports are used by us to manage contractor activity and to target visits and education.
- Contractor Education: Upon creation and dissemination of the provider scorecards, we schedule targeted education sessions. The goal is to ensure quality submissions and educate contractors on how to correct errors with their encounter data. We handle education telephonically, as well as in periodic training sessions provided by market provider representatives as needed.

- Vendor Management and National Ancillary associates meet with subcontractors regularly to review their timeliness and accuracy, ensure they are correcting and resubmitting rejected encounters, and providing additional education as needed to help them fix their data and demonstrate how to submit correctly the first time.
- If a provider is not identified on the most current provider roster file, a letter is issued to the provider that the encounter will likely reject once submitted to DMS. On an adhoc basis, we have the capability to produce a monthly report of rejections and warnings which require remediation.

e. Describe initiatives the Vendor proposes raising to the Encounter Technical Workgroup to enhance the data submission requirements and improve the accuracy, quality, and completeness of encounter submissions.

WellCare of Kentucky is committed to continuously reassessing current business processes and data quality concerns to identify opportunities for improvement. The Encounter Technical Workgroup enables collaboration with DMS on innovative strategies to improve data quality, align validation logic, and ultimately increase performance metrics utilizing the "one-team" approach, which is so deeply imbedded in the WellCare culture. Participants in the Encounter Technical Workgroup have included subject matter experts (SMEs) from our Encounters Operations Team, Enrollment, and the Market who bring knowledge, background, and experience with Kentucky-specific requirements and concerns. WellCare has the advantage of having established SMEs in all key areas who have been working with Kentucky data, people and processes for several years. Having SMEs with that history provides the continuity and in-depth understanding of Kentucky specific requirements, processes, and known challenges, which is invaluable to the process of root cause analysis and problem-solving. Additionally, bringing Robin Rhea into our organization with his knowledge from both points of view in Kentucky has been extremely helpful in identifying opportunities for improvement.

An example where WellCare of Kentucky's expertise uncovered a systemic issue that can cause provider abrasion and how we facilitated resolution.

In early 2018, one of our larger providers alerted WellCare of Kentucky that their supplemental wrap payments had abruptly stopped without explanation. Our EOT performed a detailed analysis. After ruling out claims processing/payment, state acceptance concerns, and confirming provider eligibility on the roster, we reached out to the state for coordinated root cause analysis. WellCare worked with the Encounters Technical Workgroup for resolution. We provided the Department with multiple examples of inconsistencies in encounter submissions results and supplemental payments. After much exchange of information, the Department discovered a hidden field that was not included in the provider roster file sent to MCOs, which indicated whether the FQHC license was active. Therefore, we did not have visibility into whether the FQHC's license had expired, which was the case for this provider. We notified the provider and connected them with the Department's staff who could help update their information. We also worked with the department to re-process their encounters, enabling the provider to receive $474,339 in retroactive supplemental payments. The Department also discovered this was an issue that could impact other providers and is now aware of this situation to simplify identification of this issue going forward.

To facilitate the collaborative approach with DMS, WellCare initiated JAD sessions with DMS' technical people back in 2013, have coordinated deep dive sessions with DMS' policy people, and have generally built a solid rapport and avenue for open discussion, information sharing and problem-solving. WellCare's commitment to conducting the research, asking questions, and developing ideas to offer solutions in coordination with DMS has helped more improvements be identified and resolved in a timely and coordinated manner. Our Market leadership has also initiated weekly internal focus groups to prepare for the Encounter Technical Workgroup meetings with DMS.

Initiatives that WellCare proposes for the Encounter Technical Workgroup to address are centered on reducing state rejects caused by data issues outside of WellCare's control, which are causing considerable impacts to providers. With the tightening of requirements and significant increases in penalties defined in the new contract, it is imperative that we collaborate on solutions in a timely manner.

1. CONFLICTS BETWEEN CMS AND KENTUCKY MEDICAID REQUIREMENTS :

- *Taxonomy:* Medicare does not require taxonomy and we have concluded that the CMS intermediary is dropping taxonomy upon submitting the crossover claim to WellCare. Missing data results in rejects and outreach to providers indicate the data is being provided upon submission to CMS. Lack of taxonomy information is preventing DMS from understanding Medicare claims history for Dual enrollees and is interrupting payment for impacted FQHC and RHC providers. WellCare's research concluded that providers registering one NPI with multiple Medicaid IDs are impacted.
- *Claim/provider type:* In certain circumstances, Medicare requires providers to bill services as institutional where DMS requires it to be submitted as professional. The opposite also occurs. This conflict requires additional manual processes to be completed by providers when claims are received in the wrong file type.

2. RETRO-ACTIVE DATA CHANGES

- *Retroactive enrollee/provider data:* WellCare adjudicates claims based on the enrollee and provider data available on the date the claim is processed. Because enrollee and provider eligibility dates are sometimes changed retroactively, our encounters are occasionally rejected based on information that was not available upon adjudication. As this situation is outside of our control, we would like to continue working on a solution with DMS that would both reduce retroactivity and exclude MCO's from being penalized for encounters that were adjudicated properly based upon information available at the time. MCO's should be afforded the opportunity to resolve errors caused by retro-active changes in data without penalty.

WellCare comes to the table with potential solutions to coordinate with DMS and improve processes and systems on both sides to support a successful Medicaid program in Kentucky. We look forward to continued engagement and collaboration in implementing the changes spelled out in our new contract.

C.7 Encounter Data

- Attachment C.7.b Encounter Data Processing Policies and Procedures

WellCare	Procedure
Manual Section: Corporate Policy and Procedures, Health Services Area, Encounters	**Procedure Name:** **Kentucky Submission Procedure**
Procedure Number: C7ENC-001-PR-015	**Original Issue Date:** 8/25/2014 — **Page:** 1 of 7
Prior Procedure Number(s): None	**Related Policy Number:** C7ENC-001

Applicable to:			**(Check One)**		
☒	Health Services	*Area*	**Created** (Date procedure was created)	☒	8/25/14
☒	All	*Department*	**Reviewed** (No changes to procedure)	☐	
☒	All	*All Associates*	**Revised** (Content changes made to procedure)	☒	6/13/19
☒	KY	*Lines of Business and Applicable State(s)*	**Repealed** (Procedure is no longer active)	☐	

State Agency Approval Date (Attach supporting evidence)	(State Abbreviation)	(Date)
Electronic Approvals are located in C360		

Procedure & State Specific Requirement

1 Background / Purpose

The Care Management Organization (CMO), WellCare Health Plans, of Kentucky, Inc. as part of its contracts with the Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS), is accountable to ensure that the receipt and processing of encounter and claims data files is completed in a timely and accurate manner.

2 Kentucky Procedure

2.1 Kentucky Lines of Business

Line of Business	Services
KMD	Kentucky Medicaid
KAB	Kentucky Aged, Blind and Disabled
KHK	Kentucky Healthy Kids

2.2 Encounter Submission Types

- Institutional
- Professional
- Dental
- Pharmacy

2.3 Submissions Schedule

Submission	Submission Schedule	Submission Day	Encounters Submission SLA	State Response Schedule
Pharmacy – NCPDP 2.2	Weekly	Tuesday	30 days from Received (encounters) Date	999 – within 24 hours 277U – within 48 hours
Institutional – 5010 837I	Weekly	Tuesday	30 days from Paid (claims) Date	999 – within 24 hours 277U – within 48 hours
Professional – 5010 837P	Weekly	Tuesday	30 days from Paid (claims) /Received (encounters) Date	999 – within 24 hours 277U – within 48 hours
Dental – 5010 837D	Weekly	Tuesday	30 days from Received (encounters) Date	999 – within 24 hours 277U – within 48 hours

2.4 Inbound Information

All inbound claim/encounter data (IE. Institutional/Professional/Dental/Pharmacy) are received through WellCare's secure FTP and loaded to the appropriate systems for processing.

2.5 Submission Requirements

1. Time Frame:
   - Data submitted should be reflective of the current or previous year.

2. Frequency:
   - The weekly submission processing day for WellCare is Tuesday, 12:02 AM to 8:00 PM. However, Encounter files may be submitted 24 hours a day, 7 days a week.

3. Volume:
   - Per the Kentucky 837 I, P and D Companion Guides, there is no file size limit for the 837 I, P and D file types. WellCare IT generates production files with a 5,000 records limit.
   - Per the Kentucky NCPDP Companion Guide there is a limit of 25,000 detail records per file.

4. Submission Files:
   - 5010 837 X12 files are generated for Institutional, Professional and Dental claims.
   - NCPDP 2.2 files are generated for Pharmacy claims.

5. Liquidation Damages / Withholds:

   Timeliness - Max Penalty: 0.33% of CAP payment rate
   - MCO must submit at least one file within five (5) days of assigned submission date
     - Penalty: $500/day until submitted (Daily MCO Claim Count Report)
   - 100% original encounters (paid/denied) to be submitted within 30 days of paid date
     - Penalty: $1/encounter/day beyond thirty (30) days until submitted – (ENC-0750-M)
     - Penalty: $11/RHC/FQHC encounter/day beyond thirty (30) days until submitted – all Encounters (ENC-0755-M)
   - 100% state rejected encounters to be resubmitted within sixty (60) days
     - Penalty: $1/encounter/day over 30 days until submitted – (3A ENC-253M)
     - Penalty: $11/RHC/FQHC encounter/day beyond thirty (30) days until submitted – all Encounters (ENC-1253M)

   Accuracy - Max Penalty: 0.33% of CAP payment rate

- Threshold error percentage greater than five (5) percent (ENC-0450-M)
  - Penalty: $500/file
- File Not in Required Format (Daily MCO File Count Rejection Report)
  - Penalty: $50,000/file
- Exact Duplicates (ENC-650-M)
  - Penalty: $5/duplicate encounter

Completeness - Max Penalty: 0.33% of CAP payment rate

- Failure to Submit Required Attestation within sixty (60) days of notification (Daily MCO File Count Rejection Report)
  - Penalty: $10,000/per file
  - Penalty: $1,000/per file/per each day late beyond sixty (60) days.

6. SNIP Level Edits:
   For all inbound/outbound 837 claims/encounters, SNIP levels 1 through 7 are available for use at WellCare and implemented at the various levels based on state requirements. These edits and their settings are documented by EDI-Dev in a SNIP Master List.

2.6 Encounters Submission Process – 837

837 I, P and D extract and file generation jobs are executed using the CA UniCenter AutoSys Job Management tool located on the AutoSys server. The 837 processes are scheduled to execute on the first day of the month. Requests are sent to the ITOPS team via the ITSM ticket application to manually start the processes outside of the scheduled time.

The job names are as follows:

Encounter-PROD-OB-KY-I-Main-Box
Encounter-PROD-OB-KY-P-Main-Box
Encounter-PROD-OB-KY-D-Main-Box

The final output path (post XEngine) for the above processes is

\\naswin1\PROD\HTR\EDI\TradingPartner\Outbound\837Out\9900004318-KYMEDICAID

The files are moved by the Encounters Submissions Analyst to the staging folder \\NASWin\vol1\data\Kentucky\Prod\837. They are then zipped and moved by the MoveIT job, Kentucky_837_Prod_PUT, to the secured Kentucky VPN site EDI folder. This job also places a copy of the file in the \\NASWin\Vol1\data\Kentucky\Prod\837\archive folder. An email is sent by the MoveIT jobs to the Outlook distribution list #EncInformatics identifying the file names of all files moved and the destination folder/site. The files are sent in .zip format with one file per .zip file.

The file naming convention is as follows:
KYW(837P/I/D)_9900004318_(O/R/A/V/D)_CCYYMMDD_HHMMSS.zip

- O – Original (new claims)
- R – Resubmission (claims that have been billed before but did not process for some reason)
- A – Adjustment (adjustments to existing claims)
- V – Void
- D - Denied

The Commonwealth will process the Encounters in the following order of bill type, which is identified in the file name:

- Originals
- Resubmissions
- Adjustments

- Void
- Denied

2.7 Encounters Submission Process – NCPDP

The NCPDP extract and file generation process is performed by vendor CVS.). The files are passed to WellCare using SFTP protocols and are staged in the folder \\naswin\vol1\data\EDICoordinator\CVSCAREMARK\Encounters\KY to be picked up by the automated and scheduled FTP Put job CVS_Caremark_Prod_NCPDP_Encounter_KY_FTP_GETALL to process to transfer the files to the state FTP server. The files transferred are also copied to the below folders for future reference/analysis. The files are sent in .zip format with one file per .zip file.

\\naswin\wc2vol1\data\CVSCaremark\Prod\To_WellCare\Encounter Submission\KY\Archive

\\naswin\wc2vol1\data\CVSCaremark\Prod\To_WellCare\Encounter Submission\KY\ForAnalysis

The file naming convention is as follows:
KYWNCPDP_9900004318_(O/R/A/V/D)_CCYYMMDD_HHMMSS.zip

- O – Original (new claims)
- R – Resubmission (claims that have been billed before but did not process for some reason)
- A – Adjustment (adjustments to existing claims)
- V – Void
- D - Denied

The State will process the Encounters in the following order of bill type:

- Originals
- Resubmissions
- Adjustments
- Void
- Denied

2.8 Internal Certification Form (ICF)

All file submissions to KY Medicaid must be certified with the completion of the WellCare Internal Certification Form per WellCare's Regulatory Affairs mandate. The file submission information must be completed by the WellCare Encounter submissions analyst or submissions verifier. The form is then reviewed and signed by both the Encounters Informatics Submission Manager and Director or above. The signed form is then scanned and stored in an electronic format to the appropriate folder below. The hard copy is stored in the Encounters business area.

Encounter	Completed Form Location (Electronic)
Medical	\\Naswin\vol1\SHARED\KY_Encounters_Informatics\Reporting\ICFs
Pharmacy	https://wellcareportal.wellcare.com/IT/ITInformatics/Encounters/Encounter%20Pharmacy/Forms/AllItems.aspx?RootFolder=%2FIT%2FITInformatics%2FEncounters%2FEncounter%20Pharmacy%2FPharmacy%20ICF%2FKY&FolderCTID=0x012000A43CB696806E644CBB3D6CB94664D482&View=%7B4564FE39%2D53D4%2D489F%2D8860%2D7AF5940E43D3%7D&InitialTabId=Ribbon%2ERead&VisibilityContext=WSSTabPersistence

3 Response File Reconciliation

3.1 837 Response Files

The Commonwealth of KY sends a 999 Acknowledgment file for each 837 file submitted by WellCare with the claim and reject reason for each claim in the specified file that failed their syntax validation process. Claims that have processed successfully are not included in this file. If all claims pass successfully a file with only the non-claim related segments is returned. The files are sent in .zip format with one file per .zip file.

The MoveIT job, Kentucky_837_999_Prod_GET, moves the files from the Commonwealth of KY VPN site to folder \\NASWin\Vol1\data\Kentucky\Prod\999. It also sends a copy to the \\NASWin\Vol1\data\Kentucky\Prod\999\Archive folder.

The MoveIT job, Kentucky_837_999_Prod_Move, moves the files from the folder \\NASWin\Vol1\data\Kentucky\Prod\999 to \\naswin1\PROD\HTR\EDI\TradingPartner\AckIB folder for load to the HTR Encounter Response tables.

The scheduler job, Encounter-E2E5010-Informatica-State-Response-KY-Box, contains jobs that will read the HTR 999 data and populates the ER Response tables with the appropriate response information and update the claim status to either 'REJECTED_SYNTAX' if the claim number is found in the 999 file. Using information identifying the file being processed, all other claims associated with that specific file submission will be updated with a status of 'ACCEPTED_SYNTAX'.

The second response file, 277U, is sent after the file has been processed through the Commonwealth of KY's 'Claims Adjudication' process. This file will contain a record for each claim sent in the file that was successfully processed in the syntax validation process.

The MoveIT job, kentucky_837_277_Prod_Get, moves the files from the Commonwealth of KY VPN site to folder \\NASWin\Vol1\data\Kentucky\Prod\277. It also sends a copy to the \\NASWin\Vol1\data\Kentucky\Prod\277\Archive folder.

The MoveIT job, Kentucky_277_Adhoc_Prod_PUT, moves the files from the folder \\NASWin\Vol1\data\Kentucky\Prod\277 to \\naswin1\PROD\HTR\EDI\TradingPartner\AckIB folder for load to the HTR Encounter Response tables.

The scheduler job, Encounter-E2E5010-Informatica-State-Response-KY-Box, contains jobs that will read the HTR 277U data and populates the ER Response tables with the appropriate response information and update the claim status to either 'ACCEPTED' or 'REJECTED', depending on the response codes received.

The file naming convention for the 837 999 and 277U files are as follows:

- <*ackfileid1*>_<*fileid2*>_837*t*5010X12BATCH_<OrigFileNm>.<OrigFileExt>.*n*.999.zip
- KYD837277U_<TPID>_<seq>_<date stamp>_<time stamp>_origfile837x _mcoid_O_origdatestamp_origtimestamp.zip

3.2 NCPDP Response Files

The Commonwealth of KY sends an ACK Acknowledgment file for each NCPDP file submitted by

WellCare with the detail line for each claim in the specified file in the order they are sent. Each line is prefixed with a status code of 'A' if accepted and 'R' if rejected. If a claim is rejected the reject information will follow the status code. The files are sent in .zip format with one file per .zip file.

The MoveIT job, Kentucky_NCPDP_999_Prod_Get, moves the files from the Commonwealth of KY VPN site to folder \\NASWin\Vol1\data\Kentucky\Prod\999. It also sends a copy to the \\NASWin\Vol1\data\Kentucky\Prod\999\Archive folder.

The MoveIT job, Kentucky_NCPDP_999_Prod_Move, moves the files from the folder \\NASWin\Vol1\data\Kentucky\Prod\999 to \\fservops\X:\~Process\NCPDP_KY\ResponseLoad_KY\Data folder for load to the ODSPROD ACK Encounter Response tables.

The second response file, 277U, is sent after the file has been processed through the Commonwealth of KY's 'Claims Adjudication' process. This file will contain a record for each claim sent in the file that was successfully processed in the syntax validation process.

The MoveIT job, kentucky_NCPDP_277_Prod_Get, moves the files from the Commonwealth of KY VPN site to folder \\NASWin\Vol1\data\Kentucky\Prod\277. It also sends a copy to the \\NASWin\Vol1\data\Kentucky\Prod\277\Archive folder.

- <OrigFileExt>_<*fileid*>_ACK.ncp.zip
- KYDNCPDP277U_<TPID>_<seq>_<date stamp>_<time stamp>.zip

4 Encounter Remediation

4.1 Internal Withhold & State Reject Remediation:

Each week the submission and reporting teams will review all internal with-hold and state reject encounters for 837 file submissions. The teams will prioritize each category of unsubmitted data by volume and/or by dollars and focus on the top error buckets that need to be remediated. In order to remediate, the submission team will analyze each prioritized category and solve in one of the following ways:

In certain situations the only way to remediate internally with-held encounters or rejected claims is through a code change. If a code change is required for Medical claims the submission analyst will open a WellCare Dev ticket and send all pertinent details over to the Encounter project team. Once the code has been updated/deployed the encounters are reset and reprocessed with the audit update process. If a code change is required for Pharmacy claims, the analyst will create a ticket to CVS (PBM) Encounter team for a change which is reviewed and approved by Wellcare leadership team. Once approved, the WellCare encounter team will work with CVS counterparts to detail the requirements. Once requirements are approved by WellCare, the change ticket will go through standard SDLC process on CVS side including QA testing and UAT testing by both CVS and Wellcare encounters team. Once all approvals have been obtained, the package will be managed through defined steps by CVS Change Management team and deployed to the production environment. All the change tickets are tracked through weekly Operation log meeting between CVS and WellCare.

5 Regulatory Reference

References to HIPAA Standards, Implementation Specifications or other Regulatory Standards are listed in the chart below.

Document Name	Link to document
State Companion Guides	http://www.kymmis.com/kymmis/Companion%20Guides/index.aspx \SHARED\KY_Encounters_Informatics\Companion Guides
State Website	http://www.kymmis.com/kymmis/
State Contract	http://wellcarelink.wellcare.com/C4/Government%20Contracts/Document%20Library/Kentucky%20MCO%20Contract%20and%20Appendices.pdf

6 References to Other Documents

References to other Policies, Standards, Procedures, Forms, or other Document Types in this document are listed in the chart below.

Document Name	Link to document
ICF P&P	Refer to C360

7 References

References used or sited in the creation of this document are listed in the chart below.

Reference	Reference Title	Reference link	Reference Year
WellCare-Policies	Encounters End to End Policy	C360	2014

8. Kentucky Health Information Exchange (KHIE) and Electronic Health Records

C.8. KHIE AND ELECTRONIC HEALTH RECORDS

a. **Describe strategies and incentives the Vendor will implement to encourage provider adoption and use of electronic health records that result in improvements in the quality of care for Enrollees and cost of health care services.**

b. **Describe strategies for requiring participants to establish connectivity to the Kentucky Health Information Exchange (KHIE) for a minimum of:**

   i. **Providers:** applicable public health reporting

   ii. **Hospitals:** applicable public health reporting and Admit Discharge Transfer (ADT's).

c. **Provide a description of initiatives and incentives to encourage adoption of electronic health records and information exchange.**

C.8. KHIE AND ELECTRONIC HEALTH RECORDS

a. Describe strategies and incentives the Vendor will implement to encourage provider adoption and use of electronic health records that result in improvements in the quality of care for Enrollees and cost of health care services.

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 17 Office of Health Data and Analytics and Section 18 Electronic Health Records of the Draft Medicaid Managed Care Contract and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Electronic Health Records (EHR) is key in easing administrative burden for providers and improving health outcomes. WellCare has been an advocate of leveraging EHR across the continuum of care as this offers improved integration among providers. In addition to the traditional uses of EHR data, such as supporting HEDIS measure validation, we actively use EHR data to improve the quality of care for enrollees, sharing open and pending care opportunities, care management interactions, P4Q opportunities, prior authorizations, billing which also results in the reduction of the cost of health care services. Examples of our uses of EHR data include:

- Leveraging Admit, Discharge, and Transfer (ADT) transactions to notify care managers and PCPs of enrollee admissions, enabling the initiation of discharge planning and the expansion of enrollee's care plan prior to them leaving the hospital, preventing readmissions and ensuring effective follow up treatments
- Using EHR data in combination with claims, health assessment, pharmacy, lab, and other data to improve the accuracy of our risk stratification processes, resulting in more efficient and comprehensive care plans and leading to cost reduction opportunities through prevention and treatment
- Reviewing clinical EHR data and, using machine learning and artificial intelligence solutions, identifying potential missing diagnosis indications
- Implementing Blue Button 2.0 or similar compatible solutions that allow enrollees to use Blue Button 2.0 compatible solutions (including on smart phones) to access their clinical

data and bring it along with them on their office visits. Blue Button 2.0 is a standard web function, designed by the Federal Government and first made available on Medicare.gov to promote the delivery of this type of data directly to Patients.

OUR STRATEGIES TO ENCOURAGE PROVIDER ADOPTION AND USE EHRS

Our strategies to encourage provider adoption and use to EHRs is driven by the fact that barriers to adoption of EHR exists. Barriers to adoption of EHR fall into several categories: cost, insufficient infrastructure or resources to support the technology, fear of complex or risky implementations, long payback periods for return on investment and resistance to adoption of technology. Smaller practices particularly struggle with these barriers.

As a part of our provider collaboration strategy, we work with providers to help them overcome these barriers and adopt EHRs. WellCare of Kentucky capitalizes on our relationships with providers to inform them about the benefits of the HIE, the available products and services, and how they can use clinical information-sharing to improve patient care and efficiency. While we encourage providers to adopt EHRs and connect to HIE, if they are not ready, we help them understand the value they can gain. We have had KHIE representatives attend and participate in several of our bi-weekly provider webinars to educate providers on the benefits of using EHRs and give providers the opportunity to ask questions and discuss any challenges they may be experiencing. We are committed to continue educating providers on the benefits of EHRs and clinical information-sharing through KHIE and encourage adoption, we will:

- Host webinars and video-based training and information sessions.
- Educate providers on the resources available to them to support EHR adoption.
- Invite guest speakers in our provider forums to talk about the benefits of EHRs.
- Invite KHIE to present information at our four provider summits that in 2020.

Our Network Management, Quality Practice Advisors, Provider Relations, and Operations representatives are the frontline points of contact for our providers. We have a team within our Quality team who help providers connect to EHRs. WellCare of Kentucky also has a dedicated local resource, Shannon Johnston, Business Technical Analyst, who assists our providers with EHR Flat files, ESD submissions. He has made onsite visits to assist with technical questions. We will provide training on the benefits of EHR and KHIE adoption, including available online resources (i.e., FAQs, products/services, technical assistance available) to share with providers during engagement. In addition, all staff will have access to the same online provider materials to assist them in addressing provider questions related to KHIE. Our Network Management staff will collect information on providers regarding their EHR adoption and use, and KHIE participation. Ongoing encouragement for all new and established providers in adopting electronic health records will occur as part of provider education. Our Provider Relations workflow application will include designated fields for the purpose of capturing data regarding the provider's EHR selection and usage as well as KHIE participation. By tracking the provider's choices, we can focus on our primary goal to encourage providers to take advantage of full EHR integration if the provider is only using Direct Secure Messaging (DSM) or is not integrated with the KHIE.

INCENTIVES TO ENCOURAGE PROVIDER ADOPTION AND USE EHRS

Our EHR incentive program works to motivate providers to not just adopt an EHR but to actually use EHRs to drive value and results for enrollees and providers. Our incentive program is categorized under financial, P4Q and non-financial incentives as discussed below:

Financial Incentive: WellCare of Kentucky proposes to provide a grant of up to $1000 for our eligible independent providers who successfully implement EHRs for the first time.

Partnership for Quality (P4Q) Incentive Program: Providers receive bonus payments for closing care needs on key HEDIS performance measures and timely completion of appointment agendas. Appointment agendas allow our physician partners to understand, in a single report, everything that they need to address an enrollee's needs during an appointment. Providers who implement EHR and submit EHR Flat files not only receive financial incentives but they also benefit from faster and accurate HEDIS care need closure data submissions to WellCare of Kentucky. This translates into better health outcomes for our enrollees and increased P4Q payments for our providers.

In addition to the financial incentive, **we will facilitate peer-to-peer interaction**, organizing focus groups and connecting a provider with a peer to share EHR implementation best practices and benefits gained through EHR adoption. We will also work with the providers to identify EHR systems that have little to no cost and research successful implementations to help guide them in their EHR selection. We will also help determine the potential for smaller practices to share EHRs if the appropriate safeguards of patients' PHI can be achieved.

b. Describe strategies for requiring participants to establish connectivity to the Kentucky Health Information Exchange (KHIE) for a minimum of:

The Kentucky Health Information Exchange (KHIE) brings great value to the quality, safety, and efficiency of health care. WellCare of Kentucky supports DMS' vision on how provider adoption and use of electronic health records results in improvements in the quality of care for Enrollees and cost of health care services. We view our active participation in the HIE community as an opportunity to significantly improve our existing strategies and to form collaborative efforts with DMS. Several members of WellCare of Kentucky's staff attended KHIE's "Renovate to Innovate" eHealth summit in August 2019. WellCare of Kentucky welcomes the opportunity to continue to learn and understand more about the new KHIE platform as well as the business and technical strategy of KHIE. Our efforts include expanding our provider education offerings relative to the adoption of EHRs, promoting the secure exchange of electronic health information via KHIE, and encouraging the adoption and use of both.

Our Experience in HIE Community

We have actively participated in the Health Information Exchange (HIE) community since being the first MCO to attend the State Health Information Exchange Collaborative (SHIEC) Health Information Exchange Users Group (HUG) conference in 2015 and annually thereafter. We have innovated in leveraging our MITA-informed solutions and HIE participation to improve care management processes, health outcomes, and the transition of care between MCOs.

In Georgia, we actively encouraged the use of the GaHIN to serve as a mechanism for supporting enrollee transition from one MCO to another to standardize the process of ensuring member health outcomes were not adversely impacted.

i. Providers: applicable public health reporting

Accurate Reporting: We monitor provider compliance to provide accurate public health reporting through KHIE. If we find a provider not adhering to the reporting standards we send a notice of deficiency and a suggested remediation and, when appropriate, is subject to contract compliance discussions regarding ongoing network participation. We re-audit each practice that did not comply to determine the success of education efforts. Any provider that fails the re-audit is notified by letter. The results of monitoring activities are presented to our utilization management and quality improvement committees. Corrective action plans are developed based on non-compliance to public reporting.

Provider Education Webinars: To assist providers in gaining an understanding of the importance of participation in the KHIE, WellCare of Kentucky will conduct biweekly webinars targeted to provider organizations on the process of connecting to the HIE. This will include information on how to join the KHIE, assistance that we will be able to provide, how the information will be used to support public health reporting, and other advantages of joining the HIE.

In early 2019, we invited Andrew Bledsoe, Deputy Executive Director, Commonwealth of Kentucky CHFS Office of Health Data and Analytics to speak at two of our Provider Summits. He discussed the evolution of KHIE and plan for the future. This was a great way to introduce many of our smaller providers to KHIE and the many advantages of actively sharing health care data through an HIE. KHIE also had an exhibit table at the Provider Forums where they were able to interact with many of our providers and educate them on how to participate with KHIE.

Provider Web Site: Our provider portal is a no cost and low risk manner to engage providers on how to join the KHIE, assistance that we will be able to provide, how the information will be used to support public health reporting, and other advantages of joining the HIE. This will also include a link from our portal to the designated landing page of KHIE.

Provider Participation Tracking: Our provider visit checklist will be modified to include validating the provider's participation in the KHIE and capturing this participating information in our provider data files. This will include capturing whether providers are participating through the use of Direct Secure Messaging, data extracts, or EHR integration.

Provider Contracting: In compliance with the requirement outlined in Section 17.1 Kentucky Health Information Exchange, **all our network providers will be required to sign a Participation Agreement with the Kentucky Health Information Exchange (KHIE) within one month of contract signing**. We will track and report (as requested) on the provider's participation status. Working with KHIE, we will immediately begin to assess our network providers' participation in the HIE. This will allow us sufficient time to ensure we comply with this requirement.

ii. Hospitals: applicable public health reporting and Admit Discharge Transfer (ADT's).

Hospital Contracting: Based on our discussion with KHIE, we were informed that there are very few hospitals who do not participate in KHIE's ADT reporting. We will actively solicit and encourage all our hospitals to submit ADTs to KHIE. WellCare of Kentucky will invite KHIE staff to our Joint Operating Committee (JOC) meetings to meet with the hospitals who are not fully participating in KHIE to discuss the advantages of full participation. In compliance with the requirement, our providers who do not have an EHR will be required to sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services so that they can share clinical information with other providers in their community of care.

In both of these instances, WellCare of Kentucky will be collaborating with the KHIE to ensure that the information disseminated is accurate and, to the extent they are willing, offer to have them participate directly in the webinars. This will include ensuring their permission to reference them and to establish a link to their website.

c. Provide a description of initiatives and incentives to encourage adoption of electronic health records and information exchange.

In addition to the strategies discussed above, we have made significant initiatives to incent and encourage adoption of EHR and HIE's for the providers:

Collaboration with other MCO's - As a strategy, we plan to collaborate with other MCO's to create a program which would enable us to report to DMS the providers who has not adopted EHR or connected to HIE.

Provider Summits - At our provider summits in 2019, we invited KHIE to educate our providers regarding its benefits. Andrew Bledsoe, the Deputy Executive Director of the Office of Health Data and Analytics presented to all of our participants in the Lexington and Louisville Provider Summits related to the current and future state of KHIE. KHIE also staffed an exhibit table at the Provider Summits where they we able to interact with many of our providers individually. Following the summits, we sent follow-up emails to attendees with additional information on KHIE including an invitation to the upcoming KHIE summit.

Provider Surveys - Our Provider Reps conduct annual surveys to review the barriers to adoption of KHIE/EHR. Cost being one of the major barriers, we work with providers to help them find low cost no cost EHR options and assist them with creating a work plan to connect to EHR/HIE

Provider Identification - We will collaborate with KHIE to receive a list of providers who participates in KHIE. Once we have that list, we will work on a strategy to target providers who

do not participate in KHIE, engage with them either individually or in group settings to educate them on KHIE and press the value of participation.

Access to ADT: WellCare will work to ensure that providers have access to ADT notifications, either directly from KHIE or routed through WellCare, starting with PCP groups. WellCare believes that the availability of these notifications is the quickest path to value for KHIE and that the use of this data is a motivation for providers to share their own data.

Resources available: Our Practice Transformation Specialist will assist providers in adoption to EHR and connecting to HIE. They will work in conjunction with our Quality team and monitor the provider adoption to EHR and work with them in developing corrective action plans as needed.

Online Information and Resources: Providers and their office staff experience administrative burden, particularly with regard to ongoing medical records reviews and the intense amount of manual preparation time required prior to delivery to WellCare. Participation in the KHIE will ameliorate this burden. Therefore, we will encourage Providers to participate in the KHIE to allow us access to their enrollee's EHRs using the Direct Secure messaging (DSM) service. We will emphasize the benefits of DSM such as saving time, improving care, cost effectiveness and enhancing privacy. Timely and efficient transmittal of Member health information via KHIE supports not only the HEDIS review process but also the ability to identify care needs through the integration of claims and clinical data.

Public facing website: On the public-facing “What’s New!” page of our website, we will post a static quarterly Provider banner message to reflect KHIE information. The banner messages will include hyperlinks which will redirect Providers to the KHIE.org website. Additionally, we will include similar information in the Provider Manual posted on our website, which will describe how and where prospective and new Providers can access information about KHIE and the benefits of participation.

Additional places to connect through the web will be our Frequently Asked Questions (FAQs) page which educates Providers on EHRs, KHIE and the benefits of using each. Specific questions and answers will emphasize the alignment between EHR and HIE use.

Secure Provider Portal: We will also develop and publish self-service training materials on our secure Provider portal along with job aides to provide detailed explanations about EHR and KHIE use. We will post the same job aides to our public pages enabling easy access from any point of entry.

Through the expansion of incentives and development of new programs to encourage EHR and HIE use, we are convinced that our network providers will be strongly incentivized to implement these in their practices.

9. Quality Management and Health Outcomes

C.9. QUALITY MANAGEMENT AND HEALTH OUTCOMES

a. **Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. At a minimum, the Vendor's response should address:**

   i. How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.

   ii. Strategic solutions the Vendor will use in quality management, measurement, and improvement.

   iii. Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.

   iv. Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels.

   v. Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.

b. **Indicate if the Vendor has received NCQA accreditation for the Kentucky Medicaid market, and if not, the proposed timeline for achieving accreditation.**

c. **Provide the Vendor's proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.**

d. **Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:**

   i. Proposed stakeholder representation.

   ii. Innovative strategies the Vendor will use to encourage Enrollee participation.

   iii. Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.

e. **Provide a comprehensive description of the Vendor's proposed Quality Assessment and Performance Improvement (QAPI) Program that meets all requirements of this Contract.**

f. **For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky's Medicaid population. Include discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how**

those will be addressed. Provide examples of successes in other state Medicaid programs, and how that success will be leveraged in the Kentucky Medicaid market.

i. Medication Adherence for Diabetes Medications

ii. Tobacco Use and Help with Quitting Among Adolescents

iii. Colorectal Cancer Screening

g. Describe the Vendor's proposed approach to collaborating with the Department, other MCOs, and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

i. Lessons learned, challenges, and successes the Vendor has experienced while conducting PIPs, and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.

ii. Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.

iii. Methods for monitoring and ongoing evaluation of progress and effectiveness.

h. Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.

i. Describe the Vendor's approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:

i. How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.

ii. Methods for measuring provider performance against practice guidelines and standards adopted by the QIC, and follow up activities to be conducted with providers based on ongoing review of findings.

iii. A summary of the Vendor's approach to annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.

j. Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:

i. The Vendor's lessons learned in developing and implementing VBP models, examples of models that have been most effective in improving performance and outcomes.

ii. Recommended goals and focus areas in the first two years of implementation of the VBP program.

iii. Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.

iv. Potential challenges specific to Kentucky and the Vendor's proposed methods for addressing identified challenges.

v. Regardless of the model implemented, the Vendor's approaches to analyzing performance against targets, frequency of analyses, reporting results to DMS, and use of analyses to modify interventions that are not making progress towards achieving targets.

k. Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:

i. The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.

ii. How improvement in health outcomes will be addressed through the VBP arrangements implemented.

iii. Methods for evaluating the effectiveness of VBP, including tracking of costs and improvement in health outcomes.

l. Provide results of any provider satisfaction survey reflecting the Vendor's performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, Describe strategies the Vendor has implemented to address improvement, and examples of how those strategies have been effective.

C.9. QUALITY MANAGEMENT & HEALTH OUTCOMES

a. Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. At a minimum, the Vendor's response should address:

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 19 Quality Management and Health Outcomes of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare of Kentucky has supported DMS' goal of improving health outcomes since we began serving the Commonwealth's most vulnerable and economically disadvantaged individuals in 2012. Our Kentucky-based integrated Quality, Population Health, Behavioral Health, Pharmacy and Provider Network teams, who live and work in the communities we serve, have been infusing quality throughout our operation since this time. As the MCO with the most Medicaid experience with the specific healthcare needs of Kentucky Enrollees, comprehensive data analytics capabilities, collaborative provider relationships and effective member engagement programs, our team has developed tailored programs for specific populations focused on empowering Enrollees to engage in their healthcare and aiding providers in helping Enrollees in this effort. Our success is

proven in the fact that **WellCare of Kentucky is the only MCO that has not seen any decline in our NCQA Health Plan Rating year over year from 2015/2016 to present.** We have developed a comprehensive suite of specialized programs, a leading analytics platform, tools and incentives to engage both providers and Enrollees, and a local, high-touch approach that centers on DMS' goals of 1) Empowering individuals to improve their healthcare, 2) Improving the quality of care and health outcomes, and 3) Reducing or eliminating health disparities. Our solutions have resulted in **WellCare of Kentucky achieving the highest NCQA quality rating in the State overall, AND the highest in the Behavioral Health measures.** Our relentless passion and focus on quality has led to a balanced strategy that includes programs and enhanced services, analytics and reporting, member and provider engagement, and customer satisfaction improvements that have made **WellCare of Kentucky one of only two Medicaid MCO's in Kentucky that have earned a Commendable Accreditation status for the last two years in a row and we improved our accreditation scores from 79.0 in 2015 to 85.73 in 2019.** We realize the importance of aligning with the State, the Providers, the Enrollees and our Communities to drive needed change throughout Kentucky and we have the proven track record of success to accomplish this goal.

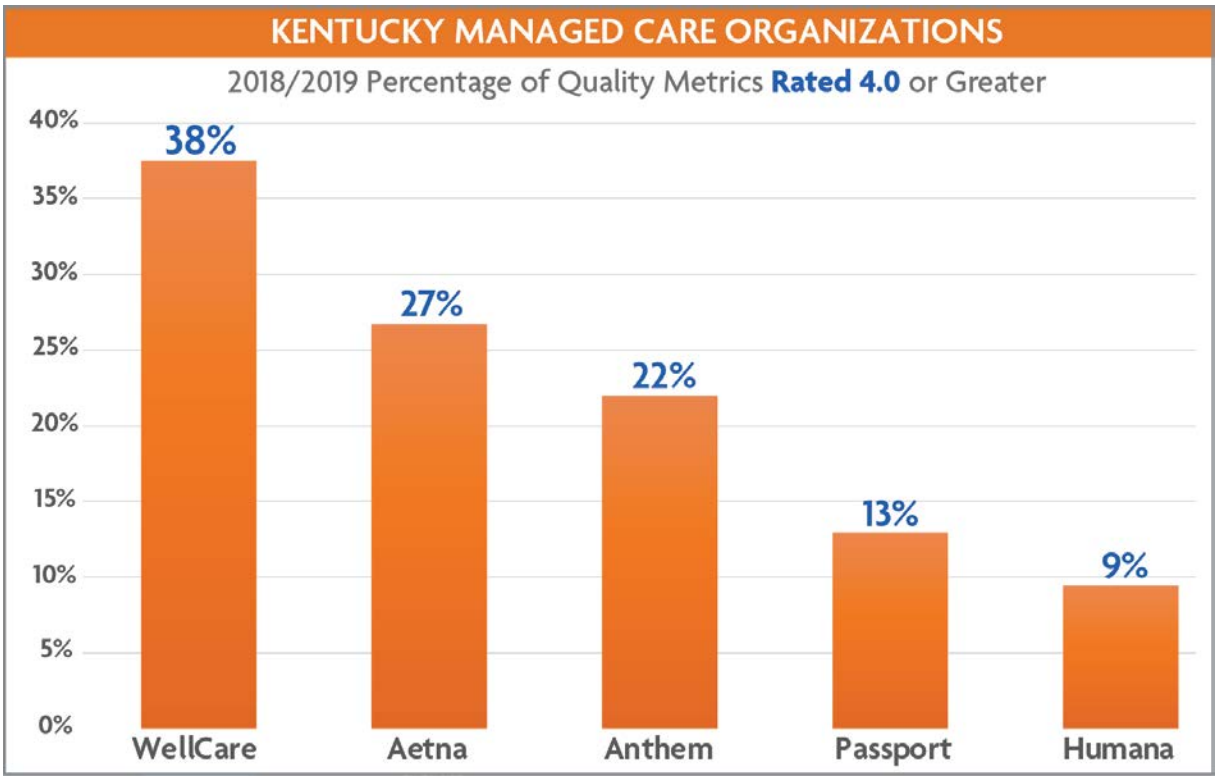


Figure C.9-1 Quality Metrics in Kentucky

In the following sections, we demonstrate that no one is more passionate and focused about improving the quality of care and outcomes in the Commonwealth than our local team. With the data to support this, 91% of our HEDIS measures have improved year-over-year from HEDIS 2013 to 2019, including all three Well-Child Visit measures: Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits. Overall,

WellCare had the highest proportion of ratings of 4 or higher in 2019 among all Kentucky MCOs, see **Figure C.9-1** for an illustration of MCO quality metrics in the Commonwealth. Under the direction of Chief Executive Officer Bill Jones and Medical Director Dr. Howard Shaps, our integrated leadership team including Quality Improvement Director Laura Betten, Provider Network Director Bonnie Irvin, Pharmacy Director Thea Rogers, Behavioral Health Director Dr. Marketa Wills and Population Health Management Director Shannon Maggard leverages this experience as we continue to collaborate with DMS on advancing and transforming the Medicaid program.

i. How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.

As an MCO that has integrated medical and behavioral health since we began serving Medicaid Enrollees in 2012, WellCare of Kentucky's structure provides a comprehensive and holistic approach to empower and engage Enrollees in improving their healthcare, support providers in helping Enrollees improve health outcomes and reduce or eliminate health disparities. Quality is woven into every element of our integrated organizational structure — from the oversight provided by the Board of Directors (the Board) and our quality committees, the day-to-day responsibilities of our Quality Department, to the cross-departmental collaboration and coordination with providers and subcontractors. These integrated organizational teams use our comprehensive data analytics capabilities and the Plan-Do-Study-Act (PDSA) model to ensure continuous quality improvement as they collaborate to improve health outcomes.

QUALITY OVERSIGHT

The Board has overall responsibility to provide strategic direction for the Quality Assurance and Performance Improvement (QAPI) program. The Board delegates to the Quality Improvement Committee (QIC), which establishes, evaluates and, as needed, revises the QAPI program with input from the Quality Member Advisory Committee (QMAC) and Utilization Management Advisory Committee (UMAC) including provider representatives, and the Quality Department.

QUALITY DEPARTMENT

WellCare of Kentucky's Quality Department consists of local experts, from leaders to support staff, who live and work in the communities they serve and are responsible for the day-to-day oversight and implementation of our Quality operations. These teams collaborate with our Population Health Management, Behavioral Health, Pharmacy and Field Network Management departments to provide comprehensive and holistic care for our Enrollees.

Our Quality leadership includes Medical Director Dr. Howard Shaps and Quality Improvement Director Laura Betten. Dr. Shaps has seven years' experience improving quality for managed care. Ms. Betten has an MBA in healthcare management and has eight years' experience in managed care. Reporting to Ms. Betten is a Senior QI manager and five QI managers with **a combined 81 years of experience** as Quality Practice Advisors (QPAs), Behavioral Health (BH) specialists and HEDIS experts. These managers lead **dedicated Kentucky-based QI teams** who empower and engage Enrollees, support providers and address larger systemic issues in Kentucky**. These teams include more than 50 quality experts**, some of whom hold advanced degrees in epidemiology, healthcare administration and social work and are supported by a

corporate Quality team of nearly 200 associates providing additional analytics, programmatic and operational support. Our integrated and focused regional team of Kentucky-based Associates engage our Enrollees, providers and stakeholders through many channels, including:

- *Health Coaches* conduct continuous telephonic outreach to our most vulnerable Enrollees and have made more than 13,000 successful coaching calls, educating them on recommended critical screenings and preventive services, helping to bring awareness to personal health needs and transform Enrollee lives since the program's inception in February 2019. In addition, we will expand our program to include two additional Health Coach teams comprising local experts focusing on smoking cessation, obesity and pre-diabetes/diabetes.
- *Care Needs Coordinators* continuously outreach to Enrollees telephonically to educate them on recommended care needs and help schedule appointments for those Enrollees not engaged in a PCA practice or a care management program.

Care Needs Coordinator Impact

An Enrollee, who was homeless, was identified as having a care need related to his medication adherence and recommended screenings and connected with a QI Care Needs Coordinator. Numbers to available resources were shared by our QI Care Needs Coordinator in addition to offers for a referral to Care Management. The Enrollee refused a referral to Care Management but he did have access to a telephone so our QI Care Needs Coordinator would call him periodically to check on him. Through the resource numbers provided, the Enrollee was able to find a stable place to live. On a subsequent call, the Care Needs Coordinator was able to help him get an appointment with his PCP, connect with Member Services to update his new address, and to obtain an insurance card. The Enrollee expressed that he felt he was now on a path to get his life on track.

- *Patient Care Advocate (PCA) team* co-located in provider offices assisting Enrollees with scheduling appointments through telephonic outreach and direct Enrollee engagement, educating on care needs and assisting in removing barriers to care.
- *Member Outreach Coordinators (MOC)* who work with our Unable to Contact (UTC) program, REACH, to locate Enrollees for whom we have incorrect or missing contact information. We currently focus our UTC outreach in region 8 due to the prevalence of clinical complexities and social determinants of health that increase the UTC rate in this rural area.
- *Kentucky Quality Practice Advisor (QPA) Teams:* Three teams of regionally located QPAs are responsible for assisting providers in closing care needs. They educate providers on HEDIS and HPR measures and the importance of completing appointment agendas. Appointment agendas enable our physician partners to identify, in a single report, Enrollee chronic conditions and care needs that need to be addressed during an appointment. QPAs assist provider groups in practice transformation to develop coordination of

In 2019, our QPAs conducted more than 6,000 visits to provider offices to educate providers and advance the Commonwealth's quality

care for Enrollees. In addition, QPAs are responsible for EPSDT and AMRR audits, reviewing results directly with providers and developing corrective action through identifying opportunities to increase efficient and effective use of EMR templates and care alerts, office workflows and coding to improve capture of quality services. In addition, QPAs assist with referrals to and coordination between care management as needed. In preparation of the new contract, we are implementing specialized QPAs to provide focused support to specialty providers, including Behavioral Health and OB/GYN. The Behavioral Health QPA will focus on care coordination between medical and behavioral health needs and the OB/GYN QPA will focus on women's health needs. Both will conduct visits with their respective specialty providers to educate them on performance management and our programs.

WellCare of Kentucky received more than 91% compliance in the last full EQRO audit

- *Our Kentucky NCQA/Audit Team* of QI project managers, QI specialists and QI coordinators are responsible for NCQA requirements and our two-year Commendable Accreditation status as well as HEDIS, EQRO and HRA audits. In addition, this team updates our program description, work plan and evaluation which contain information on our PIPs, HEDIS interventions, Annual Medical Record Review (AMRR) process and our QIC, QMAC and UMAC.

Bluegrass Community Health Center was having difficulty finding a Home Health Agency to provide services for a WellCare Enrollee. QPA Shelly Adams, who had stopped by the office for a visit, was able to garner the assistance of Paula Franklin, Care Manager, who was able to secure a home health agency. Within 30 minutes a home health agency was secured and the Enrollee started receiving services the next day.

- *Our Kentucky HEDIS Team* of QI project managers and care needs coordinators are responsible for HEDIS performance tracking, medical record review, measure intervention and implementations and Enrollee outreach. The team's focused attention has resulted in statistically significant increases in the rates of over 35 HEDIS measures from 2016-2019, including a 187% increase in "Adolescent Immunizations- Combo 2."
- *Our Kentucky Quality Analytic Team* uses our best-in-class software, including Tableau® and SQL Server Management Studio, to create detailed reports that help QPAs identify Enrollees with care needs and assist providers in improving quality and risk adjustment scores. For example, a provider requested a report to see if assigned Enrollees were receiving services from other providers. Using SQL Server Management Studio, the team compared Enrollees claims to identify the providers, if any, the Enrollees were visiting. This report allowed the QPA to review with the provider to address Enrollee outreach strategies, help direct the Enrollee to coordinated care and adjust provider panels appropriately. The team also developed an Enrollee outreach database in SQL Server to identify Enrollees at risk of becoming non-compliant and prioritize them for outbound calling by our Care Center. This system provides an all-encompassing view of the Enrollee including care needs, dates of PCP visits, ED utilization, and previous call history. The team also provides support to QI

managers, PR managers and care management for Enrollee and provider focused reports and oversight of team performance.

- *Clinical Data Capture Team:* This dedicated team includes data, systems and technical experts, such as quality analysts, providing individually tailored solutions for provider connectivity and the facilitation of electronic medical record data. This unique team of Quality and IT associates understands the data structure and the ability to map information from Electronic Medical Records, partnering with individual providers, practices and large health systems to create data exchanges for the purpose of seamless data integration.
- *Quality Statisticians:* This team includes experts in disparities and rural health providing statistical modeling and population profiles to gain insight on Enrollee trends and behaviors. The modeling includes innovative methods of detecting unique nuances of the complex populations and visualizations for accessible data for internal and external stakeholders. For example, this team recently looked at disparities among men and women as well as black, other and white races for a variety of measures for HEDIS Years 2016 and 2017 in Kentucky, as demonstrated in Question C.9.a.iv., below.

"Throughout the last several years I have worked with WellCare of Kentucky's team on a monthly basis, focusing together to achieve quality preventive care for our patients. Their focus on Quality outcomes and chronic condition education ensures that their Enrollees are getting the best possible care. They are a much needed support in meeting these initiatives."

– KATRINA BARKER, APRN, PRACTITIONER/OWNER, HOMETOWN HEALTH PLLC

COORDINATION WITH SUBCONTRACTORS

WellCare of Kentucky expects the same level of diligence and performance from our subcontractors as we do of ourselves. As part of our coordination with subcontractors, we incorporate their programs and processes into our continuous quality improvement activities. In addition, we regularly meet with subcontractors to review performance and collaborate on performance improvement opportunities as well as to innovate new programs. Examples of our coordination efforts with subcontractors include:

Avesis, our dental and vision contractor, like us, understands the importance of dental health on the overall health of our Enrollees. We also appreciate the need for vision services and their importance to our Enrollees, who have often struggled with accessing services and obtaining prescription glasses. To enhance our support for these issues, we have a quality outreach program that we have created with Avesis for our Kentucky Enrollees. We transmit a monthly list to Avesis of Enrollees who are non-compliant with the DRE (diabetic retinal eye) exams. Avesis will send out at a minimum of three letters and make at least five phone calls to the Enrollees to help educate them on the vision benefits offered by the plan and help them understand the importance of the annual diabetic eye exam.

Our **Nurse Advice Line (NAL)** is an integral part of our Enrollee supports. The NAL team takes part in our Quality Improvement Committee and Utilization Management Advisory Committee to discuss current trends and areas of need with WellCare of Kentucky leadership.

Our relationship our pharmacy benefits manager, **CVS**, is another example of the strong relationships we create with our subcontractors. CVS takes part in routine and ad-hoc conversations regarding pharmacy performance and helps strategize solutions with our Pharmacy Director and Pharmacy Quality Improvement team to create tailored solutions for Kentuckians. In 2019, as part of our 2018 QI Evaluation analysis, we determined that a focus area for our partnership with CVS and our pharmacy teams is to rebrand and refocus our attention on the pharmacy lock-in program to improve Enrollee and provider experience.

COORDINATION WITH PROVIDERS

WellCare of Kentucky recognizes the critical role that our providers play in improving quality. Our job is to wrap around our provider community with personal outreach, incentives and data sharing methods helping them to improve the quality of care they deliver to our Enrollees while reducing their administrative burden. **WellCare of Kentucky has developed a trusting relationship with our network providers by ensuring they have the support they need to provide the highest quality of care to the Enrollees they serve. As a result, we came in first for NCQA Customer Satisfaction in 2016-2019 among all Medicaid MCOs.**

Due to our responsiveness and quick action to provider concerns, our overall provider satisfaction rate increased by 22.2% from 2017 to 2019.

Coordination with Providers through Outreach

By working closely with our providers, we ensure Enrollees receive timely access to the services they need and that our providers are focused on closing Enrollee care needs.

Hands-on provider support: Provider 360 (P360) is a continuous quality improvement program aimed at service delivery, quality care, and satisfaction. Led by Provider Relations Representatives (PR Reps) and supported by QPAs, PCAs and Care Managers, P360 is based on PDSA methodology and includes in-person PR Rep and QPA meetings to review prior and forecasted quality performance against goals and other provider comparisons. The P360 team works to establish detailed work plans to improve quality including new programs, enrollee outreach, health fairs, new equipment/services, encounters/billing remediation, access to information and EMR interchange. Our PR Reps review care needs in collaboration with QPAs. Our PCAs are co-located in select high-volume provider offices and assist in scheduling appointments for targeted Enrollees with identified care needs. Our Care Managers support Enrollees following discharges from the hospital to prevent readmissions, which would adversely impact providers' quality scores.

In-person audits: In 2019, we improved our Onsite Annual Medical Record Review (AMRR) Audits process by taking a field outreach approach, where QPAs complete audits through face-to-face visits in the office, allowing them to provide immediate audit education post-audit, establish relationships/partnerships and expand the education to include care needs and HEDIS recommendations/requirements.

"WellCare has worked with us to close care needs and appointment agendas. This in turn has led to higher quality care for our patients. WellCare has assigned a dedicated Quality Practice Advisor Nurse as well as a Provider Representative to help support us here at Parkway Pediatrics. Monthly meetings keep us informed about upcoming changes and areas for improvement."
– INDIRA MOODUMANE, MD, PRESIDENT, PARKWAY PEDIATRICS

Joint Operating Committees (JOCs): For our large provider groups and hospitals, senior leadership, including our Medical Director, hold regularly occurring JOCs with formal agendas to review comprehensive performance metrics and mutually identify opportunities to improve overall success of the partnership and quality performance.

Provider Summits: WellCare of Kentucky was the first MCO to introduce quarterly provider summits throughout the Commonwealth. Summit agendas include general presentations from leadership that impact all providers (e.g., portal, case management, claims), a Q&A session with WellCare Health Plans, Inc. (WellCare) leadership, and breakout sessions on individual topics such as innovations in quality, regulatory changes, and plan highlights such as our work with Community Connections (SDOH), behavioral health and quality improvement**. In 2019, nearly 500 providers attended our regional summits,** which were held in Louisville, Bowling Green and Lexington.

Integration Meetings: We hold regular medical/BH integration meetings with network providers around the Commonwealth to facilitate progress toward the building of a holistic, person-centered model of care. Meetings include executive management, medical directors, network leadership and BH management. Our care plans and our integrated Care Central platform provide actionable insights related to quality gaps for our providers.

Coordination with Providers through Incentives

We believe that incenting providers to participate in our quality programs is an effective way to coordinate with them in improving Enrollee health outcomes. We offer the following incentives for providers:

Partnership for Quality (P4Q) program: Providers receive bonus payments for closing care needs on key HEDIS performance measures and timely completion of appointment agendas, which allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment. Our P4Q program resulted in a 249% increase in provider participation from 2018-2019. WellCare of Kentucky introduced the **Behavioral Health (BH) P4Q program** in 2019 in order to better align with DMS' goal of improving BH-related health outcomes among the people of Kentucky. In 2019, **7,039 care needs were closed at the participating CMHCs and more than $281,000 in bonus payments were paid out as a result of the new BH P4Q program**.

Value-Based Payment (VBP) program: We offer value-based payment arrangements across the spectrum of Health Care Payment (HCP) Learning & Action Network (LAN) categories, including shared savings/shared risk and full risk for providers who have the infrastructure and

capabilities to become effective at improving overall health outcomes and managing cost. Our P4Q program supports providers in preparing for advanced VBP programs by serving as a LAN Level 2 structure.

Peak Performance program: Developed in 2017, this program rewards high-volume paneled Kentucky Medicare providers for high-performance in HEDIS measures with a focus on certain measures in need of more dramatic year-end improvement. As a result of the program, **10% of participating providers representing more than 8,400 Enrollees improved their HEDIS scores from 2018 to 2019.** Due to its success, we are re-designing this program for Medicaid to enhance our provider supports for high-quality health outcomes.

Coordination with Providers through Tools and Data sharing

We connect our providers to the innovative tools they need to coordinate Enrollee care. We offer a variety of data sharing modalities, and have recently improved our data analytics capabilities to include more customized provider reports and tools with the ability to accomplish the following:

- Provide actionable data, including reason for non-compliance with A1c Control (e.g., measure is above nine or the test was not even completed or Enrollee hasn't been seen)
- Customize reporting based on specific measure sets or specific data elements by Enrollee, by provider or by zip code
- Prioritize Enrollees or families based on Quality Stratification Index which identifies Enrollees/families with multiple care gaps or individuals with difficult to address care needs that will guide CSR, CM and PCA inbound interactions
- Create a task at household, provider or Enrollee level to coordinate across the interdisciplinary care teams, quality and provider relations

P4Q Portal Reports: Our QPAs and Provider Relations Representatives (PR Reps) present to providers our P4Q portal reports (**Figure C.9-2**), which show a snapshot of their Enrollees' care needs, the status of their P4Q goals, and allow providers to prioritize Enrollee outreach based on those measures that will result in the most improved Enrollee health outcomes.

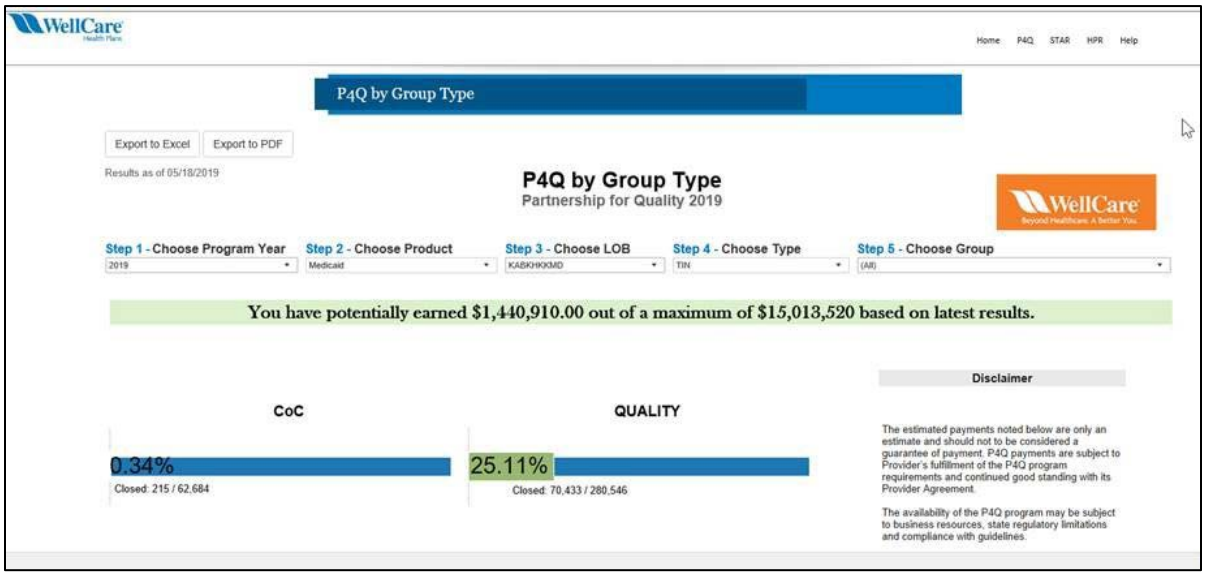


Figure C.9-2 P4Q Portal Report

Provider Portal: Our provider portal is connected to our integrated Care Management system, CareCentral, which enables us to share the outcomes of health screens, EPSDT information, social determinants of health obstacles, Enrollee assessments, care plans, and multi-disciplinary team contacts with providers. Providers can also view open and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, eMR interchange or submission of supplement medical record information. They can also view appointment agendas, which allow our physician partners to understand, in a single report, everything they need to address for each Enrollee during an appointment including all known chronic diagnoses and associated care needs derived from evidence-based guidelines. We offer a wide variety of webinars through our provider portal and access to our provider newsletter, provider manual, claims, prior authorizations and clinical practice guidelines. As part of our collaborative effort to support providers, we hosted Quality-led focus groups with providers to discuss their needs for data analytics and the provider portal. As a result of these focus groups, we received feedback on a few common themes: faster data generation, expanded data capture tools, and more flexible reporting features. We incorporated this feedback to meet the needs of the provider community in our quality programs and provider portal.

Electronic Medical Records (eMR): Our eMR flat file transfer process enables medical and behavioral health providers to submit flat file information from their eMR to provide WellCare of Kentucky with up-to-date and complete Enrollee information that is not captured on claims and encounters. Our recently updated process includes providing an accessible setup guide; providing a dedicated Quality and eMR team to help set up connections; leveraging consultants to help configure systems for export; providing error reports that show appropriate use and configuration of the system interchange; and accepting appointment agendas in various formats for ease of transition.

ii. Strategic solutions the Vendor will use in quality management, measurement, and improvement.

WellCare of Kentucky has made significant investments in strategic solutions aimed at improving health outcomes through quality management, measurement and improvement. These investments are yielding positive improvements, as evidenced by our year-over-year HEDIS performance or based on the results of individual program performance. For example, **91% of our HEDIS scores have improved year-over-year from HEDIS 2013 to 2019**, and we currently **lead the Commonwealth in 24 HEDIS measures for 2019**, including all three Well-Child Visit measures, Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits (through November 30, 2019). While our strategic solutions in quality management, measurement and improvement include standard quality framework such as Plan Do Study Act (PDSA) and rapid cycle Continuous Quality Improvement (CQI), what makes our strategies unique is how we apply this framework to our solutions with our comprehensive data analytics capabilities and integrated multi-disciplinary approach to improving the lives of our diverse, economically disadvantaged Enrollees. These strategic solutions, which leverage every Enrollee touchpoint to close care needs, are designed to empower Enrollees to improve their health and engage in their healthcare, improve health outcomes and reduce or eliminate health disparities through the following methods:

STRATEGIC SOLUTIONS IN QUALITY MANAGEMENT

Our approach to overall quality management centers around three strategies: 1) Discipline and Execution, 2) A Hands on, Data Driven Approach, and 3) Closed-loop Feedback from all Stakeholders to Continuously Improve.

Quality Management Discipline and Execution: Our Kentucky Leadership Team comprising the CEO, CMO, COO and Senior Director of Quality hosts weekly team meetings to evaluate our Quality Strategy and Plan, the effectiveness of our execution and the progress towards achieving our goals. In addition, this team meets with our largest provider groups on a quarterly basis to review their performance, discuss barriers to achieving goals, and to share our strategy to ensure continual alignment. The leadership team also engages in Quality discussions with DMS to ensure overall alignment with their objectives and goals. Our approach calls for measures at the atomistic, summary and objective levels that align with the HCP LAN "Big Dot" work. This aids in alignment and ensures that we are meeting outcomes and health objectives.

Hands on, Data Driven Approach: Our teams of Kentucky-based quality experts, described in detail in Question C.9.a.i. above, are responsible for day-to-day quality management oversight, and implementing programs that result in improved quality outcomes. These teams experience low turnover and have worked cohesively over the past eight years, enabling them to successfully manage the quality program through the following processes:

- Weekly and monthly executive quality meetings focused on overall quality strategy that enable quality leadership to determine where we are with quality, where we are going, and how we are going to get there
- Weekly QPA meetings to address providers barriers and concerns and to identify best practices that can be shared across all providers

- Weekly care needs coordinator and health coach meetings that help our teams identify trends and barriers to care.

Closed Loop Feedback from All Stakeholders: We believe in continually seeking feedback on the effectiveness of our strategy and programs from all Stakeholders including providers, community advocates, and customer-facing teams in order to improve our quality of care.

We connect with our local providers through the following methods to assist us with improving our overall quality strategy:

- Ongoing in-person provider visits through our P360 program (described in Question C.9.a.i.)
- Monthly JOC meetings as described in Question C.9.a.i.
- Quarterly provider summits as described in Question C.9.a.i.
- Quarterly provider advisory panel meetings that have recently been implemented in Kentucky. Our Provider Advisory Panel is comprised of providers from all eight regions, organized and facilitated by Providers Relations. We will use our Provider Advisory Panel to obtain input on a wide number of topics affecting our providers including quality initiatives.

We engage our Community partners to identify local nuances that may act as barriers to quality improvement, discuss additional programs that need development, provide supplemental resources and learn how to improve Enrollee and provider engagement. This critical feedback loop helps us address the reduction and elimination of health disparities in the Commonwealth.

We also engage our internal, Enrollee-facing teams to gather their feedback based on their experience with our Enrollees and providers in order to make meaningful improvements both operationally and programmatically.

STRATEGIC SOLUTIONS IN QUALITY MEASUREMENT

WellCare of Kentucky recognizes the importance of quality measurements grounded in transparency, measures that improve outcomes and a powerful analytics platform that provides meaningful, actionable information to our partners so that improvements can be made quickly. Our strategy for performance measurement is centered on three components: 1) Data provision and consumption, 2) Measure alignment with outcomes, 3) Comprehensive Data and Analytic platforms.

Data Provision and Consumption: We recognize the need for frequent and transparent data that provides the information required to drive and improve quality and the services provided by our network providers. We understand the need to design reports and provide information that is meaningful and actionable so that providers and other key stakeholders can quickly digest the information and take action. We have designed a set of reports for our providers (covered in detail in **Table C.9-1**) that drill down to the measure, provider and member level to quickly determine current quality performance, the gap to goal and the action steps necessary to meet the goal. At WellCare, we don't just send the reports to our providers and stakeholders, we meet with them face to face, review the reports, and allow the providers and stakeholders to ask questions. Our hands-on approach ensures that the data and information is consumed and acted upon.

Table C.9-1 Quality Reports for Providers

Report	Description and Use
Heat Maps	Identify regional, county, and zip code level variations in quality performance based on QI goals and measures. QPAs present these to providers during in-person visits to educate and help improve quality performance.
HEDIS Provider Performance Profiles	Generated at least monthly to show up-to-date individual practice level performance. Using profile reports, we can identify under-utilization of services for each Enrollee who has an outstanding care need. QPAs present these to providers during in-person visits to educate and help improve quality performance.
Care Needs Reports	These show all open care needs for Enrollees and are provided to all Enrollee and provider-facing staff in order to help close care needs. QPAs present these to providers during in-person visits to educate and help improve quality performance.
Behavioral Health Care Needs Reports	Unique to WellCare of Kentucky, these show all open BH-related care needs and are provided to CMHC's and five inpatient hospitals that are under the BH P4Q incentive program in order to help close BH-related care needs. BH QPAs present these to providers during in-person visits to educate and help improve quality performance.
P4Q Scorecard Reports	These interactive reports include web portal and drill down capabilities, affording providers' insight into actual and potential incentive earnings based on individual Enrollees and services. QPAs present these to providers during in-person visits to educate and help improve quality performance.
Appointment Agendas	These allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment. Our tools also suggest other diagnoses inferred from other data sources that have not yet been confirmed. For example, for an Enrollee with Diabetes, a physician will receive an appointment agenda indicating Diabetes and a list of open care needs that need to be addressed such as for a quarterly HbA1C, blood pressure control, eye exams and nephropathy screening. We provide these forms annually at the beginning of the year to guide annual physicals and EPSDT exams. In addition, when a provider performs an eligibility check on an Enrollee, we auto-generate an appointment agenda and deliver it directly to the provider via the provider portal, secure FTP, custom feed, or fax. With certain

Report	Description and Use
	connected providers, we have the capability to automatically generate and send an appointment agenda upon notification that an Enrollee is present in the office.
Emergency Room (ER) High Utilizer Reports	This monthly report details Enrollees who had any visit to the ER, including date of service, diagnosis and service codes related to the visit, method of arrival, and also indicates if there is an existing relationship with the Enrollee's PCP. The report also details the running 12 months of all visits to identify underlying trends and high utilization of multiple ER facilities. We also detail the relationship of each PCP to the rate of ER visits for PCPs assigned to them. These reports are delivered to providers by QPAs and PR Reps.
Enrollees Without Visits Reports	These weekly reports display adult Enrollees who have not been seen by a PCP within 12 months and are delivered to providers by QPAs and PR Reps.

Measure Alignment with Outcomes: We consistently examine our quality programs to ensure we align with quality measurements, address high-impact areas that safeguard public health, confirm outcomes-based programs remain patient-centered and meaningful to Enrollees and providers, demonstrate significant areas of improvement and align with programs defined by DMS or other MCOs in the Commonwealth. This approach focuses on measures where the highest opportunities exist while monitoring others at acceptable levels of performance.

Comprehensive Data and Analytic Platforms: Comprehensive data and information can only be produced if a platform and intelligence capability is built to provide it. WellCare of Kentucky has a team of local data analytics experts, some of whom hold advanced degrees in epidemiology, who collaborate with our corporate quality data analytics teams to perform quality measurement. This team builds data marts, reports and other tools that provide information to our quality teams and external partners (providers and other stakeholders) to analyze, trend and take actions to improve quality.

WellCare of Kentucky has built a Quality Performance Metrics Engine that incorporates clinical and administrative data including medical records, CAHPS, claims, complaints, appeals, grievances, encounters, authorizations, quality of care incidents, disease/care management documentation, pharmacy data, quality stratification values, unmet social needs data and other data from disparate sources that consolidate Enrollee-centric data into one platform. Our QPME displays this information through CareCentral in an Enrollee-centric, 360-degree view, known as Care Compass.

To supplement our quality data analytics efforts, our Information Systems team is building two Artificial Intelligence (AI) systems – one for clinicians and one for Enrollees – designed to analyze symptoms, demographics, medical histories and other data sources to suggest treatment plans and interventions. By feeding our data, which represents what happened with

the end-to-end (over time) treatment of our Enrollees' conditions, we can better assess patterns that rendered the highest healthcare outcome result and patterns that rendered the least amount of visits or lowest costs. Through smart learning, we can enhance predictive analytic capabilities and our targeted population health interventions to encourage more effective Enrollee and provider behavior — all aimed at improving health outcomes.

STRATEGIC SOLUTIONS IN QUALITY IMPROVEMENT

WellCare of Kentucky has been focused on quality improvement for the past eight years throughout the regions of the Commonwealth. We have achieved increases every year for the past four years in our overall HEDIS measures as a result. We continue to expand on that success through three primary strategies: 1. Member and Provider Engagement. 2. Focused Program/Resource Development 3. High Touch, Visible Partnerships.

Enrollee and Provider Engagement

In order to improve quality, Enrollees and providers must be engaged equally. Our Enrollee engagement strategies include aligned incentives, Enrollee and provider education and support and engaging family members and peer supports.

Enrollee Incentives: Our **Healthy Rewards Program** assists Enrollees in closing care needs. Through this program, Enrollees receive reloadable debit cards or gift cards for stores to purchase personal, home, baby, and family-related items that promote practicing healthy behaviors such as visiting their PCP. **In 2019, WellCare of Kentucky closed 43,738 care needs using our Healthy Rewards Program.** Through this program and others, WellCare of Kentucky has **increased the percentage of our Enrollees who have seen their PCP within 12 months by eight percent since 2015, with more than 70% of our Enrollees seeing their PCP at least once in 2018**.

Provider Incentives: Our overall approach to Value-Based Purchasing is based on a "win-win-win" philosophy that acknowledges the unique roles of the Enrollee, provider and health plan who must all come together for a quality outcome to be achieved. Our VBP arrangements – in conjunction with our broader investments related to Care Management, Quality Improvement, and other Network Performance Initiatives – are a key component of our strategy to improve quality outcomes and drive cost-efficient care. Our **Partnership for Quality (P4Q) program** enables providers to receive bonus payments for closing care needs on key HEDIS performance measures and timely completion of appointment agendas, which allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment. WellCare of Kentucky introduced the **Behavioral Health (BH) P4Q program** in 2019 to better align with DMS' goal of improving BH-related health outcomes among People of Kentucky. **In 2019, 7,039 care needs were closed at the participating CMHCs and more than $281,000 in bonus payments were paid as a result of the new BH P4Q program**. Our **Value-Based Payment (VBP) program** offers payment arrangements across the spectrum of Health Care Payment (HCP) Learning & Action Network (LAN) categories including shared savings/shared risk and full risk for providers who have the infrastructure and capabilities to become effective at improving overall health outcomes and managing cost. Our **Peak Performance program** was developed in 2017 to reward high-volume paneled Kentucky

Medicare providers for high performance in HEDIS measures with a focus on certain measures in need of more dramatic year-end improvement. As a result of the program, **10% of participating providers representing more than 8,400 Enrollees improved their HEDIS scores from 2018 to 2019.** Due to its success, we are re-designing this program for Medicaid to enhance our provider supports for high-quality health outcomes.

ENROLLEE EDUCATION AND SUPPORT

WellCare of Kentucky has developed the following suite of solutions that support and educate our Enrollees in the achievement of better health outcomes.

- *Enrollee Portal:* Our Enrollee Portal, accessible online or with a mobile device, contains a variety of resources and tools, including the Enrollee handbook and the find-a-provider tool. The portal also promotes health, wellness and services to our Enrollees. They can access information and check eligibility, authorization status, claim status, order status, update personal information, change providers and locate pharmacy information all on the portal. **In 2019, WellCare of Kentucky's public website homepage (Wellcare.com/kentucky) received 178,541 unique views.** Our **Mobile App** delivers focused, prioritized services to address open care needs in a way that Enrollees can understand. The Enrollee's PCP phone number is delivered with the care need so the Enrollee can call their PCP directly to schedule an appointment. If an Enrollee has already scheduled an appointment through our Enrollee Services team, we send a reminder through the mobile app. Due to our proactive approach and updated functionality, **in 2019 for Kentucky Medicaid Enrollees, WellCare experienced a year-over-year increase of 135.3% in downloads of the mobile app**. The top features used in 2019 were Find A Provider, Messages, and Enrollee ID card. We expect continued adoption by Enrollees in 2020.
  Preventive Service Outreach (PSO): This outbound Enrollee activation and calling program is informed by advanced analytics, based on open care needs and guided by behavioral analytics of how to best engage Enrollees. By engaging Enrollees across channels, we remove barriers to care by providing appropriate education and assistance with scheduling provider appointments, all while positively impacting the Enrollee experience and HEDIS outcomes. **In 2019, the PSO program contacted and educated nearly 67,000 People of Kentucky on important services including breast cancer screening, lead screenings, and well visits, scheduling more than 4,600 unique appointments.**
- *Enrollee Texting Program:* The program increases Enrollee engagement by conducting outreach through short message service (SMS) or text messaging. Enrollees and parents of Enrollees ages 3-20 receive messages reminding them to schedule services including well visits and medication reminders. Follow-up reminders are sent for Enrollees who need ongoing care needs addressed. Enrollees can contact us for assistance with scheduling appointments based on the texting outreach. To date, WellCare has launched nearly 1,000,000 text messages enterprise-wide since our texting campaign inception in February 2019.
- *Inbound Care Needs Program:* We are leveraging the Quality Stratification Value to prioritize care needs based on the clinical complexity and DMS' priorities in achieving better health outcomes.

- *Interactive IVR:* Our interactive IVR requires an Enrollee to verify HIPAA requirements in order to hear a targeted message regarding the care need that our analytics has identified as the most important for the Enrollee. After the Enrollee listens to the recording, they have an option to connect with a live agent to assist them with scheduling a provider appointment.
- *IVR Blast:* Our IVR blast is a one-way message recorded by WellCare's Chief Medical Officer, Dr. Leenay. The intent of the message is to be a "soft" touch for the Enrollee that we believe needs a gentle reminder to visit their provider.

Medication Adherence Program: We ensure medication adherence for conditions including diabetes, asthma and COPD through in-person Enrollee and provider education from WellCare of Kentucky staff and local community pharmacists, door-to-door medication delivery, packaging that helps with dosing, scheduling medications, and reminder mailings to providers and Enrollees.

Disease Management and Population Health Program: We offer comprehensive disease management and population health programs that help Enrollees control their chronic diseases including Asthma, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Diabetes, Hypertension and Chronic Obstructive Pulmonary Disease (COPD) through Enrollee mailings, text messaging and telephonic outreach to Enrollees to remind them on how to manage their chronic illness.

Unable to Contact (UTC) Reach Program: Our newly redesigned UTC program, Reach, helps us locate Enrollees who have been hard to find due to missing contact information. Using a data warehouse that combines information from multiple sources including WellCare systems, State files, Community Connections Help Team data sources, and information from public records and external vendors, our dedicated associates outreach to Enrollees on the UTC list. Once engaged, Enrollees are connected with network providers and services in order to improve health outcomes and close care needs. In a three-month timespan, our Reach team successfully connected with nearly 6,000 UTC Enrollees, providing important services such as education, coordinating Enrollees with primary care providers, bridging Enrollees to our community connections resources, and helping complete the health risk assessment to better identify Enrollee needs.

ENGAGING FAMILY MEMBERS AND PEER SUPPORT

WellCare is currently developing Family and Peer Support programs for 2020. We recognize that an effective method for Enrollee engagement is to involve the family (as appropriate) and a peer support network that offers encouragement and fosters accountability. Currently, Quality and Clinical systems show care gaps for the entire family of an Enrollee so that our team can identify opportunities to engage the entire family in closing care gaps. Our strategy for the future focuses on engaging families in goal setting and creating a Family-Centered Care environment that encourages behavior change for the entire Family, not just one Enrollee at a time. In addition, we intend to build out a peer support program that enables our outbound staff, many of whom are former Medicaid Enrollees, to provide peer support for Enrollees who are anxious, confused or unmotivated to get the care they need. This program will be jointly designed by our providers and our community stakeholders to ensure its effectiveness.

Our model will center on the Person and Family Engagement Cycle of Sharing Preferences and Values, Co-Creating goals, Promoting Person and Family Engagement Best Practices, Encouragement and Self-Management and Promoting Informed Decision Making.

FOCUSED PROGRAM/RESOURCE DEVELOPMENT

LifeCare Virtual Hospitalization: In order to address a care need for adolescents who were not necessarily needing hospitalization but are challenging to manage at home, WellCare of Kentucky collaborated with LifeCare in March 2019 to bring virtual hospitalization to the state. Initial clinical outcomes indicate an increase in home stability and a decrease in inpatient admissions and polypharmacy.

Community Paramedicine: One innovative approach to enhancing the health and well-being of Enrollees and improving health outcomes is Community Paramedicine. Community Paramedicine extends access to care by expanding the role of Emergency Medical Service (EMS) personnel to fill gaps in primary care availability and mitigate transportation barriers by providing home-based care. Paramedicine providers can facilitate a number of services including assessments for vital signs, medication compliance and blood pressure readings; prevention services such as immunizations and in-home fall prevention; and primary treatment such as wound care and medication administration, as well as referral to medical and social services. With the recent passing of House Bill 106, WellCare is excited to support the expansion of Paramedicine programs that further extend access to care in underserved areas of Kentucky.

Healthy Food Assistance through FARMACY: From 2015 to 2017, WellCare of Kentucky partnered with the Community Farm Alliance (CFA) in Kentucky to sponsor farmer's markets across the state with the objective of providing low-income families access to healthy local produce. We support communities with a Double Dollars program that doubles the buying power of program participants. In Eastern Kentucky, 462 households received FARMACY incentives which included 543 qualified recipients with a recorded weight loss of a cumulative 280.54 pounds and an 84.45 point decrease in BMI. In 2017, 228 WellCare Enrollees used the FARMACY program and received 895 vouchers. Community Farm Alliance has written, "To say the least, WellCare has been a creative, out-of-the-box partner with Community Farm Alliance in addressing nutrition-related health issues."

Women's Health Project: In 2019, WellCare of Kentucky developed this outreach program designed to improve women's health outcomes related to breast cancer, cervical cancer, chlamydia and postpartum complications through regular screenings. Interventions include: dedicated QI nurse for women's health, dedicated care needs coordinators to make outreach calls to Enrollees post-delivery for postpartum visit education/reminders; outreach calls for breast cancer screening reminders/education; coordination with mobile mammography units where available; care needs reports to providers indicating those Enrollees with gaps in recommended preventive care such as cervical cancer screenings, mammography and chlamydia; QPA face-to-face visits with OB/GYN providers for information sharing and education; distribution of developed chlamydia educational flyer to providers.

Maternity Care Program: The WellCare Baby Steps program improves maternal health and birth outcomes through the delivery of services by multidisciplinary, integrated care coordination

and care management services team for all pregnant Enrollees, regardless of risk level, from conception and up to a minimum of 60-days postpartum. The program covers a variety of services to manage Enrollees who are pregnant and deliver positive birth outcomes for both the mother and the infant, including a reduction in preterm births, NICU admissions, NAS newborns, and Caesarian section (C-section) rates. Program interventions include Enrollee education and incentives, OB provider education and incentives through our value-based payment arrangements, BH integration, and partnerships with community organizations including WIC and Hands.

Progeny NICU Program: We have partnered with Progeny Health to improve the health outcomes of our NICU population in Kentucky to assist in maintaining exceptional quality for our tiniest Enrollees. Progeny assists in streamlining the care plan and service provision for NICU populations while also providing support through the first year of life. Our experience with our Progeny partnership has seen a positive trend in readmissions and reduction in average length of stay.

First Year of Life Program: Designed for all infants including those discharged from a Neonatal Intensive Care Unit or other Specialty Care Unit (collectively, "NICU") or a well-baby nursery, the First Year of Life program includes care giver education and support for the welfare of the child, promotion of the recommended schedule of provider visits, immunizations and screenings through 15-months of age (EPSDT, CHCUP, HEDIS), and care management of the infant with on-going medical and care management needs.

EPSDT Program and Resources: Our EPSDT program includes local, dedicated staff focused on ensuring children receive early and periodic screenings, diagnosis, and treatment. Interventions target children and their caregivers, providers, and community partners and include mailings and phone calls reminding Enrollees of upcoming screenings. Our EPSDT Screening Ratio has increased five percentage points from 2017-2019 and our Participant Ratio has increased four percentage points in the same timeframe. We have also developed a comprehensive provider resource as a result of a post-audit provider report card indicating a lack of knowledge with respect to EPSDT-related care. The EPSDT Provider Educational and Resource Packet is available on our website and includes a variety of EPSDT-related information including screening schedule, role of the provider, expanded services, visit reporting and recommendations for preventive pediatric healthcare periodicity schedule, Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, exam forms, immunization recommendations, depression screening tools, additional risk assessment tools, medical record review tools, quick tips and coding, billing and screening flyers. This resource packet is also available to QPAs to print for targeted provider education.

Social Supports and Nutrition Counseling: WellCare of Kentucky partners with the Marshall County Health Department to provide Team Ultra programming for school-aged children in the western part of the state. Through Team Ultra, children have access to this social support along with nutrition counseling and physical activity.

Reducing Potentially Preventable Hospitalizations and ED Visits for Diabetes Project: This program was designed in 2019 to improve the rates for recommended screenings for diabetes to prevent potentially preventable hospitalizations and ED visits for short-term complications

related to diabetes. Interventions include a dedicated QI nurse for diabetes; dedicated care needs coordinator to make outreach calls for recommended screenings; outreach calls for education/reminders; care needs reports to providers for Enrollees with gaps in recommended preventive care such as HbA1c, nephropathy, eye exams and blood pressure; QPA face-to-face visits with providers for information sharing and education; distribution of developed diabetes and blood pressure education flyers to providers.

Good Measures Diabetes Program: Good Measures programs are designed to empower WellCare of Kentucky Enrollees to better manage their health through nutrition. We focus on bite-sized, highly personalized goals based on an Enrollee's preference, location, health status, lifestyle, budget, and access to food. We work closely with Enrollees to set realistic bite-sized goals that build confidence and self-reliance so that Enrollees can make lasting behavior changes that deliver results. As Enrollees begin to understand how food impacts their health and as they begin to feel better, sustainable behavior change occurs. This process results in improved health outcomes, Enrollee satisfaction and Enrollee empowerment. With a deep recognition of social determinants of health, our health coaches have fingertip access to local, client-based resources to enhance their support of each individual. From knowing the local grocery stores and popular fast food chains, to understanding health plan case management resources, our coaches become a centralized hub for Enrollee support. They often help participants find local food pantries, using resources such as WellCare's Community Care Help Line. Since Good Measures starts with food, our coaches are often able to engage with participants more deeply and more frequently than other clinicians. In many cases, they are the first people to learn about the struggles someone is having with transportation, prescription refills, or childcare. Coaches also help participants strategize on how to extend a grocery budget and avoid food waste.

ACT for Opioids Program: In order to address the opioid epidemic in Kentucky, we have partnered with the Cabinet for Health and Family Services to develop the ACT for Opioids Program. Our programs, including specialized care coordination initiatives, tailor to the needs of special populations, such as high-risk pregnant Enrollees at risk of Neonatal Abstinence Syndrome (NAS). New initiatives for 2019 include predictive analytics for the early identification of Enrollees at-risk of opioid use disorder (OUD) based on the industry standard 3-3-3+ED protocol; a Low Back Pain Management Program to support prevention and treatment protocols for the leading cause of opioid use; expanded One Provider-One Pharmacy Program referral to integrated care coordination; improved access to MAT providers; partnership with the Kentucky Court Appointed Special Advocates (CASA) Network to help children in foster care and their families; expanded use of the Screening, Brief, Intervention, and Referral to Treatment (SBIRT) model, which guides providers to rapidly assess the severity of OUD, engage in immediate feedback, and refer the Enrollee to a local treatment program; and the cCBT platform known as MyStrength, which provides Enrollees with interactive clinical programs and self-management tools empowering them to reduce the self-destructive cognitive and behavioral patterns caused by OUD.

Behavioral Health Resource Packet: Developed by WellCare of Kentucky to educate BH providers on HEDIS measures, this comprehensive resource is available on our website and includes a variety of Severe Mental Illness (SMI)-related information that providers can access

or QPAs can print for targeted provider education, including SMI principles of practice, physical disease and SMI, barriers to the recognition and management of physical diseases in adult Enrollees with SMI, risk factors and screening recommendations for SMI, monitoring adult Enrollees with SMI, metabolic and cardiovascular health issues, management issues in pregnancy and lactation, SMI and women of child-bearing age and infants.

High Touch, Visible Partnerships: The key to pulling all the pieces together is being visible with the providers, Enrollees and stakeholders, listening to their feedback, and developing a high-touch program that incorporates these improvements. Through our experience in Kentucky, we have grown to know the importance of relationships with our Enrollees, providers and stakeholders and we choose to administer our quality program in a relationship model, rather than simply pushing data and information out and expecting a material change. We start with our integrated field care management and supplement our approach with a provider relations team and a quality team that invest significant hours with Enrollees and providers educating, listening, and providing solutions that work.

Provider Relations Visits: Our local PR Reps make routine visits to our providers' offices to help them improve performance through VBP arrangements, which in turn improves Enrollees health outcomes.

Medical Director Visits: WellCare of Kentucky Medical Directors visit larger provider groups to discuss provider performance in shared savings/shared risk arrangements and improvement in topics including ED utilization and total cost of care that affect Enrollee health outcomes.

Quality Practice Advisor Visits: Our local QPAs accompany PR reps on their visits to discuss performance in P4Q arrangements, providing care needs reports and educating providers on HEDIS measures, the importance of closing care needs and completing appointment agendas, and proper coding and referral procedures. QPAs also track and trend quality improvement through multiple year comparisons as well as year-over-year comparisons, allowing providers to see how their efforts are improving Enrollee health outcomes.

Joint Operating Committees (JOCs): For our large provider groups and hospital, WellCare of Kentucky holds monthly JOCs with formal agendas to review comprehensive performance metrics and mutually identify opportunities to improve the overall success of the partnership, including performance under VBP arrangements.

Provider Summits: Each year WellCare of Kentucky hosts quarterly regional provider summits across the Commonwealth. Summit agendas include general presentations from leadership that impact all providers and breakout sessions on individual topics such as performance in VBP arrangements and how that affects Enrollee health outcomes**.**

Provider Advisory Panel: WellCare of Kentucky has created a Provider Advisory Panel comprising providers from all eight regions, organized and facilitated by Providers Relations and held quarterly. The Provider Advisory Panel serves as a consulting resource to WellCare of Kentucky in policy and operational matters, and further strengthens the bridge between WellCare of Kentucky and the provider community. We identify potential provider panel members from recommendations by the respective region's Provider Relations team. The panel members consist of PCPs and specialists who are independent providers not connected to hospitals. We

will use our Provider Advisory Panel to obtain input on a wide number of topics affecting our providers including administrative efficiencies, clinical policies, and operational issues. Examples of committee discussion items include health plan and provider experiences, coordination of care, quality initiatives, provider communication needs and educational opportunities, the integrated care model, operations, and access to care.

We perform panel audits using 24-month retrospective claims to ensure Enrollees are aligned to the providers from whom they are receiving healthcare services. This ensures accurate care needs reporting, appropriate P4Q payment and proper coordination of care. If a panel audit identifies issues with assignments, the panel can be adjusted through quarterly PCP reassignment based on the findings. We also perform pediatric panel audits to ensure Enrollees who have aged out have been reassigned to an appropriate PCP.

Provider Advisory Committee at Work

As a result of provider engagement on the Provider Advisory Committee, our affiliate health plan in Georgia implemented a partnership with the largest community mental health center on a new program to provide Omega 3 to patients with new onset psychosis due to the strong evidence this will improve outcomes and prolong the time to the next psychotic episode.

iii. Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.

INNOVATIVE STRATEGIES AND ENHANCED SERVICES

WellCare of Kentucky has developed the following innovative strategies and enhanced services aimed at improving health outcomes for People of Kentucky:

Value-Added Enhanced Services: We offer value-added enhanced services to Enrollees including a GED program, sports physicals, Boy Scout and Girl Scout annual memberships, home delivered meals and free cell phones. Our **Healthy Rewards Program** is another value-added service that assists Enrollees in closing care needs. Through this program, Enrollees receive reloadable debit cards or gift cards for stores to purchase needed personal, home, baby, and family-related items that promote practicing healthy behaviors such as visiting their PCP. **In 2019, WellCare of Kentucky closed 43,738 care needs using our Healthy Rewards Program with $1,018,155 distributed to Enrollees in the form of gift cards**.

Social Determinants of Health Support: Our Community Connections model matches Enrollees to social safety net services, family caregiver support and other formal and informal supports, to help Enrollees address their unmet resource needs. We identify needs based on resources accessed through the model, proactively designing programs to close care needs. **In 2019, WellCare of Kentucky completed 1,409 community activities that reached more than 37,500 community stakeholders**. As part of our Community Connections program, we offer employment assistance through WellCare Works. **WellCare Works Employment Tools** are designed to help Enrollees jump-start their job search, secure their GED or fill a digital gap for

Enrollees who might not be able to use physical job sites. **WellCare Works Volunteer Opportunities** have been identified by our Local Community Engagement team. **This includes more than 500 unique activities and 81,000 volunteer opportunities available between June 2019 and June 2020**. **Local Community Engagement Partners** work directly with WellCare of Kentucky Enrollees every day and are our "feet on the street" for WellCare Works. **Since January 2019, 725 community partners have been trained and 13 partnerships across the Commonwealth have been built to help connect Enrollees to WellCare Works. In 2019, WellCare Works has been accessed by over 850 WellCare of Kentucky Enrollees across 109 Kentucky counties** To address everyday issues faced by homeless people in Kentucky and meet them where they are located**,** WellCare of Kentucky has been in partnership with **HOTEL Inc.** since 2016. HOTEL Inc.'s successful **Homeless Outreach Program** and the Street Medicine Program provide individuals with pathways to self-sufficiency such as stable housing, quality food, education and employment assistance, financial assistance, regular access to doctors, case management, and transportation for medical and non-medical needs. In 2017, HOTEL INC opened their first respite home program, with funding assistance from WellCare of Kentucky. The home is used for bridging the gap of hospital discharge, preventing readmissions and reducing ED visits. HOTEL INC is now a mentor to other organizations in Kentucky interested in implementing this successful model. **Between August 2016 and August 2019, HOTEL INC provided WellCare of Kentucky Enrollees with more than 16,800 services to address housing instability and other SDOH needs.** The top services received were homeless service, food pantry, free or reduced cost health care, housing, education and employment assistance and transportation assistance. In addition, the program resulted in a **10.5% reduction in avoidable ER visits and an 18.4% reduction in flu-related visits.**

Chronic Disease Prevention through Microclinics: Working with Microclinic International (MCI), WellCare of Kentucky sponsored a program with the objective of enabling local organizations, such as the Red Bird Clinic and the Barren River District Health Department (DHD) in Kentucky, with tools and resources to stop the spread of chronic diseases. With a strong presence in the state, MCI reports that 95% of participants improved at least one indicator of chronic disease when focusing on the methodology of the program, which includes sustainable lifestyle choices, such as cooking healthy meals and physical activity. Recruiting 16 participants for the program, many of whom were WellCare of Kentucky Enrollees, **Red Bird Clinic maintained a 93.75% retention rate**, and although working amidst several obstacles, including a natural disaster, **the Barren River DHD completed four distinct MCI program launches enrolling nearly 50 participants.** Through weekly online surveys, we believe participants were able to make lasting behavioral changes to stop the trend of chronic diseases.

INNOVATIVE STRATEGIES AND ENHANCED SERVICES IN OTHER WELLCARE STATES

In addition to the innovative strategies above, WellCare is developing the following strategies in other states and is considering implementing them in Kentucky:

Clean Out Your Pantry Diabetes Program: This program was developed to address the prevalence of pre-diabetes and diabetes throughout the U.S., and to encourage Enrollees to adopt a healthy diet, active lifestyle and weight management. Health Coaches contact Enrollees identified through claims (lab data), care management programs and provider referral

telephonically or through in-person visits, educating them on the program and explaining why they were selected. For interested Enrollees, an intake assessment is completed, followed by a follow-up in-person visit to the Enrollee's residence to assist the Enrollee in removing unhealthy groceries from the residence.

School-Based Screenings: Sponsorship/support for a part-time school nurse during the start of the school session to provide additional screenings and services to children plus a connection to the school's EHR in accordance with the expansion of nurse licensure and Medicaid billing capabilities.

EXAMPLES OF SUCCESSES WITH SIMILAR MEDICAID POPULATIONS

Pacify Telehealth Lactation and Nutritional Counseling Program: In 2017, our affiliate health plan in Arizona introduced Pacify for new moms, in response to feedback from new moms who expressed challenges following hospital discharge. The program uses a mobile application to connect new moms to a lactation consultant or dietician through video chat for real-time 24/7 assistance. At the end of each interaction, Enrollees are asked to provide feedback about their experience. **Overall satisfaction with the program is extremely high, 4.9 out of 5.** We will enhance the program for Kentucky, including a direct link to our 24/7 nurse line, HRA data capture capabilities, video capabilities with the BabySteps care team, maternity education provided via articles and video.

Mobile Preventive Care: Our affiliate health plan in Florida "brings the care to our Enrollees" with mobile dental, vision and mammography programs. Mobile partners visit PCP offices and Enrollee homes to administer these potentially life-saving examinations for Enrollees who may not otherwise receive them. As a result of these programs, 1,391 Enrollees received retinal eye exams, 625 Enrollees received mammograms and 113 Enrollees received dental screenings since the program's inception in 2016.

iv. Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels.

Our Analytics and Reporting Program is a rigorous organizational structure with sophisticated internal tools and a technology infrastructure that supports our QI program measurement and improvement activities. Our infrastructure and tools enable our leadership and staff to support improvements in health outcomes and to identify, analyze, track and improve quality and performance metrics as well as the quality of services provided by providers. Our data and infrastructure are designed to stratify and report quality measures at a regional level and across provider types and Enrollee populations. We have recently **improved our quality reporting** capabilities to include more customized provider reports (illustrated in **Figure C.9-3 and Figure C.9-4**) and tools with the ability to:

- Provide actionable data, including reason for non-compliance with A1c Control
- Customize reporting based on specific measure sets or specific data elements

- View Enrollees before they are officially counted in the measure population, such as new discharges for Mental health based on authorizations and new babies that need EPSDT, immunization and lead screenings
- View a holistic view of a dual Enrollee, including care needs, campaigns and activities across Medicare and Medicaid
- Create a task at household, provider or Enrollee level
- Act on future measures such as new discharges, immunizations and well-visits
- View a holistic view of an Enrollee based on unique person identification
- Maintain and view prior activities and campaigns when an Enrollee changes ids
- Assign an associate to an Enrollee and create on-going tasks
- Create and assign tasks based on data triggers.

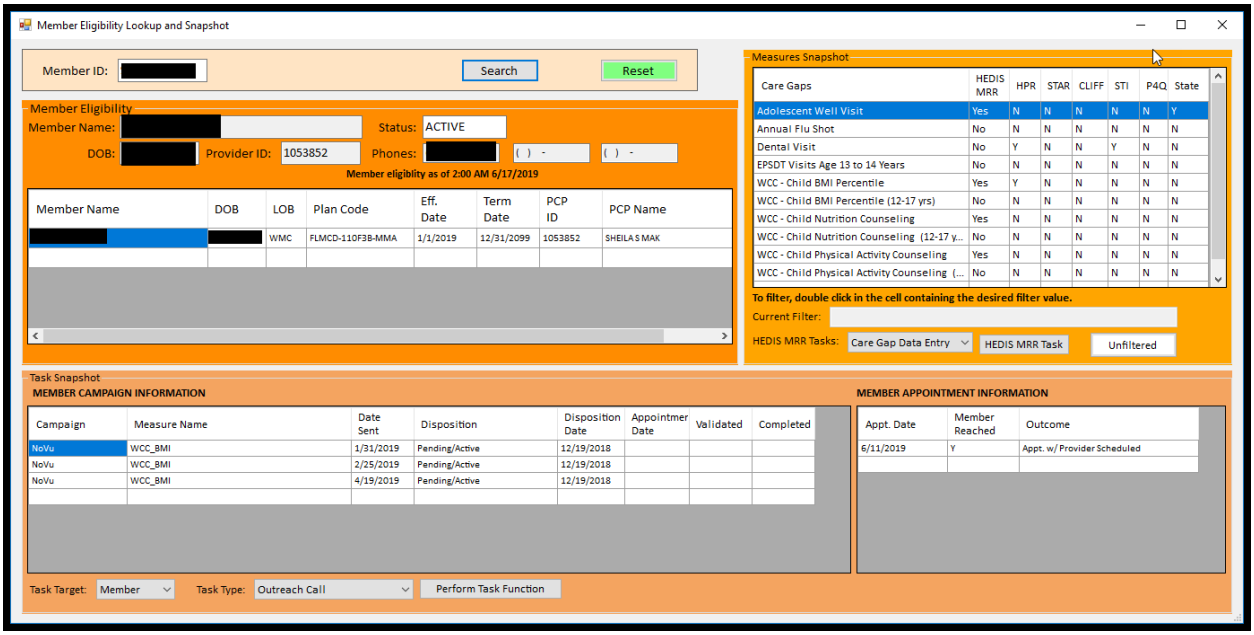


Figure C.9-3 Enrollee Eligibility Lookup and Snapshot

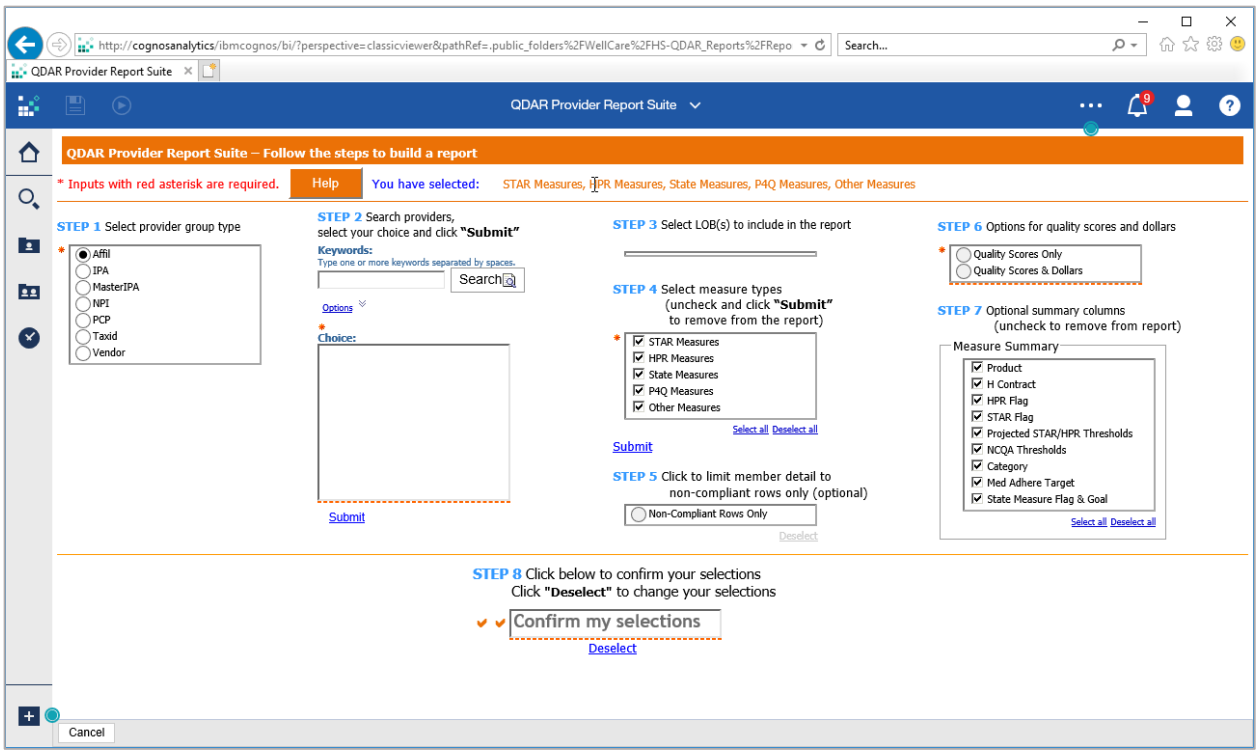


Figure C.9-4 Provider Report Suite Dashboard

In addition to these new capabilities, we use the following internal tools and technology infrastructure to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics:

Quality Performance Metrics Engine (QPME): Our QPME incorporates clinical and administrative data including medical records, CAHPS, claims, complaints, appeals, grievances, encounters, authorizations, quality of care incidents, disease/care management documentation, pharmacy data, quality stratification value, unmet social needs data from administrative, hybrid and supplemental sources. This consolidation of data from otherwise disparate data sources enhances our reporting and allows us to assess the quality and appropriateness of care quickly and easily. Benefits of our QPME include 1) reduced administrative burden on providers, 2) prioritization of Enrollee care needs for providers, 3) precise identification of Enrollees' medical and non-medical needs, and 4) ability to drill down into specific practice, provider or Enrollee results, and 5) the ability to forecast year-end results by provider, by measure or overall. **The QPME displays this Enrollee-specific information for Quality and Care Management staff in our integrated Care Management system CareCentral's single Enrollee-360 view, known as Care Compass. This information is also displayed through CAREpath for all Enrollee-facing staff including Enrollee Services and Community Connections Line representatives, allowing them to see the most critical care needs in order of importance.** For example, issues related to asthma or diabetes are prioritized over BMI.

As part of our QPME, our Business Technical Analyst (BTA) uses our **best in class software including Tableau, Cognos, and SAS**, which allow quick access to care needs, to produce a

variety of reports that our QPAs and PR Reps share with providers to assist them in improving health outcomes. These reports are listed in detail in Section 9.a.v. below.

Electronic Medical Records (eMR): Our eMR flat file transfer process detailed earlier, enables Kentucky providers to submit eMRs as a readily accessible format. Our teams will process the data to extract care needs information to close open care needs and update provider and Enrollee profiles. We have recently improved our eMR process to include a dedicated Quality and eMR team to help set up connections and we are now accepting appointment agendas in formats from other plans for ease of transition.

Clinical Data Capture Process: Our advanced analytic capabilities allow us to expand our eMR flat file process to include incorporating "as-is" files for select providers. This process enables us to expand the data capture and include providers who may lack the technical capabilities but are willing to collaborate in flexible solutions.

Geographic Care Needs Heat Maps: Heat Maps identify regional, county, and zip code level variations in Quality performance based on our goals and measures. Using our Heat Maps, our QI team analyzes the data to determine geographic hot spots of care needs while also tracking and trending geographic disparity data across the state, individual regions and zip codes by

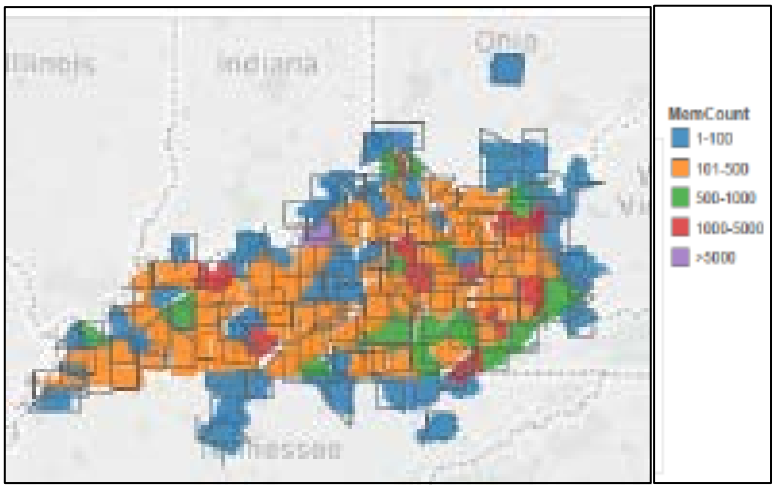


Figure C.9-5 Kentucky Geographic Care Needs Heat Map Report

provider. Additional analysis identifies if the geographic disparities are tied to population trends of race, ethnicity, gender, and language spoken which, in turn refines our PDSA cycles. Our team creates tailored strategies with our provider partners to address the needs of individual communities and populations while continuously monitoring for improvement as well as new areas of need. For example, in Kentucky we identified geographic regions in Jefferson County with a high number of Enrollees requiring mammography screenings. To address this, we partnered with the University of Louisville Kentucky Cancer Programs James Graham Brown Cancer Center to schedule appointments for Enrollees to attend their mobile mammogram screening events in 2017 and 2018. As a result, **nearly 14% of identified eligible Enrollees received mammograms through the program. Figure C.9-5** Kentucky Geographic Care Needs Heat Map displays the following information including providing meaningful insight into health disparities across the state and within regions:

- *Top 10 County Non-Complaint Member Count:* Details counties with the highest rate of open care needs which drives QPA and PCA assignments and focuses initiatives
- *Top PCP Non-Compliant Member County by County:* Details PCPs who have the highest rate of open care needs based on the membership ratio which provides refined focus for QPAs and PCAs in their partnership
- *Top 10 Zip Codes Non-Compliant Member Count:* Details which zip codes have the highest rate of open care needs driving targeted field outreach and quality initiatives
- *Top 10 PCP Non-Compliant Member Count by Zip Code:* Details a deeper dive into zip codes with high rates of open care needs by highlighting individual providers with the highest rate in a particular zip code.

Episode Provider Profiling Tool: This new tool shows adherence to clinical practice guidelines for specialists such as recommending physical therapy and cortisone shots prior to surgery for back pain and not over-testing for cardiology issues.

"Cliff" Measure Reporting: We include reporting for measures that we consider "cliff" measures, which means they have a definitive deadline based on age, diagnosis, or follow-up post-service in order to properly address the care need. An example includes our ability to include measures such as lead screening, immunizations, medication adherence, FUH, FUA, FUM in our provider profiling that are reported far in advance of the deadline for compliance with the care needs. This allows providers to have the most advanced notice and information to address the Enrollee needs.

Disparity Reporting: Using the power of our proprietary QPME and the statistical modeling performed by our team of staff statisticians, we analyze HEDIS measures by geography, race, ethnicity, and gender to precisely determine where to target our efforts and resources. We recently looked at disparities among men and women as well as black, other and white races for a variety of measures for HEDIS Years 2016 and 2017 in Kentucky, which revealed the following positive results based on targeted interventions implemented upon report findings in **Table C.9-2**:

Table C.9-2 Kentucky Disparity Reporting Results 2016-2017

Measure	Interventions	Results
Comprehensive Diabetes Care (HEDIS CDC) (HBA1C Testing)	• Enrollee outreach on healthy living with diabetes, disease management program • PCA outreach to Enrollees to educate and schedule appointments • PSO outreach • Text reminders • Targeted UTC outreach	• Increase of 1.48% for black group • Statistically significant increase from 2.15% for other group • Increase from .82% for white group

Measure	Interventions	Results
Diabetes Monitoring for People with Diabetes and Schizophrenia (HEDIS SMD)	• Promotion of SMI CPG to providers • Distribution of BH toolkits to providers • Distribution of Enrollee education materials geared toward breaking SMI stigma • Closed diabetes-related care needs	• Increase of 11.9% for men • Increase of 5.3% for women
Follow-Up After Hospitalization for Mental Illness (HEDIS FUH) (Both rates)	• New Enrollee incentives for follow-up • Targeted caregiver and parent education to combat stigma of BH treatment • Provider education on appointment availability • Enhanced provider incentives for documenting services	• 7-Day Follow-Up: • Increase of 5.49% for black group
Racial Disparities in Chlamydia Screening in Women (HEDIS CHL)	• Cultural education for providers through QPAs • Cultural education for Enrollees through PCAs	• Increase of 1.65% for black group • Increase of 1.88% for white group

CareCentral System: Our care management platform supports extensive reporting that displays open and pending care needs, information on social determinants of health, leading process indicators for utilization management that include the percentage of reviews nurses send to physicians, and core provider/hospital utilization statistics including ED use. CareCentral will eventually help care managers prioritize care needs or identify Enrollees with missing information.

Behavioral Analytics: With Decision Point software, our QDAR team uses behavioral analytics to identify the most appropriate method for engaging with Enrollees based on their past behavior and their responsiveness to targeted campaigns and care provided.

Medicaid Dashboard to Identify Targeted Improvements: Our Medicaid Dashboard provides individual measure-level performance detail, and year-to-date trended performance, peer comparison to industry performance, and forecasted final performance for future planning.

HEDIS Provider Performance Profiles: These reports are generated at least monthly with updated Quality performance data and show individual and practice level performance on each metrics, including Enrollee level detail, as well as peer comparisons to the overall performance in Kentucky, in addition to individual provider performance compared to their practice overall. Our reports detail specific care needs information including medication adherence, upcoming immunizations due, and detailed information for behavioral health coordination and chronic

condition QI. These reports are presented to providers and their staff by our QPAs. They provide detailed performance education from which detailed individualized action plans are built in conjunction with the provider and his or her staff. An example of this report is provided as **Figure C.9-6.**

MEASURE INFO		HED20 CURRENT RATE			QUALITY SCORE		NCQA ACTUAL THRESHOLDS								
LOB Name	Measure	Eligible Members	Compliant Members	Rate	Score	Weight	10th	25th	33rd	50th	66th	75th	90th	Percentile Met	Hits to Next
WellCare of Kentucky, Inc - Medicaid	ADHD Maintenance Phase - visit	1	1	100.00%	5	1	47.28%	47.13%	55.64%	57.09%	65.64%	63.72%	72.55%	90th	MET
WellCare of Kentucky, Inc - Medicaid	Adult BMI Percentile/Value	7	5	71.43%	1	1	75.95%	83.09%	89.51%	88.56%	94.54%	92.46%	97.25%	<10th	1
WellCare of Kentucky, Inc - Medicaid	Antidepressant Mgmt Cont Phase	2	1	50.00%	4	1	32.00%	33.40%	37.00%	36.40%	43.00%	42.31%	53.11%	75th	1
WellCare of Kentucky, Inc - Medicaid	App Tx for URI	25	22	88.00%	2	1	82.35%	86.63%	90.66%	90.42%	94.44%	93.77%	96.88%	25th	1
WellCare of Kentucky, Inc - Medicaid	Asthma Med Ratio 5 - 64	4	4	100.00%	5	1	51.36%	56.85%	60.39%	62.28%	66.68%	67.03%	73.51%	90th	MET
WellCare of Kentucky, Inc - Medicaid	CIS - Childhood Imm Combo 10	51	23	45.10%	4	3	27.99%	27.74%	34.76%	35.28%	41.65%	40.88%	50.33%	75th	3
WellCare of Kentucky, Inc - Medicaid	Chlamydia Testing	21	7	33.33%	1	1	47.08%	50.58%	53.00%	56.07%	63.43%	65.43%	73.26%	<10th	3
WellCare of Kentucky, Inc - Medicaid	Dental Visit	783	292	37.29%	1	1	42.14%	47.48%	52.52%	56.60%	62.66%	64.16%	67.21%	<10th	38
WellCare of Kentucky, Inc - Medicaid	IET - Engage Alcohol/Drug Tx	1	0	0.00%	1	1	13.53%	9.09%	18.50%	13.58%	23.95%	17.73%	28.75%	<10th	1
WellCare of Kentucky, Inc - Medicaid	IMA - Adolescent Immunizations Combo 2	47	21	44.68%	2	3	34.52%	26.28%	45.14%	31.87%	54.50%	37.71%	71.22%	25th	1
WellCare of Kentucky, Inc - Medicaid	Imaging for LBP	1	1	100.00%	5	1	65.05%	67.19%	70.56%	71.71%	75.76%	75.96%	81.36%	90th	MET
WellCare of Kentucky, Inc - Medicaid	Med Mgmt for People W/ Asthma: Med Compliance 75%	4	0	0.00%	1	1	27.50%	29.41%	34.88%	35.60%	40.75%	43.06%	53.31%	<10th	2
WellCare of Kentucky, Inc - Medicaid	PPC - Postpartum Visit	1	1	100.00%	5	1	54.88%	59.61%	62.37%	65.21%	68.25%	69.34%	74.45%	90th	MET
WellCare of Kentucky, Inc - Medicaid	PPC - Prenatal Visit (Timeliness)	1	1	100.00%	5	1	70.04%	76.89%	79.55%	83.21%	86.33%	87.06%	91.62%	90th	MET
WellCare of Kentucky, Inc - Medicaid	Strept Test For Pharyngitis	24	22	91.67%	4	1	70.17%	72.52%	81.30%	80.13%	86.61%	85.99%	92.67%	75th	1
WellCare of Kentucky, Inc - Medicaid	WCC - Child BMI Percentile	453	373	82.34%	3	1	63.36%	66.06%	77.53%	75.55%	84.14%	82.63%	90.51%	50th	9

Figure C.9-6 HEDIS Provider Performance Profile

v. Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.

We ensure a data-driven, outcomes-based continuous quality improvement process through the Plan-Do-Study-Act (PDSA) cycle, illustrated in **Figure C.9-7** PDSA Model**.** Each quality or process improvement effort is measured on an interval unique to that focus and as a result have different timeframes for rapid cycles of improvement. For rapid cycle, the focus is on small-scale or pilots of systematic changes in order to allow for quick implementation and review of performance indicators to determine rapid improvement. Using the measurements and benchmarks we assess if the rapid cycle change has resulted in positive, negative, or neutral impact. At this point, we reevaluate our changes to determine if they need to be altered and what changes can be made quickly to ensure continual rapid cycle analysis. The four stages of the PDSA rapid-cycle quality improvement strategy include the following:

- *Plan:* Identify an opportunity to improve a change or test of how something works
- *Do:* Carry out the plan on a small number of Enrollees; the test period may be short for small PDSA cycles
- *Study:* Examine the results
- *Act:* Use the results to make a decision, incorporate changes, and establish future quality improvement plans.

Figure C.9-7 PDSA Model

AN OVERVIEW OF DATA THAT IS SHARED WITH PROVIDERS TO SUPPORT THEIR UNDERSTANDING OF PROGRESS IN ACHIEVING IMPROVED OUTCOMES

PDSA in Action

When Primary Care Centers of Eastern Kentucky was concerned about having to submit HbA1c results manually, we advised them to bill the CPT II code through their EHR. When we learned that their EHR dropped the CPT II code because there was no reimbursement for it, and that this was occurring with multiple providers, we established a reimbursement of one penny. Now Primary Care Centers and a host of other providers can now bill CPT II codes without expensive changes to their EHR.

As part of the PDSA cycle, our local Kentucky-based business technical analyst (BTA), in collaboration with our corporate quality data analytics and reporting teams, uses our proprietary QPME to create detailed reports that our Quality and Provider Relations associates share with providers to help them understand their progress in achieving quality outcomes. Because our BTA is local and accessible to our entire Kentucky team, we have the ability to provide customized ad-hoc reporting to providers as needed in addition to monthly and quarterly reports listed in **Table C.9-3** below (and provided as Table C.9-1). In addition to these reports, our Quality and Provider Relations teams share information on high risk Enrollees provided by our Care Management team using Care Compass to perform our **ID/Stratification process**. This information includes a compliance index of how adherent Enrollees are to pharmacy and other preventive treatments.

Table C.9-3 Quality Reports for Providers

Report	Description and Use
Heat Maps	Identify regional, county, and zip code level variations in quality performance based on QI goals and measures. QPAs present these to providers during in-person visits to educate and help improve quality performance.
HEDIS Provider Performance Profiles	Generated at least monthly to show up-to-date individual practice level performance. Using profile reports, we can identify under-utilization of services for each Enrollee who has an outstanding care need. QPAs present these to providers during in-person visits to educate and help improve quality performance.
Care Needs Reports	These show all open care needs for Enrollees and are provided to all Enrollee and provider-facing staff in order to help close care needs. QPAs present these to providers during in-person visits to educate and help improve quality performance.
Behavioral Health Care Needs Reports	Unique to WellCare of Kentucky, these show all open BH-related care needs and are provided to CMHC's and five inpatient hospitals that are under the BH P4Q incentive program in order to help close BH-related care needs. BH QPAs present these to providers during in-person visits to educate and help improve quality performance.
P4Q Scorecard Reports	These interactive reports include web portal and drill down capabilities, affording providers' insight into actual and potential incentive earnings based on individual Enrollees and services. QPAs present these to providers during in-person visits to educate and help improve quality performance.
Appointment Agendas	These allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment. Our tools also suggest other diagnoses inferred from other data sources that have not yet been confirmed. For example, for an Enrollee with Diabetes, a physician will receive an appointment agenda indicating Diabetes and a list of open care needs that need to be addressed such as for a quarterly HbA1C, blood pressure control, eye exams and nephropathy screening. We provide these forms annually at the beginning of the year to guide annual physicals and EPSDT exams. In addition, when a provider performs an eligibility check on an Enrollee, we auto-generate an appointment agenda and deliver it directly to the provider via the provider portal, secure FTP, custom feed, or fax. With certain

Report	Description and Use
	connected providers, we have the capability to automatically generate and send an appointment agenda upon notification that an Enrollee is present in the office.
Emergency Room (ER) High Utilizer Reports	This monthly report details Enrollees who had any visit to the ER, including date of service, diagnosis and service codes related to the visit, method of arrival, and also indicates if there is an existing relationship with the Enrollee's PCP. The report also details the running 12 months of all visits to identify underlying trends and high utilization of multiple ER facilities. We also detail the relationship of each PCP to the rate of ER visits for PCPs assigned to them. These reports are delivered to providers by QPAs and PR Reps.
Enrollees Without Visits Reports	These weekly reports display adult Enrollees who have not been seen by a PCP within 12 months and are delivered to providers by QPAs and PR Reps.

Improving Quality Through Provider Support

Lewis County Clinic has been working closely with QPA Ashley Miller to improve their Chlamydia screening process. The QPA identified during a quality meeting and discussing the Chlamydia care needs measure that the practices only screened via pap collection. Education was provided that urine testing is an available option to complete this service to the Enrollees. Although the clinic rate was high for completing this measure there was room for improvement as they were missing screening on females that were not having pap screenings completed. They are now working to complete these on the high risk population through a urine screen as well. In 2017 their rate was 63% and in 2018 it was up to 70%. We anticipate this will continue to go up as they continue to educate and implement the system we collaborated with them to implement. This need was addressed by meeting with the case managers for each location and continuing to schedule face to face meetings with the providers at each location.

b. Indicate if the Vendor has received NCQA accreditation for the Kentucky Medicaid market, and if not, the proposed timeline for achieving accreditation.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.1 National Committee for Quality Assurance (NCQA) Accreditation of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Since WellCare of Kentucky became National Committee for Quality Assurance (NCQA) accredited in 2014, we **have improved our accreditation scores from 79.0 in 2015 to 85.7262 in 2018**, have maintained a **two-year Commendable NCQA accreditation status** and have the **highest NCQA quality ranking in the State Medicaid program at 3.5.** NCQA awards a status of

Commendable to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.

In order to achieve and maintain accreditation, WellCare's leadership has invested in national NCQA accreditation and Quality Assurance teams, both of which collaborate with the corporate organization and WellCare of Kentucky.

c. *Provide the Vendor's proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.*

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.2 Quality Committees and Meetings of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically.

The Quality Improvement Committee (QIC) oversees the QAPI program and reports to the Board. Chaired by Kentucky Chief Medical Officer Dr. Howard Shaps, the QIC membership includes WellCare of Kentucky CEO William Jones as well as the following leaders: State Pharmacy Director, Field Health Services Director, Director, Quality Improvement, Quality Improvement Manager, Chief Operating Officer, Market Directors, Finance Director, Director of Network Development, Director of Regulatory Affairs, Manager of Regional Operations, Human Resources Manager, Director of Hospital Contracting, Manager of Foster Care, Adoption, and Guardianship, Appeals Supervisor, Provider Relations Manager, all QI staff and others as may be deemed appropriate by the QIC from time to time. WellCare Corporate Representation includes: Senior Director, Chief Medical Officer, Behavioral Health Clinical Operations and Practice Senior Director, Customer Service Director, Credentialing Director, Claims Director, Appeals and Grievances Senior Director, UM Director, UM Medical Director, Senior Director of Clinical Care Management, Complaints Manager, Disease Management Director, Enrollment Director, Quality Compliance and Accreditation Director, chairs of all QIC subcommittee and others as may be deemed appropriate by the QIC from time to time.

In order to improve the Kentucky Medicaid managed care program, the WellCare of Kentucky QIC provides oversight to the QAPI program and ensures issues that are a priority for the Commonwealth such as diabetes, opioids, tobacco cessation, colorectal cancer and behavioral health are incorporated into all aspects of our QAPI. The QIC meets quarterly, analyzing and evaluating the results of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action to address deficiencies, and ensuring that appropriate follow-up occurs. The QIC maintains records that document the QIC's activities, meeting minutes, findings, recommendations, actions, and results.

These records are sent to DMS in accordance with their schedule and are available for review upon DMS's request, are available during the EQRO review, and during the NCQA accreditation review, these documents are also reviewed for compliance.

For example, the new population health program information goes to QIC for review, feedback and approval. Feedback included population-specific recommendations to improve the program. Data and information is reviewed with trends and outliers identified and interventions initiated and/or revised as needed. This enables the Plan to continue to improve

services and meet the needs of Enrollees. The Plan regularly meets with DMS, sharing data and information, including recommendations from QIC, making suggestions for improving Kentucky's Medicaid managed care program. This collaborative exchange of information enables the program to continually improve the health status for Kentucky Medicaid Enrollees.

The QIC will continue to proactively address issues as they arise during QIC meetings, for example:

When the Quality team reported that Enrollees were refusing assistance with appointment scheduling, the QIC recommended they initiate weekly communication with the postpartum outreach vendor to receive agent feedback and discontinue outreach to hospitals in order to reduce Enrollee abrasion and increase contact rates. This resulted in 45 scheduled postpartum appointments in Q4 2017.

When the Quality team reported that agents were having difficulty addressing more than one care needs on an inbound care needs call because Enrollees were in a hurry, thought the questions were too personal or wanted to schedule their own appointments, the QIC recommended they review care needs training to stress the importance of offering care needs on every call as it affects HEDIS scores, partner with vendor to update care needs scripting, remove requirement for agents to use verbatim scripting, removed questions regarding OB/GYN, sexually transmitted diseases and CM transition for children under 17 years old. This resulted in 778 scheduled appointments in Q4 2017.

d. Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.2 Quality Committees and Meetings of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically.

The Quality and Member Access Committee (QMAC) is responsible for representing the interest of the Enrollee population to ensure adherence of the quality and safety of clinical care, quality of services, and access standards. The list of Enrollee participation is submitted to the Kentucky Department of Medicaid Services annually. Our experience in implementing recommendations from QMACs are evidenced in multiple markets with similar populations as well. Examples of changes put in place (by WellCare of Kentucky and our affiliates) as a result of a QMAC recommendation follow:

- WellCare of Kentucky: A WellCare of Kentucky Enrollee mentioned in a QMAC meeting that another Enrollee's provider stopped taking WellCare and that the Enrollee's only option became the emergency room. The Enrollee noted that there should be more communication on what emergency care is and what urgent care is. As a result, WellCare of Kentucky Provider Relations Representatives began presenting lists of Enrollees who frequent the emergency room to PCPs, discussing barriers and potentially referring

Enrollees to care management based on the findings. In addition, Care Managers began performing outreach to Enrollees frequenting the emergency room, connecting them with a PCP who can meet their needs.

- Illinois & New Jersey: The QMACs in both states completed a survey which focused on gaining specific feedback on what Enrollees liked and did not like about using the plans' websites. The feedback revealed areas of opportunity to improve navigation for participants on the website such as the design of the "Find a Provider" tool along with state identifiers. This feedback was incorporated during the redesign of the website which added multiple new features including a state identification process and a keyword search in the "Find a Provider" tool.
- Hawaii: Feedback from the QMAC revealed that cultural sensitivities and discomfort had made it difficult for many women to have their recommended screening mammograms. The committee participants' feedback was incorporated into the resulting "Mammo Me, Mammo You" program. Through culturally appropriate education and convenient access to screenings, the program proved successful and was introduced in other parts of the State. 'Ohana's HEDIS rate for Breast Cancer Screening subsequently increased by more than seven percentage points from year-to-year.

i. Proposed stakeholder representation

QMAC stakeholders include Enrollees/individuals from advocacy groups or the community who represent the interests of WellCare of Kentucky's Enrollee population from each of the regions of the state, with 51% Enrollee majority for voting members. Additional QMAC stakeholders include leadership from WellCare of Kentucky's Quality Improvement, Network Development, State Behavioral Health, Customer Service, Grievances and Appeals, Account Services and Community Advocacy departments.

Enrollees and Enrollee representatives are chosen to participate on the Kentucky QMAC through a nomination and selection process. Potential QMAC participants can be nominated by WellCare of Kentucky care managers, community advocates, Enrollee outreach personnel and community relations teams and providers. We provide education about the QMAC and encourage self-nomination. We communicate nomination information to our staff via our website, internal communications and community events.

QMAC applications can be obtained from our website, our Enrollee handbook, our Enrollee Services team, our care managers or community events and may submit it by mail, fax, and secure e-mail to a dedicated inbox for the QMAC. Applications will be reviewed by WellCare of Kentucky associates on the committee, and participants will be notified of selection by telephone or mail.

ii. Innovative strategies the Vendor will use to encourage Enrollee participation.

We value the bilateral communication that occurs when Enrollees are adequately represented on our QMAC, and because this is an opportunity for Enrollees to influence benefit and program design, we plan to implement the following innovative strategies to encourage Enrollee participation on the QMAC:

- Recruiting Enrollees who are completing their care needs to see what motivates them. This will help us develop best practices surrounding outreach to Enrollees with open care needs.
- Identifying Enrollees who have had two or more calls into Member Services in order to address the concerns such as lacking information about WellCare or their coverage.
- Developing a recruitment flyer in the new Enrollee Welcome Kit.
- Leveraging our Care Gap Coordinator program to encourage participation.
- Leveraging our Hazard Enrollee Call Center to encourage participation.
- Leveraging our newly developed Member Advisory Committee to encourage participation.
- Including articles in the Enrollee Newsletter regarding the benefits of QMAC participation.
- Leveraging our Community Connections partnerships in educating Enrollees on the QMAC and recruiting QMAC members.
- Providing a QMAC sign-up sheet at community events and distributing contact information for interested Enrollees to the Quality team for follow-up.
- Creating a text message alert to all heads of household for participation in the QMAC with a link to FAQs about the process along with a phone number to participate. This option could also be sent to a random selection of Enrollees within all regions to allow for diversity but also limiting from a very large number of participation.

In addition to these innovative strategies, we have implemented the following strategies in other states to encourage Enrollee participation on the QMAC. We will consider these strategies in Kentucky:

We consider experience and input from participants on their availability and preferred location when scheduling meetings. We invite Enrollees to our offices as well as locations in the community that are familiar and accessible, such as schools and or community centers. We find that holding meetings at locations in which Enrollees frequent, such as community centers or churches, is an effective method to gain participation and input. In addition, we occasionally meet informally with QMAC participants on an individual basis to listen and facilitate input. We also solicit assistance from Community Advocates in obtaining Enrollee participation in the QMAC. To address rural challenges such as geographic distance and physical limitations, we provide a toll-free line for Enrollees when possible to participate by teleconference, transportation and attendant care services for Enrollees. We provide interpretation and translation services and make accommodations for individuals with communication support needs. We are also considering providing free child care for future QMAC meetings and identifying community partners who can invite Enrollees to the meetings.

iii. Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.

Our affiliate health plans have implemented the following successful strategies to obtain active Enrollee participation on our member advisory committees, which we will implement in Kentucky:

- Our affiliate health plan in Florida has provided Enrollees a $50 gift card to compensate them for their time at the Consumer Advisory Board (CAB) meeting. Depending on the time of the meeting, we also provide either lunch or snacks, which we mention on our scheduling

calls. As a result of these efforts, **125 Enrollees participated in the CAB meetings from 2017 to 2019.**

- Our affiliate health plan in New Jersey provides lunch and private transportation to encourage attendance at Community Advisory Committee (CAC) meetings, and provides an upgraded lunch and ceremony at the last meeting of the year in December to recognize Enrollees who have committed to an entire year of CAC meetings. Through these efforts, **an average of two to five Enrollees have participated in each of the New Jersey CAC meetings.**

e. Provide a comprehensive description of the Vendor's proposed Quality Assessment and Performance Improvement (QAPI) Program that meets all requirements of this Contract.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.3 Quality Assurance and Performance Improvement (QAPI) Program of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare of Kentucky's comprehensive Quality Assurance and Performance Improvement (QAPI) program focuses on health outcomes, health improvement and health-related social needs.

The purpose of the WellCare of Kentucky's QAPI is to improve the quality of care provided to Enrollees through the following methods:

- Objectively and systematically monitoring, evaluating and assessing the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services
- Identifying and implementing strategies to improve the quality, appropriateness, and accessibility of Enrollee healthcare
- Facilitating organization-wide integration of quality management principles

Our QAPI integrates management activities such as Utilization Management, Risk Management, Enrollee Services, Grievances and Appeals, Population Health Management, Provider Credentialing, Ombudsman Services and Provider Services.

Our QAPI is guided by NCQA standards and guidelines, and reflects a continuous quality improvement (CQI) philosophy and mode of action. QI processes are analyzed and revised ensuring consistency across the Plan. This enables the processes to be efficient and effective. For process evaluation, the organization utilizes the CQI Plan-Do-Study-Act (PDSA) method. Under the PDSA approach, the Plan reviews, analyzes and compares multiple indicators of quality care and service against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis, action plans and re-measurements occur to ensure progress toward established goals.

The QIC, QMAC and UMAC approve continuous quality improvement processes identified in the QI Program Description, Work Plan and Annual Evaluation, with interventions conducted to accomplish identified goals.

- **QI Program Description** describes the essential structure, resources and processes through which the QI Program is implemented; the QI Program scope as well as associated accountabilities and responsibilities. The program description also defines our quality objectives and guides how we continuously monitor and analyze key clinical, safety and service indicators
- **QI Work Plan** identifies specific Plan-wide activities and projects for the current year, and the performance measures used to evaluate their effectiveness throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements listing interventions and measurements to accomplish goals. The work plan is a living document that accompanies our QI program description and specifies QI activities, responsible parties, the timetable for implementation or completion, and quarterly activity summary and accomplishments
- **QI Evaluation** describes the level of success achieved in realizing set clinical and service performance goals and/or identifies opportunities for improvement, through quantitative and qualitative analysis. Prior years' findings are trended as appropriate. The annual evaluation describes the overall effectiveness of the QAPI program by including:
    - A description of ongoing and completed QI activities and projects
    - Trended clinical care and service performance measures, as well as, the desired outcomes and progress toward achieving goals
    - An analysis of accomplishments in the quality of clinical care and service
    - Current opportunities for and barriers to improvement, with recommendations for interventions

These documents also contain information on the following:

- Requirements set forth in DMS' Quality Strategy and in accordance with 42 C.F.R. 438.330, including:
    - Conducting and assessing PIPs
    - Collecting and submitting to DMS performance measurement data that enables DMS to calculate performance on required measures, including indication of progress on measures and related outcomes
    - Establishing mechanisms for detecting under-utilization and over-utilization of services'
    - Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs, as defined by the Commonwealth
- A QIC to provide oversight of QAPI functions
- Methods for seeking input from and working with stakeholders, such as DMS, Enrollees, Providers, Subcontractors, other contracted MCOs, other community resources and agencies, and advocates to actively improve the quality of care provided to Enrollees
- Methods for addressing Department mandated performance measures
- Integration of Behavioral Health indicators into the QAPI program and a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Enrollees

- Methods to collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Enrollee's overall care
- Use of a health information system to support collection, integration, tracking, analysis and reporting of data analytics specific to health care outcomes and performance metrics, including stratification of findings (e.g., by Region, provider type, Enrollee populations)
- Methods to evaluate data and findings reports to assess QAPI program activities, progress on objectives, identified areas for improvements and processes to implement changes, including methods for providing feedback or other information to Providers and Enrollees

f. For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky's Medicaid population. Include discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how those will be addressed. Provide examples of successes in other state Medicaid programs, and how that success will be leveraged in the Kentucky Medicaid market.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.4 Kentucky Healthcare Outcomes and Section 19.5 Reporting HEDIS® Performance Measures of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

We have extensive experience tracking and measuring HEDIS as well as non-HEDIS measures such as medication adherence for diabetes medications, tobacco cessation and colorectal cancer and are prepared to leverage this experience for the Kentucky Medicaid population. **Table C.9-4, Table C.9-5 and Table C.9-6** provides examples of our proposed strategies and interventions to achieve this for each of these measures:

i. Medication Adherence for Diabetes Medications

Table C.9-4 Medication Adherence for Diabetes Medications

MEDICATION ADHERENCE FOR DIABETES MEDICATIONS
With the prevalence of diabetes in Kentucky, and the more than 18,000 WellCare of Kentucky Enrollees currently prescribed diabetes medications, it is increasingly important to implement strategies aimed at improving diabetes-related health outcomes. Rates for this measure have increased from 71% in 2017 to 75% in 2018. Partners that will be necessary to achieve improvement include: CVS, EQUiPP, Good Measures. Data analytics required to achieve success for this measure include: Using our comprehensive QPME, we will include this measure in our standard data analytics reporting structure in order to align with the Commonwealth's priorities. As reflected below, our improvement plan includes near-term strategies we plan to implement in the early renewal periods as well as longer-term strategies, which are much more transformative but require longer-lead times for implementation given complexities, dependencies, and more.

Furthermore, our strategies and tactics are designed to be applied or customized to meet the needs and circumstances of providers, Enrollees, and regions in which we serve.

- Year 1 is the baseline year in which we determine the appropriate clinical and operational metrics to track for performance. Analyze disparity reports and develop interventions based on our findings. We anticipate a 5% improvement from the baseline in adherence to diabetes medications in the first year of the renewed contract.
- Year 2 we will begin to see results from the interventions with immediate impact as well as see the beginning of impact for short-term interventions and forecasting the long-term intervention impact with help of our Quality Statisticians. We anticipate a 7% improvement from the baseline in adherence to diabetes medications in the second ear of the renewed contract.
- Year 3 is our success year in which our programs come to full maturation and we are able to see the impact of all interventions. We anticipate a 10% improvement from the baseline in adherence to diabetes medications in the third year of the renewed contract.

Strategy: Enrollee education and outreach

In-person visits from care managers and local community pharmacists and **reminder mailings** assist with diabetes medication adherence.

Diabetes telephone outreach program in which Health Coaches make three calls to Enrollees identified as requiring diabetes medications to remind them to fill their prescriptions. We are introducing a Health Coach team comprised of local experts and peers responsible for supporting DMS in improving health outcomes and addressing disparities of diabetes and prediabetes. This team will provide focused outreach, education and support to Enrollees including resources and programs to each individual's needs.

Our **Community Connections** program offers Enrollees access to healthy food through food pantries as well as transportation resources to assist in getting to scheduled preventive care appointments related to diabetes.

Our **Preventive Service Outreach** outbound Enrollee activation and calling program engages Enrollees via telephone, text and IVR to remind Enrollees with diabetes of the importance of medication adherence to their overall health.

Medication Adherence Enrollee Outreach Calls: WellCare has partnered with the University of Florida College of Pharmacy Center for Quality Medication Management to perform targeted outreach to Enrollees in other Medicaid states around diabetes medication adherence, addressing barriers including cost and side effects, and providing clinical counseling from pharmacists as needed. We will implement this program in Kentucky in order to improve adherence to diabetes medications. **Enrollees contacted through this program are twice as likely to fill medications within 30 days of receiving the call.**

Good Measures Diabetes Prevention Program is designed to prevent diabetes, however it also helps diagnosed Enrollees improve the management of type 1 or type 2 diabetes through Health Coaches who help them better manage their condition(s), improve their food choices, and optimize their health. Using the Good Measures app, participants can track meals and snacks, physical activity, blood sugar, and medications to learn how different foods, medicines, insulin, and activity affect their blood sugar. The app also suggests the best meals and snacks to eat next. Notably, nutrition plays a key role in mitigating side effects and increasing efficacy. Our Health Coaches develop trusted

relationships with Enrollees to help them address medication adherence, reduce side effects, eat healthier, and feel better by building on the foods they like so they can better manage their diabetes and enjoy life.

Healthy Rewards: We understand that tying rewards to healthy decision-making can be motivating and sustainable. For that reason, we created value-added benefits that attach to preventive services/ screenings, including diabetes medication adherence and diabetic retinal eye exams. With our Healthy Rewards program, Enrollees receive reloadable debit cards or gift cards for stores to purchase needed personal, home, baby, and family-related items that promote good health behaviors for practicing healthy behaviors.

Chronic Disease Management through Microclinics: Working with Microclinic International (MCI), WellCare of Kentucky sponsored a program with the objective of enabling local organizations, such as the Red Bird Clinic and the Barren River District Health Department (DHD) in Kentucky, with tools and resources to stop the spread of chronic diseases. With a strong presence in the state, MCI reports that 95% of participants improved at least one indicator of chronic disease when focusing on the methodology of the program, which includes sustainable lifestyle choices, such as cooking healthy meals and physical activity. Recruiting 16 participants for the program, many of whom were WellCare of Kentucky Enrollees, **Red Bird Clinic maintained a 93.75% retention rate**, and although working amidst several obstacles, including a natural disaster, **the Barren River DHD completed four distinct MCI program launches enrolling nearly 50 participants.** Through weekly online surveys, we believe participants were able to make lasting behavioral changes.

Strategy: Provider education and outreach

Medication Adherence Provider Outreach Calls: We have partnered with the University of Florida College of Pharmacy Center for Quality Medication Management to perform targeted outreach to providers focused on closing care needs related to diabetes medication adherence.

WellCare of Kentucky offers **in-person education from QPAs and community pharmacists, pharmacy performance visits** and **reminder mailings** to support providers whose Enrollees require assistance with diabetes medication adherence.

Provider care needs reports will help providers identify Enrollees who need assistance maintaining medication adherence.

Our **P4Q program** offers providers bonus payments for closing care needs associated with diabetes.

Strategy: Pharmacy assistance

Our pharmacy benefit manager (PBM), CVS, offers assistance to Enrollees to ensure diabetes medication adherence including **packaging that helps with dosing, pill splitter, scheduling medications and door-to-door medication delivery.** In addition, the following pharmacy programs support diabetes medication adherence for diabetes medications:

- *CVS Health Tags:* We implemented health educational messaging to Enrollees with specific gaps in care when they fill/pick up their prescription at their local CVS Pharmacy. **In 2019, we sent over 32,000 health tags for diabetes related care needs and over 25,000 for colorectal cancer screening.** In expanding this program to our full Medicaid population, we will target

similar care needs. Our ability to adapt this program to the current needs and trends in Kentucky allows for rapid response.

- *PBM Provider Advisor Support (PAS) Program:* Pharmacy Advisor Support (PAS) program promotes medication adherence and closing care needs based on clinical quality measures. The PBM sends tailored messages via fax to our providers regarding key points in the therapy process for Enrollees with chronic conditions, such as diabetes, asthma, high blood pressure, depression, etc. Messages target Enrollees not adhering to their medication regimen (late-to-fill) or provide clinical considerations and recommendations that will help close a care need, such as adding a statin for Enrollees on anti-diabetic medication. **Through these outreach efforts, the PAS program sent nearly 17,000 messages for adherence to diabetes medication and more than 7,000 messages for care needs related to diabetes.**

Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP): Pharmacy Quality Solutions (PQS) administers EQuIPP, a pharmacy benchmark system that provides performance data associated with quality measures to health plans and community pharmacy organizations. EQuIPP enables community pharmacist providers to identify non-adherent Enrollee opportunities, collaborate with provider practices to close care needs, and improve medication adherence. Currently, the EQuIPP network includes 95% of all pharmacies nationwide, with 90% of these pharmacies used by WellCare Medicaid Enrollees. Using EQuIPP, our network pharmacies can view Enrollee care needs specific to medication adherence. Because **95% of Kentucky pharmacies are on the EQuIPP platform**, the state has performed better in improving medication adherence for diabetes in our population as compared to the National benchmark. **For example, WellCare of Kentucky's Medication Adherence for Diabetes Medications measure improved by 3.7% from 2017 to 2018.**

Potential challenges and how these will be addressed

Social determinants of health: We will continue to address SDOH, including lack of transportation, through our pharmacy assistance programs listed previously, including scheduling door-to-door medication delivery and CVS health tags. We will continue to provide transportation assistance through our referral program to Non-Emergency Medical Transportation (NEMT) services, which is facilitated by the Kentucky Transportation Cabinet, Office of Transportation Delivery. For Enrollees who do not qualify for this service, we leverage our Community Connections team to connect them with external, non-profit community agencies that provide transportation to medical appointments. We also engage the Enrollees friends and family, if available, to find the best and most easily accessible option. **Today, we offer referrals to over 200 organizations providing NEMT, with almost more than 28,000 total referrals made to date.**

Health Literacy: Lack of education regarding the importance of taking diabetes medications poses a significant potential challenge to improving medication adherence for diabetes medications. For example, Enrollees often skip oral medications because of side effects or because they don't "feel bad." We will address this by continuing to educate Enrollees on the importance of taking diabetes medications through the strategies and interventions mentioned previously, including in-person care manager and pharmacist visits, diabetes telephonic outreach and the Good Measures diabetes program.

Unable to Contact (UTC) population: A potential challenge in achieving improvements in adherence to diabetes medication adherence includes locating and connecting with our Enrollees because we have incorrect or missing information. Our Enrollees may be dealing with unstable housing, a lack of

awareness of who their insurance carrier is, or a cultural or social level of mistrust for companies trying to engage. This poses a challenge to providers who are responsible for closing care needs for Enrollees with diabetes. In order to address this, we have implemented our Unable to Contact (UTC) Reach program, which provides important services such as education, coordinating Enrollees with primary care providers, bridging Enrollees to our community connections resources, and helping complete the health risk assessment to better identify Enrollee needs.

Access to Providers and Pharmacies: The rural nature of much of Kentucky poses access challenges to maintaining adherence to diabetes medications. To address this, we will offer door-to-door medication delivery as well as the following strategies to increase access:

- *Mobile screenings:* In addition, to address access challenges faced by many People of Kentucky we will provide rural screenings for diabetic retinal eye exams at localized mobile events as an alternative for Enrollees to complete well visits and engage in their healthcare. Our experience includes hosting health fairs, conducting rural mobile health clinics, and establishing pop-up clinics in remote locations.
- *Telehealth:* To address limited access to providers, we will support the Commonwealth's objective to expand the use of telehealth in conjunction with the passing of Senate Bill 112 that expands telehealth coverage and payment parity for telehealth services. WellCare of Kentucky has developed a multi-faceted strategy to expand the use of telehealth that builds on national research, as well as our experience in the Commonwealth, where we paid claims to providers for more than 6,800 telehealth services and more than 20 different types of services in 2018, and in our other markets. Through our national model for telehealth, we have made investments to educate Enrollees on telehealth opportunities and train providers on telehealth access and reimbursement policies. We will leverage that experience and work with DMS and our network partners to examine opportunities to promote the expansion of telehealth under the new regulations through direct education of our provider and Enrollee communities.
- We also partner with local *FQHCs and RHCs* to provide Enrollees living in rural areas with additional access to providers.

ii. Tobacco Use and Help with Quitting Among Adolescents

Table C.9-5 Tobacco Use and Help with Quitting Among Adolescents

TOBACCO USE AND HELP WITH QUITTING AMONG ADOLESCENTS
With more than 31,000 WellCare of Kentucky Medicaid Enrollees identified as "Positive Smokers", tobacco cessation in adolescents is a significant area of focus for improving population health for the Commonwealth. According to the most recent CAHPS survey, rates for tobacco cessation for Medicaid Enrollees increased by .25% for "Discussing cessation strategies" from 2017 to 2019. Partners that will be necessary to achieve improvement include: American Cancer Society, COBALT, and Kentucky Quit Line. Data analytics required to achieve success for this measure include: Using our comprehensive QPME, we will include this measure in our standard data analytics reporting structure in order to align with the Commonwealth's priorities.

As reflected below, our improvement plan includes near-term strategies that we plan to implement in the early renewal periods as well as longer-term strategies, which are much more transformative but require longer-lead times for implementation given complexities, dependencies, and more. Furthermore, our strategies and tactics are designed to be applied or customized to meet the needs and circumstances of providers, Enrollees, and regions in which we serve.

- Year 1 is the baseline year in which we determine the appropriate clinical and operational metrics to track for performance. We anticipate a 5% improvement from the baseline in tobacco cessation among adolescents in year 1 of the renewed contract.
- Year 2 we will begin to see results from the interventions with immediate impact as well as see the beginning of impact for short-term interventions and forecasting the long-term intervention impact with help of our Quality Statisticians. We anticipate a 7% improvement from the baseline in tobacco cessation among adolescents in year 2 of the renewed contract.
- Year 3 is our success year in which our programs come to full maturation and we are able to see the impact of all interventions. We anticipate a 10% improvement from the baseline in tobacco cessation among adolescents in year 3 of the renewed contract.

Strategy: Enrollee education and outreach

PCAs and QI Care Needs Coordinators provide outreach and education to Enrollees, including guidance on tobacco cessation and connection with resources to help. We are introducing a Health Coach team comprising local experts and peers responsible for supporting DMS in improving health outcomes and addressing disparities of tobacco cessation. This team will provide focused outreach, education and support to Enrollees including resources and programs to each individual's needs.

Healthy Rewards: Our Healthy Rewards program provides Enrollees with value-added benefits for completing preventive services including tobacco cessation. **In 2017, more than 1,500 WellCare of Kentucky Enrollees received more than $30,000 in Healthy Rewards incentives for participating in tobacco cessation programs.**

Tobacco Cessation Program: We offer the **Quit For Life Program**. Health coaches telephonically manage Enrollees by coaching and educating them to make lifestyle behavior modifications. During coaching sessions, Enrollees receive encouragement, problem-solving techniques, relapse prevention strategies, and a smoking cessation toolkit to reinforce training sessions and coaching calls. Enrollees receive tobacco cessation counseling and pharmacotherapy. As a result of our tobacco cessation program, which was implemented as part of our Management of Physical Health Risks of the Seriously Mentally Ill Population PIP **from 2015-2018, we saw a 12.25% increase in the rate for Tobacco Screening and Follow Up - Tobacco Cessation Intervention among Enrollees with schizophrenia or bipolar disease.**

Our new My Strength program offers free, confidential online behavioral therapy through the Web-based COBALT program for Enrollees with depression, anxiety, insomnia and substance abuse.

Our **Community Connections** program offers Enrollees transportation services to preventive care visits in which providers can educate them on the importance of tobacco cessation and connect them to resources to help them quit smoking.

Our **Preventive Service Outreach** outbound Enrollee activation and calling program engages Enrollees via telephone, text and IVR to remind Enrollees of the importance of tobacco cessation to their overall health.

Strategy: Provider education and outreach
Our **QPAs** identify Enrollees who require tobacco cessation based on care needs reports and share this information with providers during in-person performance visits. WellCare of Kentucky reviews **provider medical records** during the annual medical record review to ensure tobacco cessation strategies are being discussed. For providers who are not compliance with the guidelines, we implement interventions and educations to improve compliance. Our **P4Q program** offers providers bonus payments for closing care needs associated with tobacco cessation.
Potential challenges and how these will be addressed
Health Literacy: The primary potential challenge in improving tobacco cessation rates among adolescents is lack of education surrounding the potential health improvements and resources available to assist with quitting. We will continue to address this through the strategies and interventions targeted at educating Enrollees and providers listed previously, including our PSO outbound telephonic outreach, PCA and Care Needs Coordinator Outreach, QPA outreach, Quit for Life program and Healthy Rewards. **Social Determinants of Health:** SDOH pose additional potential challenges in improving tobacco cessation rates among adolescents. For example, lack of transportation creates a barrier to wellness visits in which providers can educate Enrollees on the benefits of quitting and resources available to help them quit. We will address this through our referral program to NEMT and Community Connections resources mentioned previously. **Unable to Contact (UTC) population:** Enrollees for whom we have missing contact information pose another potential challenge to improving tobacco cessation rates among adolescents. We will use our UTC Reach program described previously to locate Enrollees identified as smokers and educate them on the importance of tobacco cessation.

iii. Colorectal Cancer Screening

Table C.9-6 Colorectal Cancer Screening

COLORECTAL CANCER SCREENING
With more than 72,000 Enrollees over age 50, and nearly 600 Enrollees diagnosed with colon cancer, WellCare of Kentucky is committed to continuing to improve colorectal cancer screening rates over the next three years. Rates for this measure have increased from 52% in 2017 to 62% in 2018. Partners that will be necessary to achieve improvement include: Home Access, COBALT, and American Cancer Society. Data analytics required to achieve success for this measure include: Using our comprehensive QPME, we will include this measure in our standard data analytics reporting structure in order to align with the Commonwealth's priorities.

As reflected below, our improvement plan includes near-term strategies which we plan to implement in the early renewal periods as well as longer-term strategies, which are much more transformative but require longer-lead times for implementation given complexities, dependencies, and more. Furthermore, our strategies and tactics are designed to be applied or customized to meet the needs and circumstances of providers, Enrollees, and regions in which we serve.

- Year 1 is the baseline year in which we determine the appropriate clinical and operational metrics to track for performance. We anticipate a 5% improvement from the baseline in colorectal cancer screenings in year 1 of the renewed contract.
- Year 2 we will begin to see results from the interventions with immediate impact as well as see the beginning of impact for short-term interventions and forecasting the long-term intervention impact with help of our Quality Statisticians. We anticipate a 7% improvement from the baseline in colorectal cancer screenings in year 2 of the renewed contract.
- Year 3 is our success year in which our programs come to full maturation and we are able to see the impact of all interventions. We anticipate a 10% improvement from the baseline in colorectal cancer screenings in year 3 of the renewed contract.

Strategy: Enrollee education and outreach

PCAs and QI Care Needs Coordinators provide outreach and education to Enrollees including guidance on the colorectal cancer screening, education on the test and its recommendations as well as connection with appropriate means to complete the care needs screening.

Our current outreach for **Healthy Rewards** Enrollee incentives includes colorectal cancer screening for Medicare Enrollees. **In 2019, our Medicare program activated nearly 34% of the targeted population for Enrollee incentives on colorectal cancer screening** and we will leverage this experience to implement the incentive for Medicaid.

Colorectal Cancer Screening Kits: WellCare of Kentucky has partnered with Home Access to provide at-home **colorectal cancer screening kits** for select affiliate health plans. Targeted at Medicare Enrollees ages 50-74, Home Access provides: Enrollee and provider letters, reminder IVR and postcards, Enrollee and provider results letters. WellCare of Kentucky provides additional education and outreach to eligible Enrollees through periodicity letters, newsletters and the Enrollee portal. Enrollees receive the kits in the mail, collect their sample and submit to the Home Access lab for testing. Results are then provided to the Enrollee, provider and health plan. The program has resulted in a **19.23% year-over-year improvement in colorectal cancer screenings for Kentucky Medicare Enrollees for 2016-2018.** With our approach in supporting local People of Kentucky, we will enhance our Home Access program for colorectal cancer screenings to leverage the relationship between care management and the Enrollee. Our care management team will bring the testing kits to Enrollees under their care management supervision and provide direct education on colorectal cancer, the screening kits, and why it is important to complete them.

Our **Community Connections** program offers Enrollees transportation resources to assist them in getting to scheduled colorectal cancer screenings.

Our **Preventive Service Outreach** outbound Enrollee activation and calling program engages Enrollees via telephone, text and IVR to remind Enrollees of the importance of colorectal cancer screenings to their overall health.

Strategy: Provider education and outreach
We offer in-person education from **QPAs** on colorectal cancer screenings including care needs and resources during performance visits. WellCare of Kentucky **reviews provider medical records** through annual medical record reviews to ensure colorectal cancer screenings are being discussed. For providers who are not compliance with the guidelines, we implement interventions and educations to improve compliance. Our **P4Q program** includes a provider incentive for compliance with the colorectal care needs screening.
Potential challenges and how these will be addressed
Health Literacy: A potential challenge in improving colorectal cancer screening rates is lack of Enrollee education on the importance of such screenings in early detection and overall health. To address this, we will continue to educate Enrollees through our PSO outreach and Healthy Rewards programs mentioned previously. We will also offer health coach support to Medicaid Enrollees. **Social Determinants of Health:** Another potential challenge to improving colorectal cancer rates includes social determinants of health such as lack of transportation. We will address this by referring Enrollees to NEMT and Community Connections' transportation resources as well as by offering colorectal cancer screening kits mentioned previously. **Access to Providers:** The rural nature of much of Kentucky poses access challenges to Enrollees requiring colorectal cancer screenings. We will address this by offering colorectal cancer screening kits to Medicaid Enrollees and by partnering with FQHCs and RHCs. **Unable to Contact (UTC) population:** We will use our UTC Reach program described above to locate Enrollees who require colorectal cancer screenings and educate them on the importance of such screenings.

g. Describe the Vendor's proposed approach to collaborating with the Department, other MCOs, and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.6 Performance Improvement Projects (PIPs) of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare of Kentucky has vast experience with clinical and non-clinical PIPs, performing 13 unique PIPs on subjects including Reducing Potentially Preventable Hospitalizations and Emergency Department (ED) Visits for Ambulatory Care Sensitive Care, Prenatal Smoking, Chronic Obstructive Pulmonary Disease (COPD), Childhood and Adolescent Immunizations, Postpartum Care, Antipsychotic Medication Use in Children and Adolescents, and Pediatric Oral Health since 2012. Throughout this time, we have collaborated with DMS to develop and implement PIPs through IPRO

training, data sharing and leadership meetings. We will use this experience and the lessons learned to continue to collaborate with DMS and other MCOs on determining which PIPs to implement in order to improve health outcomes in Kentucky.

i. Lessons learned, challenges, and successes the Vendor has experienced while conducting PIPs, and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.

The following lessons learned and challenges represent common trends within each of the PIPs:

LESSONS LEARNED

A collaborative effort between WellCare of Kentucky, DMS, IPRO, Enrollees, and internal and external partners is essential. Through our experience in implementing PIPs, we have learned that our Quality Improvement Department has a key role in bringing all parties together to ensure everyone has the information needed to participate in the performance improvement activities and to make changes to drive positive outcomes. Key to this collaboration is clear communication and input from all parties as it contributes to the identification of gaps in care, barriers and interventions for improvement that result in improved health outcomes for Enrollees. We have demonstrated our experience and collaborative effort through the Serious Mental Illness (SMI) PIP led by the Kentucky Department of Medicaid Services (KDMS) and all MCOs.

Narrowing the intended focus of a project helps to concentrate efforts and available resources toward accomplishing meaningful improvement. During implementation of our Postpartum Care PIP from 2014 to 2017, our efforts and resources were divided among the several objectives associated with PIP, which may have hindered the achievement of our desired goals. While the desire was to effect change in many areas related to postpartum care, the expanded focus of the PIP created a complicated project. This taught us the importance of focusing our efforts in order to improve health outcomes.

Active interventions are more effective than passive interventions. Our experience implementing PIPs over the past eight years has taught us that although passive interventions including targeted mailings can have positive effects, more active interventions such as increased face-to-face provider contacts via QPAs may be more effective at driving positive outcomes. We will continue to apply to future PIPs the interventions that have proven effective.

CHALLENGES

Provider knowledge challenges: While conducting our PIPs, we discovered that providers often lack knowledge regarding best practices including indications or contraindications to immunizations, providing and documenting recommended screenings, risk factors for postpartum depression, diagnosis of COPD and adoption of the use of dental sealants. This lack of knowledge poses a challenge in providing adequate care to Enrollees and adversely affects providers' HEDIS scores. To address this, we deployed QPAs and PR reps to provider offices to help close care needs through education on topics including dental care, COPD, SMI and post-partum depression and the distribution of HEDIS toolkits. We provided online education on these topics through our provider portal as well. In addition, we developed a comprehensive

Maternal Health Program to provide risk assessments to identify women at risk of preterm birth and other pregnancy-related complications and made the Edinburgh Postnatal Depression Scale available to providers on our provider portal. We also implemented a process between Utilization Management and Care Management to identify and refer Enrollees hospitalized with COPD.

Care coordination challenges: Another challenge we discovered while conducting our PIPs was lack of care coordination including discharge planning and coordination of care for Enrollees hospitalized for COPD, and coordination between BH providers and PCPs for Enrollees with schizophrenia or bipolar disorder. When an Enrollee's care needs are not appropriately communicated among his or her care team, Enrollee health outcomes and provider HEDIS scores are adversely affected. To address this, we implemented integration meetings with WellCare of Kentucky leadership including our medical and BH directors and provider leadership. We also developed new Clinical Practice Guidelines (CPGs), which are available on the provider portal, addressing discharge planning and care coordination at transitions and smoking cessation.

Access challenges: Limited transportation; access to services including tobacco cessation programs and prenatal care and screenings; and access to providers including BH and dental providers presented an additional challenge as we implemented our PIPs. If Enrollees are unable to receive the services and access needed for recommended preventive care, health outcomes are less likely to improve. To address limited transportation, we refer eligible Enrollees to NEMT services and our Community Connections team connects Enrollees with external, non-profit community agencies that provide transportation to medical appointments. To address access challenges, we partner with FQHCs and RHCs throughout rural areas. We also implemented Cobalt Therapeutics free web-based self-management BH program for Enrollees on our member portal. In addition, we collaborated with Avesis to recruit and contract additional dental providers who accept Medicaid/pediatrics in rural areas.

Improving Access for Enrollees

An Enrollee living in Grahn, Kentucky was having difficulty getting to medical appointments due to a damaged wheel chair ramp. In response, a WellCare of Kentucky Care Coordinator contacted The Holy Rollers Motorcycle Club, who repaired the ramp, allowing the Enrollee to easily leave his house for medical appointments.

Health literacy challenges: A significant challenge to our PIP implementations was lack of Enrollee health literacy, including knowledge of the proper use of urgent care centers and health departments versus PCPs for vaccines; risks associated with tobacco use for an unborn child; importance of postpartum and dental care; appropriate management of COPD; and available resources to assist with ongoing disease management. Without knowledge on how to properly manage their healthcare, Enrollees are unlikely to make informed decisions to improve their health. To address this, we developed and distributed Enrollee-specific informational material including targeted letters and newsletters for Enrollees to improve health literacy, screening and monitoring rates with regards to dental, postpartum, BH, and COPD care. Through telephonic outreach, care needs coordinators educated Enrollees regarding dental, postpartum, and COPD and care managers educated Enrollees with SMI. **We implemented a**

24/7 "BabyLine" with nurses available to offer support and answer questions through telephonic interactions with Enrollees. We also referred smoking Enrollees to KY Quit Line for assistance for access to additional/available resources. In addition, we initiated an Enrollee Healthy Rewards incentive for annual dental visits, well child visits and adolescent well care visits.

SUCCESSES

We have seen the following successes as a result of our PIPs:

Postpartum Care PIP (2014-2017): Postpartum Care increased by **5.53%** and Healthy Kentuckians Postpartum Depression Screening increased by **10.2%.**

Chronic Obstructive Pulmonary Disease (COPD) PIP (2013-2015): Enrollees age 40 and older who were dispensed a systemic corticosteroid within 14 days following acute inpatient discharge or an ED encounter for COPD exacerbation increased by **3.92%**; Enrollees age 40 and older who were dispensed a bronchodilator within 30 days following acute inpatient discharge or an ED encounter for COPD exacerbation increased by **3.91%**; and Use of Spirometry Testing in the Assessment of COPD increased by **7.22%.**

Management of Physical Health Risks of the Seriously Mentally Ill Population (2015-2018): Body Mass Index Screening for People with Schizophrenia or Bipolar Disorder increased by **2.92%**; Blood Pressure Assessment for People with Schizophrenia or Bipolar Disorder increased by **6.81%**; Tobacco Screening and Follow Up - Tobacco Screening increased by **42.09%**; Tobacco Screening a rate for Tobacco Screening and Follow Up - Tobacco Cessation Rx Prescribed increased by **12.25%**; and Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications increased by **2.07%**.

Improving Pediatric Oral Health (2015-2018): Annual Dental All Members increased by **.09%**; Annual Dental Members age 2 to 3 increased by **.49%;** Annual Dental Members age 4 to 6 increased by **.36%**; Annual Dental Members age 7 to 10 increased by **1.13%**; and Annual Dental Members age 11 to 14 increased by .**67%.**

Childhood and Adolescent Immunizations (2016-2019): Childhood Immunization Status - Combo 10 increased by 16.66%; Immunizations for Adolescents - Combo 1 increased by 10.93**%;** and Immunizations for Adolescents - Combo 2 increased by 95.94**%**.

HOW WELLCARE OF KENTUCKY WILL CONSIDER THOSE EXPERIENCES IN COLLABORATION WITH DMS ON IDENTIFIED PIPS

Leveraging the lessons learned, challenges and results of previous PIPs, we will continue to collaborate with DMS as well as other MCOs on determining which PIPs to implement in order to improve health outcomes in Kentucky. WellCare of Kentucky would encourage and appreciate consistent interaction, partnership and engagement with the other MCOs. The combined knowledge, experience, and skills of the cumulative MCOs' associates will only enhance our ability to improve the health outcomes of Kentucky Enrollees. By applying like interventions to population health issues, the MCOs, along with DMS and the DPH, can influence providers, community partners and Medicaid Enrollees across the state. This type of extensive and all-consuming approach will

prove to influence Enrollees health behaviors through provider engagement and Enrollee awareness. In addition to collaborative PIPs, the MCOs should be jointly working on assisting providers with low quality scores/care, improving regional health literacy, increasing KHIE adoption and eMR implementation.

As such we will continue to collaborate with DMS, IPRO, Enrollees and internal and external partners on identified PIPs. As part of this effort, we will participate in a collaborative workgroup that will meet monthly with the purpose of collaborating with DMS, appropriate agencies, and other MCOs on issues including focus areas for PIPs. This workgroup will include WellCare of Kentucky's Medical Director Dr. Howard Shaps, Provider Network Director Bonnell Gustafson Irvin, Pharmacy Director Thea Rogers, Dental Director Dr. Jerry Caudill, Behavioral Health Director Dr. Marketa Wills, Quality Improvement Director Laura Betten, Population Health Management Director Shannon Maggard, and Chief Financial Officer Laurie Holden During these collaborative workgroup meetings, we will evaluate future PIPs to ensure they align with a specific focus for a project and consider available resources to have the greatest potential to effect positive change.

ii. Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.

WellCare of Kentucky recommends the following focus areas for collaborative PIPs for the first two years of the Contract:

STATEWIDE RECOMMENDATIONS

Neonatal abstinence syndrome (NAS): As a substance use-related issue that is important to Kentucky's Governor, WellCare of Kentucky recommends reducing the incidence of NAS as a focus area for a future PIP. We have partnered with Addiction Recovery Center to provide a treatment program for pregnant women who are addicted, paying a bonus to providers for every infant that goes home with his or her mother and not to the NICU. We have also provided funding for a similar program with Volunteers of America.

Enrollees without PCP visits: In order to reduce the number of Enrollees who have not received annual physicals, EPSDT services and immunizations, and prioritizing those Enrollees using the ED inappropriately, we suggest a PIP focused on this subset of the larger population. To determine which Enrollees to target, we recommend conducting a 12 and 24 month claims review, which will allow us to identify those Enrollees with the greatest need for intervention.

Hepatitis C: As one of the states hit hardest by the national opioid epidemic, the people of Kentucky struggle with high rates of addiction, overdose deaths, and Hepatitis C. For this reason, we recommend **improving the Integration of Hepatitis C Prevention and Care for Kentucky's Medicaid Population** as a statewide PIP.

REGIONAL RECOMMENDATIONS

Breast cancer screenings: With a high prevalence of breast cancer in regions five and six, we recommend a breast cancer screening PIP for these regions.

Preterm Birth: Kentucky currently has an overall 11.1% preterm birth rate according to the March of Dimes. Two of the top six counties are located in Region 6: Kenton with a 12.2% rate

and Boone with 10.6% rate so we would begin to focus our efforts in these counties. The regional PIP would build off of our experience impacting birth outcomes through use of our Patient Care Advocate model exemplified in another program where the state rate of 11.5% and the national rate of 11.8%. The low birth weight (Under 5 ½ pounds or 2,500 grams) rate for WellCare of Kentucky Enrollees included in our collaborative program was 7.92%, which was significantly lower than the state rate of 8.4% and the national rate of 8.0%.

Substance Use: As one of the states hit hardest by the national opioid epidemic, the People of Kentucky struggle with high rates of addiction, overdose deaths, and Hepatitis C. Along with several other states, Kentucky experiences the third highest rate of deaths due to a drug overdose. The CDC analyzed measures that include overdose deaths, per capita income, unemployment, and sales of painkillers to determine which counties in the nation were at the highest risk for a disease outbreak. Of the 220 most vulnerable counties in the nation, 54 are in Kentucky—with the majority located in the southern and eastern regions of the Commonwealth. For this reason, we recommend the following areas of focus for regional PIPs: **Improving the Safe and Effective Management of Pain for Medicaid Enrollees in Kentucky; Reducing Chronic Opioid Use in Kentucky's Medicaid Population.**

iii. Methods for monitoring and ongoing evaluation of progress and effectiveness.

Using the PDSA model of measuring and re-measuring in order to continuously improve, we employ a variety of current and proposed methods for monitoring and evaluating the progress and effectiveness of our collaborative PIPs.

OUR CURRENT METHODS FOR MONITORING AND ONGOING EVALUATION OF PROGRESS AND EFFECTIVENESS OF COLLABORATIVE PIPS INCLUDE:

- Participating in collaborative meetings with DMS and other MCOs to discuss progress of PIP interventions, identifying areas for improvement and proposing additional or modified interventions
- Sharing data with other MCOs and DMS through in-person visits or electronically, including results of PDSA methodology such as Enrollee needs; hot spots of identified needs; segmentation data; and unmet health-related resource needs such as housing instability, food insecurity, and lack of health literacy. Also sharing data resulting from statistical modeling to identify statistically significant opportunities and trends
- Performing monthly data reviews of PIP intervention metrics utilizing fishbone diagrams, comparing against national Quality Compass data
- Presenting data quarterly to ALL MCOs calls
- Reporting quarterly to the QI Work plan
- Reporting annually PIP interventions to DMS, QMAC, QIC and UMAC
- Reviewing PIP performance against national research studies

OUR PROPOSED METHODS FOR ONGOING EVALUATION OF PROGRESS OF EFFECTIVENESS OF COLLABORATIVE PIPS INCLUDE:

- Collaborating with health departments to institute disease-specific education programs. For example, in our current collaborative Ambulatory Care Sensitive Conditions (ASCS) PIP we have an external collaboration with Barren River Health Department in implementing a

diabetic education program. The program, in which 100 Enrollees have been identified to begin in February 2020, will include monthly meetings with BRHD to review Enrollee engagement and Enrollee health outcomes. This collaborative initiative provides opportunities to reduce potentially preventable hospitalizations and ED visits for individuals with one or more ACSCs, thus improving the overall health of Kentucky's Medicaid Enrollees

- Comparing current results against national statistical data, such as American Diabetes Association, CDC. CMS with information shared during collaborative calls
- Tracking and trending Enrollee, provider, and plan barriers to receiving care through our Care Gap Coordinator database. The Care Gap Coordinator database contains Enrollee specific data obtained through our Enrollee outreach and engagement program. This program focuses on a three-way phone call with the Enrollee and provider for appointment scheduling assistance

h. Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 19.7 Department for Public Health Initiates of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare of Kentucky has been collaborating with the Department of Public Health (DPH) and other public health departments on improving health outcomes in the Commonwealth since we began serving the People of Kentucky in 2012. Our Community Relations Specialist and Public Health Liaison educate DPH and other public health departments on our Care Management and Health Coach programs to which WellCare of Kentucky Enrollees can be referred for support and services related to public health issues. In parallel, the Care Managers and Health Coaches work with the public health departments to refer Enrollees to health programs such as 5-2-1-0 Healthy Numbers for Kentucky Families and the Diabetes Prevention and Control Program. In addition, our Quality and Community Connections associates use public health data provided by DPH and other public health departments to analyze key population-based health trends by region, race, ethnicity and gender to identify public health areas of focus. We will leverage this experience to continue collaborating with DPH and other public health departments, focusing on the following DPH priorities in order to have the most impact on health outcomes in Kentucky:

- Substance Use Disorder
- Smoking
- Obesity
- Adverse Childhood Experiences
- Integration to Health Access

We are currently developing the following public health initiatives which are aligned with the DPH priorities:

Public Health Collaboration project: For public health departments, establishing partnerships with managed care organizations has not been a priority. However, many of WellCare of Kentucky's more than 430,000 Enrollees live in rural areas and receive their healthcare from their local health departments. Therefore, **we identified an opportunity** to forge a partnership with the local health departments in order to understand health outcomes and healthcare service utilization in the local communities. This collaboration project **has the potential for the most impact** because it focuses on improving health outcomes through preventive screenings and recommendations for **children and adolescents**, who comprise 43% of our Enrollees. WellCare of Kentucky leadership attended the Kentucky Public Health Association conference in April 2019 to begin discussions with all public health departments in all 120 Kentucky counties on the partnership. **Our rationale** for pursuing this partnership is to combine community services provided by public health departments with our understanding of the prevalence of disease conditions such as diabetes, COPD and heart disease in local Kentucky communities to improve health outcomes for rural People of Kentucky. Project interventions include a dedicated QI nurse working with health departments, dedicated care needs coordinator making calls to parents to remind them of immunization recommendations, telephonic outreach to health departments to promote best practices on sharing information, face-to-face visits with health department directors and staff to establish a collaborative partnership for exchange of information, working with compliance and privacy teams to develop care needs reports for information exchange with health departments and access to the Kentucky immunization registry.

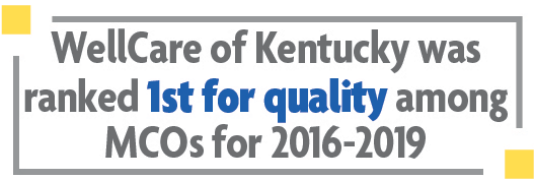
Diabetes prevention initiative – Barren River District Health Department (BRDHD): Because diabetes has been identified as a potentially preventable condition by the Agency for Healthcare Research and Quality (AHRQ) and the 2018 IPRO focused study on "Potentially Preventable Hospital Admissions and ED Visits due to Ambulatory Care Sensitive Conditions", **we identified an opportunity** to partner with BRDHD to develop the Diabetes prevention initiative. Aimed at improving the rates for recommended screenings for diabetes, this opportunity **has the potential for the most impact** because of the significant health outcome improvements and cost savings associated with preventing potentially preventable hospitalization(s) and ED visit(s) for diabetes short term complications. **Our rationale** for developing the pilot with BRDHD is to allow WellCare of Kentucky Enrollees who are at risk for diabetes to participate in the CDC's National Diabetes Prevention Program (DPP) program which has proven outcomes and is not currently covered by Medicaid. We plan to work with Barren River by funding the pilot through a grant and will refer approximately 250 WellCare of Kentucky Enrollees to BRDHD who are at risk for diabetes. The year-long DPP (Prevent T2) follows evidence-based CDC National Diabetes Prevention Program model, aligns with the CDC 6|18 public health initiative, and aims to help participants at risk for type 2 diabetes learn how to make lifestyle changes to prevent or delay the onset of diabetes. Groups meet weekly for 16 weeks, then 1-2 times per month to complete 12 months total. Barren River has in the past offered in-person sessions, but are currently also offering online sessions via Facebook Live. All

classes are conducted by Registered Dietitians that are trained Healthy Lifestyle Coaches. Outcomes collected include weight, A1C, and minutes of physical activity per week.

i. Describe the Vendor's approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:

WellCare of Kentucky will comply with the DMS' expectations and requirements as specified in Section 19.8 Quality Management and Performance Improvement Monitoring and Evaluation of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

i. How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.



WellCare of Kentucky takes a comprehensive and systematic approach to monitoring and evaluating progress in improving the quality of health care and outcomes. Our Quality leadership, medical directors, QIC and UMAC review data on a monthly, quarterly and annual basis, identifying trends and areas for improvement. Nationally, our Business Technical Analyst (BTA) and Quality Data Analytics and Reporting (QDAR) team use our Quality Performance Metrics Engine (QPME) powered by Tableau and SQL Server Management Studio, to produce reports that help us prioritize Enrollee care needs. In order to improve our abilities in this respect, we have recently developed enhanced data analytics capabilities that allow us to:

- Customize reporting based on specific measure sets or specific data elements by Enrollee, by provider or by zip code
- Prioritize Enrollees or families based on Quality Stratification Index which identifies Enrollees/families with multiple care gaps or individuals with difficult to address care needs that will guide CSR, CM and PCA inbound interactions
- View Enrollees before they are officially counted in the measure population, such as new discharges for mental health based on authorizations and new babies that need EPSDT, immunization and lead screenings
- View a holistic view of a dual Enrollee, including care needs, campaigns and activities across Medicare and Medicaid
- Create a task at household, provider or Enrollee level to coordinate across the interdisciplinary care teams, quality and provider relations
- Act on future measures such as new discharges, immunizations and well-visits
- View a holistic view of an Enrollee based on unique person identification

Monthly we review data including HEDIS results, effects of interventions on HEDIS results, adverse incidents, Enrollee and provider satisfaction, complaints, medication adherence and pharmacy data.

Quarterly we review under-and over-utilization, adverse incidents, HEDIS results, effects of interventions on HEDIS results, EPSDT results, appeals and grievances, complaints, medication adherence, pharmacy data and claims data.

Annually we review under-and over-utilization, adverse incidents, Enrollee and provider satisfaction survey results, medical record review findings, HEDIS results, effects of interventions on HEDIS results, EPSDT results, appeals and grievances, complaints, medication adherence, pharmacy data and claims data.

Using this information and our comprehensive QMPE, our quality teams monitor trends and build interventions that address 1) the quality and appropriateness of care for Enrollees with special healthcare needs 2) health disparities, 3) over-and under-utilization of services, including Enrollees without visits, and 4) critical incidents.

Using Data to Improve Enrollee Satisfaction

While reviewing our 2015 Enrollee satisfaction results, we noticed a decrease of 0.3 percentage points in Enrollee satisfaction for "Rating of Health Plan." We immediately responded by requiring Care Gap Coordinators to inquire about Enrollee satisfaction during each interaction. As a result, our Enrollee satisfaction increased by 2.10 percentage points in 2017.

ii. Methods for measuring provider performance against practice guidelines and standards adopted by the QIC, and follow up activities to be conducted with providers based on ongoing review of findings.

WellCare of Kentucky uses the following methods for measuring provider performance against practice guidelines and standards adopted by the QIC and follow up activities based on ongoing review of findings:

Annual Medical Record Review (AMRR) audit: The AMRR audit is a review of contract practitioner office medical records in accordance with federal and state regulations and assesses the adherence to general record keeping requirements, EPSDT requirements, continuity of care, adult preventive care, quality of care events, treatment for Enrollees with special health care needs, and compliance with regulatory reporting and coding practices. In 2019 we improved our process based on provider feedback by implementing a field outreach approach, where QPAs complete audits through face-to-face visits in the office, allowing them to provide immediate audit education post-audit, establish relationships/partnerships and expand the education to include care needs and HEDIS recommendations/requirements. Non-compliant AMRR results are issued corrective action plans with guidance on opportunities and possible consequences for repeat non-compliance. **According to our 2019 AMRR results, 96.67% of providers passed for Medicaid standards and 94.44% of providers passed for EPSDT standards.**

The office manager at East Bernstadt Medical Clinic which scored 56% in 2017 called and stated they were unfamiliar with the process and required additional support to understand the results and implement changes. Our field team provided guidance on the AMRR audit, including interpreting results and next steps on how to improve scores. Upon receiving a brief explanation of the AMRR audit on the phone, followed by more detailed education during a visit with QPA Shannon Sullivan, the provider scored a 91% 2018.

External Quality Review Organization (EQRO) audit: WellCare's corporate EQRO audit team annually conducts reviews of applicable documentation to measure provider adherence to EQRO standards. Non-compliant EQRO results are issued corrective action plans with guidance on opportunities and possible consequences for repeat non-compliance.

WellCare of Kentucky received more than 91% compliance in the last full EQRO audit

HEDIS Provider Profiles: Our comprehensive reporting suite provides detailed insight into individual provider performance according to NCQA guidelines which adopts nationally recognized clinical practice guidelines. Our QIC adopts these guidelines to provide consistency and validity in our approach to measuring quality.

EPSDT Provider Scorecard: Creates a quick-look tool to assess compliance with EPSDT visit requirements. The Scorecard includes applicable HEDIS measures and a facsimile of the CMS 416 Screening and Participation ratio.

Performance Improvement Projects (PIPs): By targeting specific health outcomes associated with targeted HEDIS measures, our PIPs allow us to measure provider performance over a three year period. For providers who have not met performance standards identified within the PIP, we conduct targeted outreach and education in order to provide an understanding of our goals for the PIP and the interventions available. For providers in need of additional assistance, we collaborate with them to design interventions rooted in their local practice to enhance our overall PIP's impact. Our goal in PIP design is to create meaningful interventions that work for all levels of practice.

Hands-on Provider Support: Our P360 continuous quality improvement program is aimed at service delivery, quality care, and satisfaction. Led by Provider Relations Representatives (PR Reps) and supported by QPAs, PCAs and Care Managers, P360 is based on PDSA methodology and includes in-person PR Rep and QPA meetings to review prior and forecasted quality performance against goals and other provider comparisons. The P360 team works to establish detailed work plans to improve quality including: New programs, Enrollee outreach, health fairs, new equipment/services, encounters/billing remediation and access to information and eMR interchange.

iii. A summary of the Vendor's approach to annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.

Annually, Quality Improvement Director Laura Betten leads our formal evaluation process, engaging stakeholders throughout our organization to assess the success of our QI program and develop our QI evaluation, which is presented to the Quality Improvement Committee (QIC) for review and approval. Our QI evaluation describes the level of success achieved in realizing established clinical and service performance goals through quantitative and qualitative analysis. Our evaluations include prior measurement period trending and performance against goals or targets, as appropriate. The annual evaluation describes the overall effectiveness of our quality assessment and improvement program by:

- Describing ongoing and completed QI activities and projects
- Trending clinical care and service performance measures and the desired outcomes and progress toward achieving goals
- Analyzing accomplishments in the quality of clinical care and service
- Identifying opportunities for improvement with recommendations for interventions

Our annual evaluation informs the following years' program, indicating which PIPs and quality improvement programs should be implemented based on specific needs identified. For example, our 2014 annual evaluation indicated only 52.44% of women had a postpartum visit, and of those women, only 9.29% were screened for postpartum depression. In response, we developed the Postpartum PIP in 2014, in which we introduced QPAs to educate providers regarding Postpartum HEDIS measures, developed a comprehensive Maternal Health Program to identify women at risk of preterm birth, implemented the 24/7 "BabyLine" to provide RN support to pregnant Enrollees, conducted Enrollee outreach post-delivery, and provided targeted Enrollee information on postpartum care. As a result, **our postpartum depression screening rate increased by 54%** during the second year of the PIP.

As part of our 2018 WellCare of Kentucky QI Evaluation we identified several areas of focus, enhancement, or continued support in 2019 including the following:

- Create a platform to allow the care management teams to have complete access to Enrollee information, provide a status and notes for complete Enrollee visibility
- Establish a process and team to focus facilitation of telehealth services for psychiatry to increase Enrollee access to psychiatrists
- Establish a cross departmental team to address high-cost, high-risk Enrollees with a history of chronic hospital readmissions to provide focused interventions and supports with the goal of reducing preventable hospitalizations and ED visits, and help manage complex comorbidities. The team will consists of staff from UM, CM and the corporate WellCare Advocacy and Community Based Programs teams and meet on a re-occurring basis to address these identified Enrollees
- Expand the transitional care nurse program to increase number of Enrollees impacted, streamline referral process to get referrals early in admission and decrease number of

j. Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:

i. The Vendor's lessons learned in developing and implementing VBP models, examples of models that have been most effective in improving performance and outcomes.

ii. Recommended goals and focus areas in the first two years of implementation of the VBP Program

iii. Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.

iv. Potential challenges specific to Kentucky and the Vendor's proposed methods for addressing identified challenges.

v. Regardless of the model implemented, the Vendor's approaches to analyzing performance against targets, frequency of analyses, reporting results to DMS, and use of analyses to modify interventions that are not making progress towards achieving targets.

k. Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:

i. The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.

ii. How improvement in health outcomes will be addressed through the VBP arrangements

iii. Methods for evaluating the effectiveness of VBP, including tracking of costs and

l. Provide results of any provider satisfaction survey reflecting the Vendor's performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, Describe strategies the Vendor has implemented to address improvement, and examples of how those strategies have been effective.

WellCare of Kentucky will comply with the DMS' expectations and requirements as specified in Section 19.10 Conduct of Surveys of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

91.6% of our Kentucky providers would recommend WellCare to other providers.

Gauging the satisfaction of our provider partners is a critical part of our continuous quality improvement efforts. We use a variety of different methods to capture provider feedback and satisfaction. These include post-call surveys, website surveys and our provider advisory committees. In addition, we administer a more formal annual provider satisfaction survey to measure provider satisfaction with our health plans. This survey is designed to support NCQA standards for health plan accreditation, as well as ensure our provider satisfaction program remains compliant with key reporting requirements. Our survey helps identify opportunities for improvement by asking providers for feedback on a variety of topics listed in **Table C.9-7** below. In an independent provider satisfaction survey in 2019, Kentucky Medicaid providers ranked WellCare of Kentucky with the highest overall satisfaction of all Medicaid MCOs in the state. In that survey, the highest performing composite score of the over 40 questions we asked providers was WellCare Provider Relations

WellCare of Kentucky earned #1 NCQA Customer Satisfaction from 2016-2019 among all Medicaid MCOs.

Representative's ability to answer questions and resolve problems. Through our efforts to continuously improve the way we support providers mentioned below, WellCare of Kentucky **earned #1 NCQA Customer Satisfaction from 2016-2019 among all Medicaid MCOs.**

PROVIDER SATISFACTION SURVEY RESULTS OVER THE LAST THREE YEARS

From 2017 to 2019, scores on 26 measures on our provider satisfaction survey improved.

Table C.9-7 WellCare of Kentucky Provider Satisfaction Survey Results 2017-2019

Composites	Attributes	2017	2018	2019
Overall Satisfaction	Would you recommend WellCare of Kentucky to other physician practices?	89.5%	93.4%	91.6%↑
Overall Satisfaction with All Other Plans	How would you rate WellCare of Kentucky compared to all other health plans you contract with?	89.9%	93.2%	91.1%↑
Overall Satisfaction with WellCare of Kentucky	How would you rate your overall satisfaction with WellCare of Kentucky?	70.6%	92.1%	90.7%↑
Provider Relations	Do you have a Provider Relations representative from this health plan assigned to your practice?	73.7%	75.3%	74.0%↑
	Provider Relations representative's ability to answer questions and resolve problems.	88.9%	94.0%	91.6%↑
	Quality of provider orientation process.	82.6%	90.7%	89.7%↑
	Quality of written communications, policy bulletins and manuals.	87.9%	93.6%	92.2%↑

Composites	Attributes	2017	2018	2019
Network/Coordination of Care	The number of specialists in this health plan's provider network.	81.8%	91.0%	94.5%↑
	The quality of specialists in this health plan's network.	89.1%	95.3%	97.9%↑
	The timeliness of feedback/reports from specialists in this health plan's provider network.	94.7%	94.3%	94.9%↑
Utilization and Quality Management	Access to knowledgeable UM staff.	89.4%	93.5%	93.1%↑
	Procedures for obtaining pre-certification/referral/authorization information.	83.3%	86.2%	86.8%↑
	Timeliness of obtaining pre-certification/referral/authorization information.	83.3%	87.4%	88.9%↑
	The health plan's facilitation/support of appropriate clinical care for patients.	87.1%	94.0%	94.1%↑
	Access to Case/Care Managers.	85.1%	93.6%	93.2%↑
	Degree to which the plan covers and encourages preventive care and wellness.	90.2%	94.8%	96.5%↑
Health Plan Call Center Service Staff	Ease of reaching health plan call center staff over phone.	88.9%	90.0%	89.0%↑
	Process of obtaining Enrollee information (eligibility, benefit coverage, co-pay amounts).	95.1%	95.5%	94.5%
	Helpfulness of health plan call center staff in obtaining referrals for patients in your care.	92.5%	94.6%	91.7%
	Overall satisfaction with health plan's call center service.	92.8%	94.3%	91.3%

Composites	Attributes	2017	2018	2019
Finance Issues	Consistency of reimbursement fees with your contract rates.	87.9%	91.1%	89.0%↑
	Accuracy of claims processing.	84.5%	88.9%	89.9%↑
	Timeliness of claims processing.	87.9%	94.5%	92.5%↑
	Resolution of claims payment problems and/or disputes.	79.4%	83.0%	83.5%↑
Pharmacy	Consistency of the formulary over time.	83.4%	93.5%	92.9%↑
	Extent to which formulary reflects current standards of care.	83.4%	93.8%	91.5%↑
	Variety of branded drugs on the formulary.	78.5%	86.3%	85.8%↑
	Ease of prescribing your preferred medications within formulary guidelines.	80.0%	87.0%	86.6%↑
	Availability of comparable drugs to substitute those not included in the formulary.	81.1%	86.3%	89.0%↑

AREAS FOR IMPROVEMENT, STRATEGIES TO ADDRESS IMPROVEMENT AND EXAMPLES OF WHERE THESE STRATEGIES HAVE BEEN EFFECTIVE

Although we deliver the highest level of provider satisfaction in Kentucky according to the past two provider satisfaction survey results, we have continued to make improvements aimed at reducing provider administrative burden. Our analysis of the results over the past three years revealed areas of improvement in claims processing and coordination of care between PCPs and specialists. In response, and in order to continue to improve upon our provider satisfaction, we implemented Provider Summits, Provider Focus Groups and created a Provider Advisory Panel as previously discussed. Based on provider feedback in these forums, we implemented a variety of strategies to improve provider satisfaction.

2018 overall provider satisfaction for WellCare of Kentucky was 92.1%, a 21.5% improvement over 2017

STRATEGIES TO ADDRESS IMPROVEMENT

Claims Processing Improvement

- Removed authorizations on 1,422 procedure codes
- Implemented dedicated Issue Resolution Team to perform root cause analysis on claims issues and improve systems to better serve our provider partners
- Improved our auto assignment algorithm and evaluated membership quarterly perfecting panel assignment to providers based on claims attribution

Coordination of Care Improvement

- Made 24/7 live reviews available for Behavioral Health providers
- Introduced AccuReports, Quality Scorecards, and other tools that increased our ability to share relevant performance data
- Implemented a "Gold Card" program for BH providers, which rewards inpatient facilities for their performance with key utilization metrics by only requiring prior approval of an admission with no concurrent review for medical necessity. Early results indicate increased provider satisfaction and decreased administrative burden for BH providers
- Deployed PCAs, QPA and OARs to support improved provider satisfaction

EXAMPLES OF WHERE THESE STRATEGIES HAVE BEEN EFFECTIVE

Applying the strategies listed above, WellCare of Kentucky was able to improve provider satisfaction with respect to call center/member services staff, claims processing and coordination of care from 2017 to 2019.

Claims Processing

- Timeliness of WellCare of Kentucky's claim processing increased by 5%
- WellCare of Kentucky's resolution of claims payment problems or disputes increased by 5.1%
- Accuracy of WellCare of Kentucky's claim processing increased by 5.2%
- Consistency of reimbursement fees with your contract rates increased by 1.2%

Coordination of Care

- Do you receive feedback/reports from specialists regarding Enrollees in your care increased by .2%
- Quality of specialists in WellCare of Kentucky's network increased by 9.8%

10. Utilization Management

C.10. UTILIZATION MANAGEMENT

a. Describe strategies the Vendor will implement to identify and reduce inappropriate utilization of services, including emergency departments. Address the following at a minimum:

i. Proposed approach to using data to inform the Vendor's efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential Fraud and Abuse referrals.

ii. Overview of the Vendor's methods for monitoring appropriate health care utilization, including two examples of identified negative trends, initiatives undertaken to improve them, and the results of these initiatives.

iii. Frequency in which the Vendor proposes to re-evaluate its approaches to identify need for adjustments (e.g., re-evaluation of existing prior authorization requirement for appropriateness)?

b. Describe the Vendor's proposed Utilization Management (UM) Program, assuring that it addresses requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." In the description, include information about the following, at a minimum:

i. Approach to align the UM Program with the Department's required clinical coverage policies.

ii. Proposed evidence-based decision support tool(s).

iii. Innovations and automation the Vendor will implement, for example, to reduce provider administrative burden under the UM Program.

iv. Methods and approach to balance timely access to care for Enrollees with the administration of the UM Program

v. Approach to integrate medical and behavioral health services in the UM program.

vi. Approach to ensure UM Program is compliant with mental health parity.

vii. Approach to ensuring accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers.

viii. Processes and resources used to develop and regularly review Utilization Review (UR) criteria.

ix. Prior Authorization processes for Enrollees requiring services from non-participating providers or expedited Prior Authorization, including methods for assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope.

x. How the Vendor will use its Utilization Management Committee to support Utilization Management activities.

C.10. UTILIZATION MANAGEMENT

a. Describe strategies the Vendor will implement to identify and reduce inappropriate utilization of services, including emergency departments. Address the following at a minimum:

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 20.0 Utilization Management of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix,** provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

STRATEGIES TO IDENTIFY, REDUCE INAPPROPRIATE UTILIZATION OF SERVICES: AN OVERVIEW

We understand the important role we play in the coordination of a care delivery system that assures Enrollees access to all appropriate and medically necessary services. And we also understand our role in assuring a sustainable program for the Commonwealth by having a utilization management program that is defined by national and community-standard evidence-based guidelines and includes the following core components:

- An integrated continuous monitoring process
- Active and informed high-quality providers
- Engaged and empowered Enrollees
- Innovative systemic solutions

From 2016 to 2018 WellCare of Kentucky has achieved a **12.9% reduction** in ED utilization

Continuous monitoring: Reducing inappropriate utilization of services requires us to first identify the misuse and to fully understand the drivers of that utilization pattern, as well as the interventions that will be most successful in addressing those drivers. Our UM monitoring program integrates into our organizational quality improvement program and leverages both data analytics and our deep knowledge and understanding of the Kentucky landscape over the past eight years. Continuous monitoring efforts, described in more detail to our answer to i. below, are overseen by our Quality and Affordability Initiatives (QAI) Team. This cross-functional team is led by Medical Director Dr. Howard Shaps and Chief Operating Officer Ben Orris and includes leaders from every segment of our integrated clinical, quality and network operations. With formal meetings at least twice a month combined with daily and weekly off-schedule reviews of utilization trends, this group uses our suite of advanced data reports (shown below) to identify over and under-utilization trends and put solutions in place at the provider, Enrollee and system levels to address those trends. Solutions are unique to the trend identified and can range from simple provider and Enrollee education (i.e. a mailing on appropriate ER use) to changing prior authorization requirements, such as implementing first-time Opioid prescription limits. Details of our monitoring strategies are provided in our responses to the questions below.

Once identified, our strategies to reduce inappropriate utilization are applied at the provider, Enrollee and system level.

Informed Providers: Managing appropriate utilization requires us to work closely with providers at every level of care, sharing data and Enrollee-specific information with them, to help them

coordinate the right care for our Enrollees at the right time. We start this effort with our intensely local provider engagement model (with staff placed across the state) and extends to how we educate and inform providers through electronic data sharing and with personal engagement by our provider relations representatives and Quality Practice Advisors. We give providers detailed reporting on care needs of individual Enrollees and equip them with tools to help close those gaps in preventive and chronic condition care. Through our quality and utilization monitoring oversight, we identify negative trends at the individual provider level and support interventions, including direct engagement from Dr. Shaps or another one of our clinical leaders to discuss challenges facing the provider in improving the quality of the care they are providing. We also leverage prior authorizations on certain higher levels of care or more costly services to help us stay engaged with the provider to ensure alignment with standards of care. Our authorization team ensures the Enrollee has the right services at discharge or step down from an acute care hospital to avoid future inappropriate or avoidable utilization. Finally, we leverage value-based payment methodologies to incent providers to better coordinate Enrollee care to ensure Enrollees are getting medically necessary services at the right place and right time. For example, our shared savings arrangements with certain high-volume primary care providers give those providers a share in savings generated for reducing inappropriate ER use, which incents them to extend hours or outreach to their patients for preventive care visits. **Table C.10-1** shows other provider-based strategies aimed at reducing unnecessary utilization.

Table C.10-1 Provider-Based Strategies for Reducing Unnecessary Utilization

Strategy	Description
Medical Necessity Criteria and Prior Authorization Process	Based on Inter-Qual national for evidence-based clinical guidelines, our medical necessity criteria for certain services helps guide providers in selecting the most clinically sound course of treatment for Enrollees and helps us work directly with providers during the prior authorization process (include doctor to doctor peer review process) to prevent unnecessary utilization. We educate providers on criteria and guidelines both at the time they contract with us and continually as criteria and requirements are updated.
Care Needs Data Sharing	We use multiple modalities to share care needs, including our "Appointment Agenda" which tells a physician in one view, everything the Enrollee needs during that visit to be compliant with evidence-based preventive and chronic care clinical guidelines.
ED High Utilizer Information	This information is given to providers monthly via in-person PR Rep visits, email and/or by secure FTP to providers to empower them with information about their patients so they can address any non-emergent conditions the enrollee may have, educating the enrollee on the cost benefits of coming to the PCP office for non-emergent conditions and developing a long term care plan to help improve the Enrollee's health.

Strategy	Description
On-Site Care Coordination Support	Through our care gap discussions with providers, we found many were engaged and eager to address gaps in care but lacked resources needed to conduct member outreach and follow-up. So, we placed WellCare employees in select network provider offices or group practices and focused on scheduling appointments for targeted members with identified gaps in care signifying underutilization of healthcare services (i.e. annual well visits, immunizations or other preventive services). We also provide in-person nurses in two of our largest high-volume hospitals to help those facilities with discharge planning directly. Our nurses engage directly Enrollees and the hospital staff and address post discharge needs to prevent avoidable hospital readmissions.
Provider Score Card Program	We complete quarterly and monthly provider scorecards, which uses claims and authorization data to track utilization trends at the provider level. WellCare's clinical and quality integrated leadership team conducts onsite quarterly visits with providers to review the data and help sort out unfavorable trends. They conduct follow-up in-person visits as necessary.
Integrated Provider Portal	The provider portal tells providers if a member has had an emergency room visit, what medications they are taking and what care gaps they have open. It also allows providers to close those care gaps by submitting data through the portal interface with WellCare so we can appropriately track open preventive and chronic care gaps and target interventions most effectively to members who have continuing health care needs.
PCP P4Q Program	Providers receive bonus payments for closing for closing key preventive and chronic care needs, which we know ultimately support more appropriate utilization of services.
Behavioral Health P4Q program	We introduced the BH P4Q program in 2019 in order to address the prevalence of BH conditions in Kentucky. Unique to WellCare of Kentucky, this program offers bonus payments to all 14 Kentucky CMHCs and BH hospitals including Bourbon Community, Sun Behavioral Health, The Ridge, Lourdes and Baptist Corbin for improving BH-related measures such as Antidepressant Medication Management, Medication Adherence to antipsychotics and Follow-up after BH Inpatient hospitalization. In only five months, nearly $30,000 in bonus payments have been paid to providers and 738 care needs have been closed as a result of the new BH P4Q program.

Engaged Enrollees: When Enrollees are engaged in their health care, they are more likely to make the right choices, including choosing primary care over an ER visit, for example. Our enrollee engagement efforts begin with our initial outreach to screen Enrollees to ensure they are getting the services they need and educational materials, like EPSDT periodicity letters, that empower Enrollees to engage in their healthcare by telling them about necessary preventive care and how to access services. We watch Enrollee behavior closely through data reporting and use predictive analytics to identify Enrollees at risk for over-utilizing certain services

unnecessarily. We intervene at the Enrollee level through intense outreach and education such as outreach calls to close open care needs and we contact our Enrollees who do not have a PCP visits within the past year to ensure they are getting proper preventive healthcare. And when we see trends across populations, like increases in NICU rates for babies with neonatal abstinence syndrome (NAS) we collaborate with our provider and community partners to bring about larger scale initiatives to address the underlying drivers of the trend. (One example related to NAS rate increases is the work we are doing with the introduction of our ACT for Opioid program that works to prevent Opioid misuse in the first place and we connect Enrollees to evidence-based SUD services, including medication assisted therapy, earlier in their addictions). Also critical to our engagement with Enrollees is our proprietary approach to addressing social determinants of health. Through our Community Connections program, we are able to help Enrollees who may use healthcare services inappropriately because of social barriers (i.e. using the ER to help get a warm place to stay) by leveraging our database of more than 300,000 social services and our peer supported social services through our Community Connections call line to connect Enrollees to services they need and track them to ensure they received the needed service.. **Table C.10-2** shows other enrollee-based strategies aimed at reducing unnecessary utilization.

Table C.10-2 Enrollee-Based Strategies for Reducing Unnecessary Utilization

Strategy	Description
Transitional Care Support and Outreach	We place nurses in high-volume hospitals to engage Enrollees before they discharge to support their discharge plan or in the ED in real time. The nurses collaborate with the hospital staff to improve the efficiency of efforts between the hospital and health plan team for all aspects of care management, service authorizations and discharge planning.
24-Hour Nurse Line/BH Crisis Line	Enrollees are provided a nurse advice line they can call when they are uncertain about a condition or whether the Enrollee should make a trip to the ED. The nurses triage the call and provide advice on the best course of action. They also provide follow-up information to our Population Health Management (PHM) staff as needed. We see an average of 83.1% of triage callers to the line are diverted to non-emergency resources. The Behavioral Health Crisis Line is a dedicated 24-hour call line that assists members in crisis due to behavioral health condition. We assisted more than 237 members through our Behavioral Health Crisis Line through the first quarter of 2019.
Care Management Interventions	For those who are frequent users of the ER, we provide another layer of intensive care coordination with our WellCare at Home, field-based care management program. This high-touch care management model uses RNs and licensed social workers and field outreach coordinators to meet Enrollees in-person and outreach telephonically on a frequent basis. With care managers in every region of the Commonwealth, they meet with Enrollees in their homes and communities to provide assessment, care planning and monitoring of interventions. In 2018, members enrolled in our Filed Based Care Management program experienced a 22% reduction in ED utilization 12 months

Strategy	Description
	following their enrollment compared to the 12 month period prior to their enrollment.
Ensuing PCP Visits	One of our most useful metrics to reduce ED utilization as well as avoidable hospital admissions is to ensure that our members are using their assigned PCPs as their medical home. To address this, we identify when our members have professional visits with other network PCPs to determine if they are utilizing another provider other than their assigned PCP. Each quarter we submit PCP changes to reassign the member to the provider they are frequently visiting for care. In the first quarter of 2019 WellCare has already reassigned the PCP for 8,658 members.
Efforts to Find Difficult to Reach Members	We employ varied approaches to finding difficult to reach Enrollees who may not be engaging in their preventive and chronic condition care, but may be admitted the hospital for an ambulatory sensitive condition or ED unnecessarily. We use data mining techniques to find updated contact information and "feet on the street" efforts to knock on doors directly. We to partner with community social service providers to help us find Enrollees and ask these social service providers to contact us when they do find our hard to reach member. We specifically hired three dedicated Member Outreach Coordinators in Region 8, which is particularly challenged with isolation and Enrollee engagement challenges, to find Enrollees. After implementing that program, we saw a **more than 16% reduction in utilization of high-cost services for those Enrollees served.**
Value-Added Services and Enrollee Incentives	We have designed a thoughtful expanded benefit package with the goal of improving quality and reducing unnecessary utilization. Within this package, we offer our Healthy Rewards program, designed to incent Enrollees toward healthy behaviors like seeing their PCP. Enrollees receive a gift card for accessing preventive health screenings, PCP visits, Well-Child visits, prenatal care visits, well-women visits (including mammography, cervical cancer and chlamydia screenings), diabetes HbA1c screenings and eye exams, and preventive dental care among others.
Support Finding Alternatives to the ED	Members can access the member portal and receive text messages on specific health topics including preventive care via our mobile app, empowering them to make more informed decisions on their healthcare and avoid unnecessary trips to the ED. They can also use it to map out the closest urgent care center as a preferred option if it is after hours or their PCP is not available.

Innovative Systemic Solutions: Sometimes, we find identified over- or under-utilization of services being driven by larger challenges within the care delivery system. When we see those trends, either through our data analysis, through our stakeholder engagement or through collaboration with DMS and other MCOs, we seek to implement broader solutions. These solutions can be such initiatives as offering a provider an alternative payment contract to

expand access to care through urgent care centers, increasing the number of available billable behavioral health outpatient services or tackling the systemic lack of transportation in certain underserved areas of the state. This is why our Community Connections program, for example, expands beyond our database and referral process to services and includes our Community Impact Councils (CICs) and Community Health Investment Program. We use our CICs, which include engagement with local community stakeholders such as public health departments and social service organizations, to identify a need in the community that is impacting quality health care outcomes and to help find shared solutions. It's also why we prioritize access to services and collaborate with providers regularly to expand access and availability to needed services, such as adding advanced telehealth services with the opening of Direct to Consumer telehealth options. This service can ultimately prevent overutilization of unnecessary services.

i. Proposed approach to using data to inform the Vendor's efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential Fraud and Abuse referrals.

Addressing Utilization of Unnecesary Services in a Holistic Way: An Example

In 2016, WellCare of Kentucky developed the METS program, which is now WellCare's national model. Based on SAMHSA's 10 Fundamental Components of Recovery, this integrated, holistic recovery-oriented program is for Enrollees in care for an extended period with high utilization associated with their outpatient services who might be able to graduate to self-care with other supports We assign targeted Enrollees a dedicated, specially trained METS care manager who develops a current clinical picture, including medication history. After establishing a clear clinical profile, the care manager presents the Enrollee in a Treatment Team Review (TTR) meeting. The multidisciplinary TTR meeting identifies barriers, strengths, and other factors to develop the care manager's next steps to follow-up on the Enrollee's case and develop a tailored Roadmap to Recovery. Results for program participants include a 54.7% reduction in total visits, a 6.1% reduction in emergency department use, and an increase in pharmacy use – suggesting improved medication adherence. For these Enrollees, the total cost for professional behavioral health visits dropped by 35.7%. By ensuring Enrollees are in the right levels of outpatient care, we are able to free-up the system to manage new Enrollees or Enrollees immediately after crisis in the community.

USING DATA BEGINS WITH COMPREHENSIVE DATA ANALYTICS AND REPORTING

The QAI Team uses an array of data to inform our efforts to improve appropriate use of service and cost efficiencies. The data analytics we leverage also help us spot outlier trends that can identify potential fraud and abuse referrals. Our Enterprise Information Management System (described in our response to question C.27 Contractor Reporting Requirements), gathers data from a variety of sources (i.e. claims, authorizations, operational metrics, etc.) and serves as the backbone of our utilization data reporting and analytics infrastructure.

Based on specific data analytics pulled from multiple sources including medical and pharmacy claims and authorizations, we track trends to detect potentially preventable events, outlier facilities, PCPs and specialists with unusual trends, instance of fraud, waste and abuse, high-utilizing members and cohorts, condition specific outliers, as well as unexplained region-specific variances. We also look at data by membership type (ABD, TANF/CHIP and Expansion) to spot any unusual trends. As described in our example of a negative trend asked for below, this kind of analysis helped us see, the sudden and drastic uptick in ER utilization by newly insured Enrollees in the Expansion population and allowed us to implement solutions specific to that phenomenon.

The centerpiece of our approach to using data for healthcare transformation is our comprehensive suite of daily, weekly, and monthly operational reports. All of our reporting is driven by organizational needs and the specific functions we need to meet as a managed care organization. **TableC.10-3** Reports used in Utilization Management contains just a sample of the reports which are frequently review by our QAI leadership to identify trends, outliers or emerging issues and explanations of how the data is used to address over and under-utilization trends.

TableC.10-3 Reports used in Utilization Management

Data/Report	Description
ED Utilization	Examines ED utilization trends across several informative cohorts including facility (to examine spikes in frequency), procedure codes (to allow for coding review and ancillary service utilization), region, line of business and age grouping.
ED High Utilizer	For the last 12 rolling months, this report reflects the enrollees who are assigned to the respective provider group and/or IPA who have utilized the ED, how many visits they have had; which hospital they have utilized; when the last emergency room visit was; what their most frequent diagnosis was during all of their visits; and how much WellCare has paid for the enrollee's ER utilization during the respective number of ER visits. This report helps the PCP to address any non-emergent conditions the enrollee may have, educating the enrollee on the cost benefits of coming to the PCP office for non-emergent conditions. This helps the PCP develop a long term care plan to help improve the enrollee's health. This report is distributed monthly via in-person PR Rep visits, email and/or secure FTP.
Pharmacy Utilization Reports	Reflect a provider's generic dispensing rate (which helps mitigate cost), breaks down the provider groups/IPAs individual prescriber profiles, which helps address any therapeutic equivalent recommendations and ensures that the enrollee receives consistent care which reduces unnecessary medical costs.
Physician Profiling	With a focus on primary care providers, the report examines a PCP's specific member attribution experience using claims data. The report details expense and utilization across a wide array of service categories including inpatient, outpatient, ED, behavioral health, professional and pharmacy, with even

Data/Report	Description
	greater granularity under these cohorts. The metrics examined include utilization/1000, utilizing members, high cost specialist referrals and to whom, and performance against predefined targets.
Authorization review	Produced three times per week, this report trends inpatient, outpatient, post-acute care and behavioral health authorizations by specific lines of business including TANF, ABD, Expansion and Foster Care comparing to predefined targets and other similar state's performance. It details the volume of authorizations/1000 approved and authorizations/1000 requests not meeting evidence-based medical necessity criteria.
P4Q Portal Reports	Includes web portal and drill down capabilities, which QPAs and PR Reps provide to WellCare of Kentucky providers monthly, provides a snapshot of care gaps for their enrollees tied to performance payments, allowing them to prioritize those measures that will result in the most improved enrollee health outcomes.
Performance Scorecards	Contains measures tied to quality objectives, Total Cost of Care, and Key Performance Indicators such as ED utilization, IP utilization, and IP readmissions.
Behavioral Health Specialization Report:	Monthly report detailing services offered at professional BH practices, allowing for the sharing of areas of expertise not noted by provider type or licensure and streamlines the referral process.
Members Without PCP Visits for 16 Months:	Included with the respective identifying enrollee information, and respective Primary Care Provider information, this is a detailed list of WellCare Enrollees who have not had a PCP visit within the last 16 months.
30-Day Readmission Report	Reflects Enrollees who have been readmitted to the hospital as an inpatient within the last 30-days; detailed information regarding both admission and re-admission including the facilities of both admissions, diagnoses, and respective amounts paid.
High Cost Member Report (reflecting claims >$50K)	Report of Enrollees who have claims over $50,000 (catastrophic claims) for the last 12 months; includes claim category with the amount paid over $50,000—inpatient hospital, outpatient, emergency department, physician office, or pharmacy; distributed monthly via in-person PR Rep visits, email and/or secure FTP.
Top 10 Claims Denials Report	Top 10 claims denial reasons for the respective provider group/IPA for the preceding month; summary dashboard of the claims denial reasons; breaks down the claims denials by tax ID/practice; distributed monthly via in-person PR Rep visits, email and/or secure FTP.

Data/Report	Description
IPA Funding and Expense Report	Primary financial report utilized by provider groups/IPAs in VBP arrangements. The report shows the provider's Medical Loss Ratio (MLR) and is distributed monthly via in-person PR Rep visits, email and/or secure FTP.
PCP Peer Group Comparison (for non-value based contracted providers/IPAs):	For provider groups/IPAs not in a VBP arrangement, reflects the provider group/IPAs premium, MLR, risk, and breakdown of claims expense: inpatient, outpatient, ED, physician office, and pharmacy. The report benchmarks the respective provider group/IPA against all other PCPs in the state, and breaks down the provider group/IPAs individual providers by the respective report segments.
Care Needs Reports	The Care Needs Report shows the outstanding Care Needs, such as a mammogram or colon cancer screening, for specific Enrollees, allowing the provider to address the outstanding Care Needs to help improve quality outcomes; distributed monthly via in-person QPA visits.
Specialty Provider Report	We have the capability to evaluate our specialty providers, such as cardiologists and orthopedic surgeons. This is performed using medical episode grouper technology which accounts for member risk profiles and helps us determine which specialists deliver the most efficient care.

USING THE DATA TO INFORM PROGRAMS TO REDUCE UTILIZATION

Each report is used in varying ways to address unnecessary utilization. Our QAI team, for example, uses the ED High Utilizer data to identify Enrollees with the highest rates of ED use and to examine the data for trends beyond the individual Enrollee, such as shared providers, diagnoses, population type, previous engagement in our Population Health Management (PHM) program, etc. That data is then further used to support the next levels of interventions such as sharing the names of high utilizers with PHM staff to enroll them in care management and with their primary care providers to support PCP-level interventions. If trends show an outlier of ED admissions in a particular region or with a particular hospital, Community Connections staff may be engaged to identify what challenges that community faces that are driving individuals to the ED unnecessarily.

Other examples of how some of the data identified above is used include the following:

PCP Utilization Data: Our quality team staff use this data to conduct direct outreach to Enrollees who haven't seen their PCP to help them make an appointment and make sure they are getting necessary preventive care. We know, for example, that a woman who gets her cervical cancer screens timely can avoid more challenging and higher cost health conditions in the future.

Authorization Data: Reviewed at regular frequency, we use authorization data to spot trends early (without having to wait for claims to come in) and to identify any upticks in denials that may require us to review our authorization criteria or application. Using this data, we're able to work directly with providers to ensure they understand the evidence-based medical necessity

criteria and that it is being applied appropriately in more "real-time" than data just based on claims.

Care Needs Data: Showing up in several different reports, care needs are an essential component of our utilization management strategy. We use this data to trend needs at the individual Enrollee, provider and even regional level. We share open care needs, such as lacking immunization or other preventive care service, with providers so they can close those needs with their patients. We also share them with Enrollees through the secure Enrollee portal so they can see what services for which they are due, and finally, we map care needs regionally looking for trends across a community to bring in broader interventions like "WellCare Days" with a local provider where we target larger groups of Enrollees to set up appointments and close care needs all at one time.

USING DATA TO IDENTIFY FWA AND SUPPORT COST EFFICIENCIES

These varying data sets, along with advanced data sources used specifically by our Special Investigations Unit detailed in our response to question C.26 Program Integrity, also help us spot potential cases of Fraud, Waste and Abuse (FWA) in the system. By looking, for example, at utilization data by code type and provider type, we can identify unusual spikes in utilization of a specific service that tend to indicate at least some level of waste, if not outright fraud or abuse.

For example, during a Monthly Utilization Review meeting in the first quarter of 2016, we identified an emerging trend occurring during a review of our outpatient utilization report that is regularly examined. This drove further analysis of the spike and we quickly identified the provider type and specific procedure code responsible for the increase in utilization. Over the course of just two months, nearly all of the 14 Community Mental Health Centers (CMHC) began billing Therapeutic Rehab (TRP) under a procedure code H2019 as a result of a significant increase in reimbursement in that specific code, going from approximately $20 per hour to nearly $35 per 15 minute increment. Utilization for that particular code had not varied from baseline for the previous two years. Through a combination of education with the CMHCs and collaboration with DMS, we were able to address any misuse of the code with zero impact to Enrollee care.

ii. Overview of the Vendor's methods for monitoring appropriate health care utilization, including two examples of identified negative trends, initiatives undertaken to improve them, and the results of these initiatives.

METHODS FOR MONITORING APPROPRIATE HEALTH CARE UTILIZATION

In the previous section, we discussed the data, tools, and reporting capabilities that form the foundation of our strategy to monitor and reduce inappropriate utilization of services and support our fraud, waste and abuse activities. While analytical tools and reporting provide a solid foundation to identify problem areas, it is through monitoring and taking action on business intelligence that our analysis is transformed into interventions and improved outcomes for WellCare and DMS.

We employ a comprehensive, periodic, and thorough review of all regular information generated through the tools and reports listed in the previous section. Our analytics exist to inform our staff and drive improvements, and in order to ensure that process leads to continual improvement, we employ a regular cadence of review and analysis by our leadership and subject matter experts to review and react to our data.

Our QAI Team, led by Dr. Shaps and our integrated leadership team, meets bi-weekly at least to discuss trends in cost of care, quality and affordability and to conduct a financial review of our operations. During the Cost of Care meeting, we review several of the reports listed above to spot trends, both positive and negative medical expense trends. The team looks for opportunities to drill down into the data and develops remediation efforts when negative trends are identified. During Quality and Affordability meetings, we review not just cost trends, but also trends in specific utilization metrics (sometimes medical expense can go up even as utilization goes down due to increased service costs which is also a trend worth noting), as well as payment trends (i.e. spikes in claims denials, etc.)

This monitoring activity is further supported and bolstered by the broad experience of the larger WellCare organization, which provides additional monitoring of Kentucky trends, comparing to national standards and monitoring the local team's activity to ensure long term financial sustainability. WellCare conducts Quarterly Business Reviews for all of its Medicaid markets. Attended by the company's executive leadership team, these reviews help monitor trends on a quarterly basis and allow leaders the opportunity to drill down on trends that may be local to a particular state or emerging trends across Medicaid populations that require broader solutions. Another way our national expertise supports monitoring of utilization in Kentucky is with our FWA activities. We meet monthly with Program Integrity professionals who bring their broad experience across our affiliated health plans to help us identify unusual trends that could be identified as fraud or abuse and require further investigation and notification to DMS.

Review of trends or performance against national standards does not end with our formal series of regularly scheduled meetings. During our normal meeting cadence we use our standard reporting to identify areas for additional research and insight. WellCare takes the larger trends identified in the structured setting and creates new investigative reports, task forces, or ad hoc analytics to probe more thoughtfully into the major issues identified by our standard reporting.

From all of this monitoring activity, we develop remediation activities and the QAI team monitors those remediation efforts with subsequent reporting. This quick process of Continuous Quality Improvement (CQI) allows us to make changes in remediation in near real-time and to address new and emerging trends quickly. Below we show two examples of negative trends we identified through our monitoring efforts and the steps we took to address them, along with results.

Example #1: Avoidable Emergency Department (ED) Utilization

Identifying the Trend: Following the launch of the Expansion population in 2014, we began serving nearly 140,000 new Enrollees that were previously not covered under traditional

Medicaid. By about 2016, our regular monitoring as described above showed a nearly 5% spike in ED utilization that was not only unusual within the Kentucky program, but was a significant outlier among WellCare affiliates across the country. By looking at the data by population type and through our on-the-ground knowledge of the people we serve, we quickly identified the root cause was related to the Expansion population, many of whom were accustomed to receiving their primary care through the emergency room.

Implementing Solutions: In addition to pulling on the variety of ED Diversion strategies described in the response above, we initiated targeted interventions that included the following strategies:

- PHM Intervention: We broke the individual high utilizer report down further and identified those Enrollees who would be most likely to benefit from Chronic Condition Management or Complex Care Management interventions and referred those Enrollees to our PHM staff for outreach and enrollment into care management. We know that Enrollees engaged in care management have a dramatic and lasting reduction in avoidable ED utilization.
- Telephonic Follow-Up Outreach Campaign: We called Enrollees who had a non-emergency ED visit and educated them on the use of the PCP for non-emergent issues and helped them connect to their PCP.
- Provider Engagement: We increased our sharing of high-utilizing information with PCPs, specifically showing them non-emergent use. Our quality and provider relations staff collaborated with providers on outreaching to new Enrollees and helping them understand the role of the PCP. This was especially helpful for those providers who had a risk-arrangement with WellCare. When ED utilization decreased, WellCare was able to reward these providers with additional financial payments.
- Emergency Department Engagement: We shared with facilities information about how to refer Enrollees to care management, and we shared with them our Community Connections capabilities, so we could jointly help Enrollees who were being treated in the ED unnecessarily because of social service barrier.

Results: Between 2016 and 2018, we saw an overall decline in ED utilization of 12% attributable to the targeted and ongoing interventions we put in place to address unnecessary utilization.

Continuing Approach to Address Unnecessary ED Utilization

We continuously work to expand our network of urgent care providers available to our members. Statewide we have 168 contracted urgent care centers in our Kentucky network. WellCare has worked directly with First Care, and organization that has chosen to invest in Kentucky through expansion of Urgent Care clinics in rural areas of the Commonwealth. We have fueled their launch of new facilities over the last three years through contractual agreements that incentivize appropriate triage of members, treatment and discharge. The cost of an urgent care visit is nearly 75% less costly than the ED, and eliminates unnecessary risk to the Enrollee of being in an acute care hospital setting. Following the opening of the new urgent care center through our partnership with First care, we saw an immediate 15% reduction of ER visits at facilities within the geographic catchment area of the sites.

Example #2: Preventing Inpatient Hospital Readmissions

Identifying the trend: It is not unusual for Medicaid utilization trends to be hidden when reviewing information at a high level. WellCare regularly examines information beneath the surface to determine if there are unfavorable trends emerging by line of business, region, facility or age cohort to name a few. In 2018 we experienced a 3.3% year over year increase in our Aged, Blind and Disabled (ABD) inpatient readmission rate which went from 18.0% in 2017 to 18.6% in 2018. Identifying drivers of the adverse trend, we saw a need for ABD Enrollees to be more engaged in their discharge planning and after-care and a greater need for collaboration for discharge services.

Implementing Solutions: In addition to the Enrollee, provider and system level strategies to reduce inappropriate utilization, we implemented targeted initiatives to address this adverse readmission trend, including the following efforts:

- Enhanced Discharge Planning Collaboration: Our care management, UM and provider relations team began collaborating on clinical rounds for Enrollees identified through our predictive discharge algorithm, known as LACE+, as being at the most risk for a readmission. We run the predictive scoring algorithm at the time of admission and throughout the stay to identify risk. Our collaborative team works to identify discharge needs (including behavioral, physical, pharmacy and social needs). We worked closely with the hospitals, including placing care coordinators in certain high-volume hospitals, to collaborate on discharge plans ensuring that needed services such as DME or home health were in place when the Enrollee goes home.
- Care Management Integration: When it becomes clear through our discharge efforts that an Enrollee will need more intensive follow-up, our PHM staff is engaged for follow-up and referral to Chronic Condition Management or Complex Care Management.
- Medical Leadership Engagement: A key strategy for addressing inpatient readmissions includes intense local engagement with individual hospitals. Dr. Shaps worked extensively with hospitals systems throughout the state as we saw the spike and trend (and ongoing) to provide education and discuss methods to prevent avoidable inpatient hospital readmissions. Hospital systems across the state included, but were not limited to, the University of Kentucky, St. Elizabeth Healthcare, Norton Healthcare, KentuckyOne and Baptist Health. Meetings and collaboration with key stakeholders which included hospital or health system leadership, consisted of reviewing historic readmissions data, profiling high-risk patients, providing WellCare resources upon hospital discharge such as connecting discharging members with social gaps in care, and assisting with arranging post-acute care.
- Enhanced Data Exchange: We have used admission, discharge, and transfer data to stay better informed on Enrollee discharge status and to inform our providers when an Enrollee has a change in status so they can be empowered to help prevent an unnecessary readmission.

Results: With the greater awareness and focus on our ABD enrollees through the first 6 months of 2019, our ABD readmission rate has improved by 7% and currently running at 17.3%; the lowest readmission rate we have achieved for the ABD population since inception.

iii. Frequency in which the Vendor proposes to re-evaluate its approaches to identify need for adjustments (e.g., re-evaluation of existing prior authorization requirement for appropriateness)?

We update our CPT and HCPCS Codes annually in accordance with CMS guidance. Our Medical Director Dr.Shaps meets with the team on a regular basis (both through monthly and quarterly activities), to review the need to make adjustments through the variety of monitoring activities noted above.

To illustrate WellCare's commitment to process improvement, WellCare updated its outpatient authorization rules in 2018 to provide consistency across all outpatient places of service. This resulted in a reduction of authorization requirements by almost 10,000 codes, taking into account all sites of service. Additionally, WellCare will update authorization rules, either adding or removing the authorization requirement as needed after feedback is presented by both internal and external stakeholders. This is based on internal data, suggestions from providers, or to promote high quality care. As an example of our rapid ability to respond to changes in healthcare, WellCare recently removed the authorization requirement for Cologuard, a new technique that Enrollees can use at home to be screened for colorectal cancer.

Many other factors contribute to the frequency by which we adjust our approach to prior authorization requirements. WellCare realizes the importance of staying updated with new technologies and procedures. By staying up-to-date, we can make determinations as to which services may or may not need an authorization. Our network providers, comprised of both behavioral health and medical providers, who participate in our quarterly Utilization Management Advisory Committee make suggestions on our clinical coverage and practice guidelines that align with our authorization requirements. Finally, due to our national presence, we can look to other markets to scale best practices. The can occur on a scheduled basis, but often occurs ad hoc.

b. Describe the Vendor's proposed Utilization Management (UM) Program, assuring that it addresses requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." In the description, include information about the following, at a minimum:

WellCare of Kentucky has a well-documented, fully-integrated, Enrollee-centered utilization management program that serves over 430,000 Enrollees across all 120 counties. Our utilization management program connects with our with our fully integrated population health management program through CareCentral, our clinical IT platform that offers a single 360-degree view of every Enrollee which empowers staff and our providers to address Enrollee needs in real time. WellCare's utilization management program was built specifically for Medicaid and ensures that all services approved are in accordance with 42 CFR 440.230.

Nationally, WellCare performs more than one million authorization reviews for Medicaid Enrollees annually, including an average of 800,000 outpatient pre-service, 200,000 inpatient, and 200,000 retrospective, or post-service, reviews, as represented in below.

The program assesses the Enrollee's needs on a case-by-case basis to ensure every Enrollee has the opportunity to receive the most effective and appropriate services in the least restrictive setting of their choice and to reduce variations of care. Through our experience, we have built

our UM program around six guiding principles that are integrated within and reinforced throughout our systems, processes, policies and staffing.

- *Effective:* The criteria and processes by which we evaluate requests for services are based on current scientific, evidenced-based guidelines with proven results in improving outcomes.
- *Safe:* We manage and coordinate utilization of services with an aim of connecting Enrollees to care which is helpful and not harmful.
- *Timely:* We aim to prevent unintended delays, and we monitor our staff and processes to ensure accessibility and promptness consistent with our Enrollees' health needs.
- *Efficient:* We seek to reduce waste by creating value, monitoring health outcomes relative to cost, and minimizing errors. We also continually apply process improvement methodologies.
- *Equitable:* Our safeguards assure that our Enrollees, regardless of diagnosis, race, age, ethnicity, primary language or socioeconomic status, receive appropriate, high quality care.
- *Person-Centered:* We connect Enrollees with culturally, socially and linguistically-appropriate healthcare that empowers health care decision-making.

Our utilization management program features:

- A written Utilization Management Plan that aligns to items A-L described in Section 20.1 Utilization Management Program
- An organizational structure with clear lines of accountability for policies and individual determinations
- Aligned accountability and processes to facilitate the development and review of Enrollee-centered care and service plans
- Processes for determining medical necessity through highly-experienced, well-trained personnel with medical and UM expertise to address Enrollees' person-centered needs
- Defined processes and evidenced-based data sources to identify services subject to prior authorization
- Proven processes to develop and maintain review criteria for both physical and behavioral-based services as well as methods to ensure authorized services are delivered
- Flexible policies and process that provide for the authorization of services from out-of-network Providers as well as expedited reviews of requests for services when needed
- Comprehensive oversight and evaluation to ensure consistency of reviews
- Effective systems to allow for the easy recognition of initial and continued authorizations
- Defined processes for accurate, consistent assessment of medical necessity

i. Approach to align the UM Program with the Department's required clinical coverage policies.

CLINICAL COVERAGE POLICIES

Under the leadership of our CMO, Dr. Shaps, we tailor our UM program, specifically designed for government sponsored plans, to align with each unique Kentucky requirement. Our UM program is based on nationally-recognized, evidence-baseddecision support methodologies

adapted to and by Kentucky standards. This approach supports the evaluation of requestedservices and adoption of DMS's coverage guidelines upon request. WellCare works with our Regulatory leads to maintain compliance at all times. WellCare takes a hierarchical approach to the medical necessity and clinical criteria we use in reviewing requests for services. All policies and guidelines will be aligned to Kentucky's requirements and any state regulations. The Medical Policy Committee (MPC), Utilization Management Advisory Committee (UMAC) and Kentucky Quality Improvement Committee (QIC) are responsible for all published and utilized policies, procedures and guidelines. Kentucky-specific guidelines will be the top of the hierarchy. While clinical judgment may supersede the guidelines, in general these are evidence-based and aid Providers with their own medical necessity determinations. The guidelines utilized support quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. Guidelines are reviewed annually and revised as necessary. When there are differing opinions noted by national organizations, WellCare will default to the Enrollee's benefit structure as deemed by state contracts and Medicaid and Medicare regulations. If there is no specific language pertaining to the topic, WellCare will default to the following:

- CMS guiding criteria (NCDs/LCDS)
- Federal regulations
- National Committee for Quality Assurance (NCQA) requirements
- InterQual or other nationally recognized, evidence-based criteria
- WellCare Clinical Coverage Guidelines
- Behavioral Health Criteria such as: American Society for Addiction Medicine (ASAM) Criteria; Level of Care Utilization System (LOCUS); Child and Adolescent Utilization System (CALOCUS); Children and Adolescents Needs and Strengths (CANS); Early Childhood Services Intensity Instrument (ESCII)
- Hayes, Inc. Online™ (Medical Technology)

To validate existing guidelines or create proprietary new ones, Dr. Shaps and his team, meet with guideline methodologists annually or more frequently per state requirements. We conduct an extensive review of industry literature and apply clinical evidence, healthcare knowledge, and familiarity with our Member populations. We also incorporate the opinions of national organizations including CMS, the NCQA, the United states Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ), state Medicaid offices, and medical specialty societies; and meet NCQA requirements for Health Plan Accreditation. Along with WellCare's Clinical Coverage Guidelines, all other UM policy/procedure documents are aligned with Kentucky-specific requirements and all UM staff are trained in the use of these requirements during their initial on-boarding orientation, when updated or when needed.

ii. Proposed Evidence-Based Decision Support Tools(s)

WellCare uses commercially available, evidence-based guidelines for Utilization Review criteria where available. These criteria, such as InterQual Guidelines for inpatient severity of illness and intensity of service, are updated annually, are industry standard guidelines, and are based on well-established clinical practice guidelines and physician consensus panels. WellCare uses

Clinical Coverage Guidelines for UM review for procedures that do not have specific InterQual coverage. The purpose of WellCare's Clinical Coverage Guidelines (the "Guidelines") is to guide health care coverage determinations for the Enrollees. The Clinical Coverage Guidelines address selected clinical issues and medical services that are new or emerging. These medical services or procedures generally exhibit significant variation in utilization and practice pattern, and generally warrant additional sources of expertise. Some examples are procedures performed for cosmetic purposes, or that involve the treatment of a rare disease. The Guidelines are interpreted in conjunction with the Enrollee's specific benefit plan and in consultation with the treating physician. WellCare makes actual coverage decisions on a case-by-case basis and clinical judgment may supersede the Guidelines.

For behavioral health services, we also use ASAM criteria for medical necessity determination and have strong, clinically-sound CPGs for Medication Assisted Treatment and opioid-based treatment.

WellCare staff are supported by our industry leading guidelines and criteria for standard physical and behavioral health services to ensure decisions are fair, impartial, consistent and evidence-based. Standards and decision support tools are shown in **Table C.10-4**.

Table C.10-4: Evidence-Based Review Tools

Guideline Category	Summary
InterQual Review Manager	A nationally recognized decision tool for level of service, length of service, discharge planning readiness and level of care
ASAM	American Society of Addiction Medicine (ASAM)
Behavioral Health Guidelines	Level of Care Utilization System (LOCUS) & Child and Adolescent Level of Care Utilization System (CALOCUS) for adults & children, respectively; and Guidelines from leading organizations (i.e., the American Society of Addiction Medicine, Substance Abuse and Mental Health Services Administration) for behavioral health & substance use disorders
Children and Adolescents Guidelines	Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII)
Clinical Coverage Guidelines	Appraisals and guidance for 200+ procedures and services Range of topics including DME, Disposable Incontinence Products, Food and Lodging Services, Oral Function Therapy for Feeding Disorders and other benefits

Guideline Category	Summary
Hayes, Inc. Online™ (Medical Technology)	Hayes is a subscription based tool utilized by the medical directors to solidify medical necessity as well as to research new procedures and technologies, subject to approval by DMS
eviCore Guidelines	Advanced radiology (i.e., MRI, CT), cardiology (i.e., advanced imaging), radiation therapy management, pain management, sleep management, PT/OT/Speech services, molecular and genetic lab testing
HealthHelp	Medical oncology and radiation guidelines to help providers optimize cancer treatment protocols
CMS Guidelines	Guidelines as defined in the contract National Coverage Determinations (NCD), Local Coverage Determinations(LCD) used in Durable Medical Equipment (DME) reviews

iii. Innovations and automation the Vendor will implement, for example, to reduce provider administrative burden under the Program.

We are proud of the partnerships we've forged with Kentucky providers over the past 8 years, and we respect their concerns related to administrative burdens. That's why we have continued to innovate with DMS and our provider partners on ways to ease the administrative burden within the UM process. Just some of the solutions we offer include the following:

"WellCare has been the easiest managed care organization to do business with. Claim issues, authorization problems, or quality questions are addressed quickly by making a call to our Provider Relations Representative or Quality Practice Advisor. They are one of the few companies that provide resources such as these to assist with questions and concerns."
– CONNIE CASTLE, PRACTICE MANAGER, QUANTUM HEALTHCARE ASSOCIATES, HAZARD, KY

Common Authorization Form: To help our providers with timely authorization, we prioritize use of the common authorization form and educate providers on its use. We limit the number of repeated contacts with requesting providers in our policies and procedures because managing utilization effectively through the provider community supports the most significant quality outcomes.

Automation for Select Authorizations: Even before Kentucky Senate Bill 54 was passed, WellCare was making changes to the prior authorization process, adding transparency for providers, automating where possible to reduce turnaround time, and reducing the administrative burden--all in an effort to help providers serve our Enrollees better. Our authorization alignment initiative was designed to enhance the consistency and timeliness of our service authorization processes and better coordinate care for our members. We

implemented change to our existing Prior Authorization code rules in an effort to alleviate administrative burden placed on providers. As a result of this change we developed a uniform outpatient Prior Authorization rule set, allowing us to remove variability between procedures and their relationship to place of service. The initiative had a direct effect in making it easier for a Provider to request a Prior Authorization and receive a consistent and faster determination. Improvements included:

- **Net reduction of individual codes requiring review: 1,422**
- **Added codes that go through auto approval once the request is data entered; the system generates auto approval, decreasing time**

Electronic Request Intake process: Providers can request authorizations electronically, through the WellCare portal or through a standard 278 file exchange. Additionally, we have begun accepting pharmacy requests through e-prescribing modules within providers' electronic medical record. So, when a provider enters a prescription into their EMR, it is automatically forwarded to us for authorization and approval if it requires Prior Authorization (PA). For example, our Georgia health plan accepts most PA requests electronically (into CareCentral) through a state hosted authorization platform.

24/7 Provider Portal: Our fully integrated Provider Portal allows providers to see all important and necessary information about their patients, including our Member 360 view reflecting all relevant clinical and utilization history (such as screenings, comprehensive assessments, admissions/readmissions, medications),eligibility verification, PCP assignment, authorization history, and status, claims status , service and benefit limits, care need reports, preferred drug list, important updates and notices, Multidisciplinary Team (MDT) team contacts, and population health training materials. This one-stop shop, with a single sign-on, allows provider offices to spend their time on what matters most, providing care and service to their patients, as opposed to spending time gathering information necessary to receive payment.

UM Call Center: Our UM Call Center is open seven days a week for authorization questions or concerns. Behavioral health UM staff, including a UM Supervisor and Medical Director is available 24-hours a day, and we facilitate pharmacy PA 24-hours a day. Additional medical professionals are also available after hours.

Authorization look-up tool: Our authorization look-up tool allows providers to quickly discern which services require authorization and the appropriate guidelines to help them provide the best information to make a medical necessity determination. We accept medical information in whatever form is easiest for the provider through web portal, fax, or other means.

Provider Training and Support: We offer web based training and FAQs that are available for providers to address any questions about the UM process. At a provider's request, we may also offer in-person or telephonic consultation to address gaps in knowledge. We also provide on-site provider education from a WellCare specialist for those providers who have higher than anticipated denial rates. We monitor our provider Net Promotor Score closely and have seen improvements as a result of changes in our authorization processes which also leads to improved Member satisfaction due to the streamlined process.

Gold Card: We have "gold carded" certain behavioral health providers, which allows those providers to manage utilization of their patients for certain services without having to request PAs through us if they show consistent decision making against national guidelines.

Authorization Streamlining: Based on provider feedback and other expert guidance, WellCare undertook an initiative to review the application of prior authorization (PA) requirements and medical necessity criteria on more than 10,000 individual codes across 22 different specific outpatient places of services. Through this detailed initiative, we streamlined our PA protocols down to 3,500 codes with the most clinical variation, and eliminated the requirement for providers to indicate specific outpatient places of services. Each of these code reductions have dramatically improved the speed of services for Members, and enable our providers to spend more time thinking about care and less time thinking about system functions.

iv. Methods and approach to balance timely access to care for Enrollees with the administration of the UM Program.

The administration of our UM program requires the appropriate clinical information be provided at the time of the request. To balance timely access to care Enrollees, we have provided education to our providers so they know up front what is necessary, prior to submitting an authorization for services. Our associates and medical directors review all aspects of an Enrollee's clinical profile housed in CareCentral as well as the clinical circumstances to inform the decision-making process to reduce the number of provider contactsWe are consistent in providing timely authorizations to ensure that enrollees are able to get the right care at the right time. If after review of the Enrollee's record, additional information is needed, prior authorization nurses outreach to providers and field care managers to obtain the needed clinical information. As needed, our provider relations team can help. Finally, our providers have the liberty to discuss cases with Dr. Shaps as well as WellCare's medical directors who review service authorization requexts by following a well-defined process.

Our policies ensure covered services are furnished in an amount, duration and scope that align with an Enrollee's person-centered needs and care planning goals. We do not arbitrarily deny or reduce benefits in amount, scope or duration solely because of an Enrollee's diagnosis, type of illness or condition.

We will meet the requirement for timeliness standards for Kentucky as outlined below:

- Standard Authorization Request: Two business days upon receipt of request, with an extension up to 14 days, upon request – Today, **99% of prior authorization requests are processed within 24 hours**
- Expedited Authorization Request: If determined to be an expedited request, we will turn the request around within 24 hours
- Substance Use Disorder (SUD) Request: Is considered an Expedited Authorization Request which we will turn around within 24 hours
- Post-Services (Retrospective) Review: Completed within 14 days with an extension up to 14 days, upon request

- Written Confirmation: In accordance with Enrollee rights and responsibilities, and upon request, written confirmation of our decision is provided within three days, if initial decision was not in writing
- Peer to Peer Outreach: We make our doctors available for peer-to-peer outreach with our network providers to discuss individual cases and move quickly on authorizations. This process allows our communicty based clinicians to discuss member needs and collaborate on an evidence-based plan of care.
- Dedicated Expedited Team: Our dedicated team helps expedite authorizations for services requiring that level of expedition. This team allows for quick decision making and appeal if necessary.

v. Approach to integrate medical and behavioral health services in the UM program.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH SERVICES IN THE UM PROGRAM

WellCare has built a fully integrated, person-centered model of care – the hallmarks of which are that all services are managed within our one entity, using one comprehensive approach, leveraging one integrated team, supported by one single system, CareCentral, built specifically to serve Medicaid (and other government) programs. In our UM program, we manage all domains with WellCare associates including medical, behavioral and pharmacy. This integration is critical as it helps us better manage Member holistic care based on individual need. Often, when a company carves out BH, UM decisions are determined strictly by mixed-services protocols leading to denials based on siloes of care (i.e. the need being labeled as a "physical health" need or a "behavioral health" need.) This fragmentation can leave the provider to work between multiple entities and the Enrollee lacking needed care.

At WellCare, we do things differently. Our UM nurses and social workers look at Enrollee needs holistically. If a provider is requesting inpatient psychiatric care, we train and alert our social workers to evaluate for co-morbid physical conditions that may be triggering the Enrollee's psychiatric condition. They are able to see this because medical management platform shows a single integrated view of the Enrollee regardless of primary condition. They are then able to confer with our multi-disciplinary team of nurses, psychiatrists and other medical professionals to help the provider determine the best course of treatment and ensure the Enrollee gets clinically-guided care to match their specific co-morbidities. And upon discharge, the integrated discharge team can create a discharge plan that address both medical and behavioral needs. Because of our single integrated platform and integrated staff, we are able to establish medical necessity and facilitate Enrollee transitions without further burdening the providers or Enrollee in the process. Some key features of our integrated approach to UM include the following:

Single, centralized UM Platform: We developed CareCentral, our clinical and care management platform, to house all BH and physical health UM and authorizations into a single Enrollee view. Fully integrated with our single claims systems, it provides a complete view of each individual's health record, medication history, unmet health-related resource needs, claims history, authorizations, and care plans. All clinicians and service providers have access to this complete picture of individual Member needs across the entire spectrum of care when considering authorization decisions and utilization trends.

Integrated Clinical Leadership and Staff: Local clinical leadership represents physical, BH, pharmacy, , and social services expertise, and is integral in designing and implementing cohesive population health strategies and programs to improve health outcomes and enhance care coordination and Member satisfaction. Dr. Shaps and our local BH medical director integrate into local clinical leadership to conduct joint rounds and consult on cases with multiple comorbidities. We conduct multidisciplinary rounds to collaborate on the coordination of care for our Inpatient Enrollees. This approach provides an opportunity for a team review of the clinical reasons for the Member's admission to determine the appropriate path to discharge and remove any barriers that exist to effective transitions. Through this approach we review outpatient service requests and consider the Member's entire history in the context of a requested service. We devote significant attention to investigating the nuances of integrated service delivery, soliciting perspectives from an array of providers and community advocates.
Integrated Guidelines: One hundred percent of our CPGs emphasize integration of physical and behavioral health across health domains.

vi. Approach to ensure UM Program is compliant with mental health parity.

MENTAL HEALTH PARITY

WellCare was an early adopter of utilization management policies in support of mental health parity rules in consultation with our state partners. **Attachment C.10.b.vi WellCare Parity Submission Form** shows our compliance with mental health parity requirements and regulations. Because our services are provided in house, we were able to review the service requests, perform complex parity analysis on Enrollee access by type, category and location of service. We are responsible for all UM activities. In addition, policy and criteria changes were implemented by a single team inside a single system without the need of negotiating with an outside vendor. This single team gets feeback from both our internal BH and medical directors and receives feedback from our UMAC members. These UMAC members have both a BH and medical backgrond.

We continually support compliance with mental health parity by:

- Making sure our utilization grids comply with mental health parity
- Providing ongoing expert consultation and recommendations regarding compliance with MHPAEA as specified in the benefit plan
- Verifying medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits
- Ensuring the criteria for medical necessity determinations for mental health or SUD benefits are available to Enrollees, potential Enrollees, and network providers by making our level of care and coverage determination guidelines available online
- Ensuring plan benefits include a clear description of the behavioral levels of care and covered services
- Maintaining a clear and easily accessible process for filing appeals and complaints, which complies with regulatory requirements
- Offering robust provider network and monitoring the availability of providers

- Providing a clear reason to Enrollees and providers for any denial of reimbursement or payment with respect to mental health or SUD benefits

Our UM Program complies with federal laws and regulations on mental health parity, including the Mental Health Parity and Addiction Equity Act (MHPAEA), and federal regulations. We do not require referral for behavioral health services, and we ensure that Enrollees have access to a mental health or substance dependence assessment without requiring prior authorization. Specialty services like psychological testing require authorization, which similar to authorization for medical specialty providers. To ensure ongoing compliance with parity requirements, we established and maintain a cross-functional task force with executive leadership support that audits, monitors compliance, and collaborates to ensure behavioral health and substance use disorder services remain in parity compliance with physical health services. The task force conducts a thorough review of the impact of MHPAEA to all key functions covering our benefits, clinical management processes, and network contracting.

In 2017, WellCare developed a template analysis document, using the CMS Parity Compliance Toolkit, published in January 2017 as a guide. The document is the basis for assessing our compliance with the MHPAEA. Within it, there are five sections, each addressing a specific parity component. Those are: Benefit Classification; Analysis of Financial Requirements, Quantitative Treatment Limitations (FRL), and Aggregate Lifetime and Annual Dollar Limits; Non-Quantitative Treatment Limits (NQTL); and a Compliance Monitoring Plan. **Our internal audits have shown we are consistently within parity along each domain.** We will leverage this experience continuously monitoring our compliance to annually submit a completed standardized parity analysis workbook, developed by DMS, to demonstrate compliance. To ensure ongoing parity, we have accountable leaders in our Product team and our PHS team responsible to review parity status, along with Kentucky behavioral health leaders including our Behavioral Health Medical Director Dr. Timothy Houchin and Lori Gordon, our Director of Behavioral Health when we have changes with benefits or UM authorization requirements. Our template analysis document was submitted to the Commonwealth for their submission to CMS for compliance.

vii. Approach to ensuring accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers.

ENSURING ACCOUNTABILITY FOR DEVELOPING, IMPLEMENTING, AND MONITORING COMPLIANCE WITH UM POLICIES AND PROCEDURES

To ensure accountability for the development, implementation and monitoring compliance with UM Policies and Procedures, WellCare of Kentucky has two primary teams dedicated to support these activities: the UMAC and the QIC. A formal process of tracking is used for each activity with senior leadership accountable for each area.

Development of Policies and Procedures

Our Chief Medical Director for Medical Management oversees a dedicated team that is responsible for development and updating of all UM medical and behavioral P&Ps. The team consists of research writers and analyst working directly with Medical Directors and UM

operation leaders to develop P&Ps that align with DMS' contract requirements. All P&Ps are tracked and submitted for a two-level approval process in our internal C360 (Compliance) system. All P&Ps are reviewed and updated annually and more frequently as we are notified of updated state requirements. With notification of updates or changes in DMS' policy, the appropriate P&P is pulled for update with specific state addendums to memorialize the change. Additional tracking and approval is then performed by the assigned physician reviewer/approver.

To prepare for implementation of the P&Ps, a dedicated team of documentation writers prepare step by step document tools (Step Action Tool - SAT) to assist in the training of our UM staff. These SATs are role based documents that provide support to the process outlined in the P&Ps. Our Vice President of UM Operations has accountability for the UM leadership to review and sign off on the SATs that will be the basis of our initial implementation training and ongoing up-training.

Implementation of Policies And Procedures

Our Vice President of UM Operation and National Chief Medical Director are accountable for the accurate implementation of the UM P&Ps. Supporting both leaders is our Enterprise Learning and Development team. To prepare our associates for implementation of the Kentucky P&Ps, a robust training program is developed by a dedicated team of trainers. The training team consists of Trainers and Designers who have knowledge of the UM SATs/P&Ps and system workflows. Using these tools, they create a curriculum that is role based and provides training on operational process application, clinical criteria application and system documentation application.

Upon hire, all clinical services staff responsible for medical necessity reviews complete a two-week orientation followed by four weeks of classroom-based, instructor-led training. All training is tracked in WellCare University, our platform that provides education to our associates.

Following training, newly hired associates are subject to routine compliance assessments to ensure appropriate review completion, including timeliness, case notes, evaluation criteria, use of prior authorization tool, and notifications. Additionally, we perform ongoing audits of clinical documentation and review decisions of all staff throughout the year to ensure accurate and consistent application of criteria. As training and education are ongoing processes, WellCare provides its clinical reviewers with scheduled case studies to review and complete throughout the year. These reviews reinforce our commitment to inter-rater reliability (IRR) to proactively track and monitor decision-making so it is both consistent and evidence-based.

Monitoring Compliance with Policies and Procedures

Our commitment to ensuring consistent application of criteria is further demonstrated through our investment in our Dedicated Performance Monitoring Team. In partnership with the UM departmental leadership, clinical (licensed) associates within UM-medical and behavioral, and appeals are identified and participate in monthly performance review with audit tools approved by UM leaders. The UM Performance Monitoring Team comprises 10 licensed auditors, completes three reviews per assigned associate monthly to measure adherence to UM

performance requirements. Monthly audits of random, targeted samples, measure adherence to department processes and quality process measures. Audits are used to ensure WellCare is meeting contractual requirements such as turnaround times, Enrollee experience and outcomes. We evaluate important elements of needs assessment, discharge planning, Enrollee engagement, care coordination, follow-up for goal achievement, and Enrollee needs in medical necessity reviews. UM teams who are responsible for identifying opportunities for improvement and taking action receive summary reports, including staff training and coaching. The team also compiles and analyzes data to identify trends related to associate, team and departmental performance. This data report is made available in SharePoint and reviewed monthly in business meetings with UM leaders. We formally track and review Performance Monitoring results in our monthly Business Performance Governance meeting.

Our KY UM leaders are accountable to address areas that need improvement and take the appropriate action including team up-training and individual coaching. For associates with compliant review performance scores, UM leaders meet with individual associates. Each leader completes coaching sessions for associates within 30 days of a completed audit and is included in Associates annual performance review.

Inter-Rater Reliability Testing (IRR)

WellCare also conducts online IRR testing using a commercially-available IRR product for all clinical review staff involved in assessments, service plan development, and utilization decisions. We use nurse and team/plan-specific effectiveness reports to include work load/productivity and approval rates that help us identify needs for process, system, criteria updates or other training. At least annually, our staff completes the interactive assessment through a variety of case scenarios for their respective areas of focus (e.g., behavioral health, durable medical equipment) and must assess if the services are to be approved or denied. All associates tested must achieve at least 85% on their IRR assessment. Those scoring less than 85% undergo training, coaching, and additional oversight until they achieve desired performance expectations. Continued poor performance results in additional disciplinary action including termination of employment.

Out of 123 associates 80% passed on the first try. Of those who didn't 96% passed on the second attempt.

viii. Processes and resources used to develop and regularly review Utilization Review (UR) criteria.

WellCare is continuously enhancing our proprietary coverage to meet the needs of those we serve. We have 126 proprietary physical health, behavioral health and pharmacy guidelines in our library. These guidelines reflect evidence-based practices from leading specialty associations, colleges and societies (i.e., American Psychiatric Association, American Geriatrics Society, American Diabetes Association) as well as peer-reviewed literature and studies.

Our guidelines address the quality of clinical care and non-clinical services, including availability, accessibility, coordination and continuity of care. Our clinical leadership team and guideline methodologists review thousands of articles each year to validate specialty society and society guidelines or to create proprietary guidelines when those do not exist. They then apply the

clinical evidence and their knowledge of health care and the populations we serve to create our evidence-based guidelines.

MEDICAL POLICY COMMITTEE (MPC)

The MPC, our dedicated guidelines and fully integrated oversight committee, oversees the development and maintenance of guidelines. MPC is comprised of all corporate and market physical and behavioral health medical directors. Beyond implementation of existing guidelines, the MPC monitors the need for new guidelines, called Clinical Coverage Guidelines and oversees their development and maintenance. Clinical Coverage Guidelines are reviewed annually and approved by the Medical Policy Committee prior to being sent to the UMAC committee. MPC uses a variety of inputs to determine need including utilization management and clinical data, variance in care data, information regarding new treatments and technology as well as feedback from providers, Enrollees, staff and others. Our in-house pharmacy team promotes adherence to AHCA guidelines. Medical policy recommendations and decisions are then reviewed by our Utilization Medical Advisory Committee (UMAC) as described below.

To ensure alignment with Medicaid benefits and policy, we evaluate our universe of existing guidelines, against the Commonwealth of Kentucky's requirements and other sources to identify if additional guidelines are needed, as may be the case for some select home and community-based services (HCBS). If new guidelines are needed, we systematically review and develop the guidelines with input from providers, Enrollees, staff and others as necessary.

In addition to evaluating the need for new guidelines, we evaluate our existing guidelines for needed revisions for the Kentucky Medicaid membership. Guidelines are created internally, per our standard procedures, and submitted to Kentucky as part of our readiness review. As with new guideline development, revisions are analyzed against evidence-based practices from leading specialty associations, colleges and societies as well as peer-reviewed literature and research studies for rigor and clinical relevance. We assure that all nationally-recognized quality measures, are incorporated. We engage with local providers for additional input, where appropriate.

UTILIZATION MANAGEMENT ADVISORY COMMITTEE (UMAC)

Included in our development process is consultation with contracted health professionals to maximize the practicality and utility of final guidelines. This assures critical evaluation and modification against local standards and resources. We apply this practice in Kentucky where guidelines are reviewed by our UMAC.

Our UMAC represents a clinically integrated membership. We have participation from primary care physicians, nurse practitioners, psychiatrists as well as pediatricians and other specialists. Membership is geographically diverse with providers joining us from counties across the Commonwealth: 2 from Paducah, McCracken County; 1 from Jackson, Breathitt County; 1 from Louisville, Jefferson County; 1 from Glasgow, Barren County; 1 from Richmond, Madison County; 1 from Corbin, located in both Whitley and Knox counties.

The UMAC committee meetings are a great opportunity for the local providers to give input into policies and guidelines at the same time they take part in the approval process.

Attendance from Kentucky's medical and behavioral health medical directors and pharmacy director, clinical leadership and staff from various units including: Provider Relations, Risk Management, Appeals & Grievances and Quality add a comprehensive and interdisciplinary focus as we review guidelines and discuss educational and preventive initiatives for the Kentucky population. These reviews allow for a wide range of medical knowledge, including local community-based experience related to caring for our Enrollees. Upon UMAC approval, guidelines are submitted to the state for review. We apply proven strategies to integrate evidence-based guidelines into decision making for our Enrollees which is evaluated and shared with the UMAC, including:

- *Align accountability:* We align accountability for guidelines and clinical decision making under singular leadership within our clinical organization.
- *Use guidelines to develop care and service plans:* Our care managers use guidelines to develop person-centered care and service plans that describe condition-specific measurable health outcomes, guide care planning and development of individualized health outcome goals, offer guidance to build self-management skills, recommend condition-specific educational resources and supports, and provide pharmacology information.
- *Incorporate guidelines into medical necessity review criteria:* Our clinical coverage guidelines are incorporated into the clinical management platform, as we do for our other Medicaid and Medicare programs. Staff systematically engages with the guideline recommendations as they complete medical necessity reviews.
- *Apply evidence-based guidelines into development of discharge plans:* Concurrent review staff uses guidelines to prepare discharge plans for Enrollees with an inpatient admission.
- *Factor evidence-based guidelines into decisions about Enrollees education and covered services:* We assess Enrollees and provider education materials, covered services and more against guidelines to ensure alignment with recommendations and standards of care.

ix. Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization, including methods for assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope.

PRIOR AUTHORIZATION FOR NON-PARTICIPATING PROVIDERS

Our UM Prior Authorization team has processes implemented to address non-par provider requests. This includes understanding need for Continuity of Care and Transition of Care and other provider exceptions, such as second opinions. First, our team determines if there is a need for the Enrollee to remain with the non-participating provider, such as when the service is not provided by an in-network provider. In general, our process is to redirect our members to a participating provider. By following the standard UM process WellCare ensures that a consistent, repeatable process is followed for each request. If unable to re-direct, the non-par provider request follows the standard UM process. However emergency medical services provided by non-par providers for our members do not require an authorization.

We recognize, particularly when working with complex physical or behavioral health conditions, Enrollees may have existing relationships or specialized needs that fall outside of our

contracted network. These steps include assessing the quality of the provider, documenting expectations, coordinating care, and monitoring and assessing the care provided.

Because out-of-network providers are not credentialed with us, we may lack information about their qualifications. Therefore, prior to authorizing services, we first review and verify the provider's qualifications using a variety of methods including state and federal registries for sanctions, internal and external consultation and review of publicly-available databases.

Once a provider's qualifications have been verified and evaluated, we negotiate a single-case agreement with the provider clearly outlining the scope of what is authorized and terms of the agreement including that the provider must work directly with WellCare for services beyond the initial scope. Upon execution of the single-case agreement, we provide a WellCare-issued provider identification number to the providers, which is needed to access our systems

EXPEDITED AUTHORIZATIONS

Our UM team has an Expedited Team handles both in-network and out-of-network provider authorizations with a focus on timely, accurate turnarounds. The team monitors requests to ensure timely review and resolution of all requests. The team utilizes standard reports that are generated at regular intervals during the weekdays and on weekends/holidays.

ENSURING SERVICES ARE NOT ARBITRARILY OR INAPPROPRIATELY DENIED OR REDUCED IN AMOUNT, DURATION, OR SCOPE

WellCare of Kentucky has a process for a Medical Director to review specialty referrals, Inpatient stays and Outpatient services when established criteria does not reflect medical necessity which ensures appropriate utilization decisions are made. Our policies and procedures ensure covered services are furnished in an amount, duration and scope (42 CFR 440.230) and align with an Enrollee's person-centered needs and care planning goals. We do not arbitrarily deny or reduce benefits in amount, scope or duration solely because of an Enrollee's diagnosis, type of illness or condition or if services are provided by an in- or out-of-network provider.

To ensure appropriate utilization denial decisions, a Medical Director or Dr. Shaps may collaborate telephonically or in person with the PCP or attending physician.

The Medical Directors have access to board certified specialists for consultation if necessary when making a utilization decision in determining medical necessity.

Board-certified physicians are the only reviewers permitted to deny any request based on medical necessity. Additional board-certified medical directors support pharmacy PA requests on an ongoing basis. Our clinical reviewers are pharmacists and physicians who use their professional judgment to approve or deny requests based on clinical parameters. One hundred percent of our reviewing pharmacists hold a PharmD degree and are permitted to approve requests. These pharmacists may deny requests for administrative reasons only (i.e., missing clinical information) but not for medical necessity.

x. How the Vendor will use its Utilization Management Committee to support Utilization Management activities.

WellCare of Kentucky's Medical Director Dr. Shaps, oversees and exercises operating authority over the UM Program in the state and chairs the UMAC, a multidisciplinary committee comprising a range of providers within the WellCare of Kentucky network (e.g., Family Medicine, Internal Medicine, Pediatrics, Behavioral Health, etc.) and across the regions in which we operate. The UMAC includes executive and senior leadership from WellCare's departments such as Utilization Management, Care Management, Quality, Provider Relations, Network and Pharmacy. The UMAC gives providers a mechanism for actively participating in the review and approval of the health plan's clinical coverage guidelines. Additionally, the UMAC:

- Reviews and approves clinical policies, medical necessity criteria, treatment protocols as well as UM policies and procedures on an annual basis and more frequently as necessary
- Providing peer review of all professional and technical activities
- Provides feedback for WellCare's preferred drug list
- Evaluates performance of our vendor's utilization management performance
- Holds responsibility for reviewing UM activities and performance including identifying positive and negative utilization trends
- Provide recommendations to our QIC
- Reviews the UM program description and work plan on an annual basis

WellCare's external UMAC providers are charged with representing their peers throughout the state. This includes providing feedback regarding WellCare's current externally facing policies, performance of vendors, including the effectiveness of the vendor interacting with our provider network, and evaluating the overall utilization management performance of the plan. The services they evaluate include both Inpatient and Outpatient care, and includes both physical and behavioral health. Our external providers' feedback help shape future policy, take our local network into consideration and ultimately help improve member outcomes. For example, Dr. Donald Wilson, an Obstetrician/Gynecologist who works at Primary Plus in Lewis County provided direction for the utilization of 17-P, a medication used to prevent preterm birth, in rural Kentucky.

WellCare understands that improved member outcomes and the continued success of our performance in the Kentucky needs input from our provider partners. Quarterly meetings, along with ad hoc meetings, help us to enhance our outputs with affect both internal and external stakeholders. For instance, during a quarterly UMAC meetings Dr. William Mitchell, from the University of Kentucky, has provided useful advice regarding the approach to appeals that are frequently overturned and how to evaluate services provided to retro-eligible members. These meeting have helped to build relationships with our providers and strengthen our footprint in Kentucky. Our UMAC members continue to push us for improvement and are valued members of the WellCare team and WellCare community.

- Attachment C.10.b.vi WellCare Parity Submission Form (Provided Electronically)

11. Monitoring and Oversight

C.11. MONITORING AND OVERSIGHT

a. **Describe the Vendor's proposed approach to internal monitoring of operations to ensure compliance with this Contract.**

b. **Describe the Vendor's proposed approach to providing oversight of its Subcontractors, including examples of actions the Vendor takes when a Subcontractor is found to be non-compliant or when performance improvement opportunities are identified.**

C.11. MONITORING AND OVERSIGHT

WellCare of Kentucky complies with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 21 Monitoring and Oversight of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

As we have been an active participant in the Commonwealth of Kentucky for 8 years , we actively participate in all scheduled meetings, respond quickly to Department inquiries and findings from monitoring and oversight activities, respond to requests for corrective action plans, provide reports within the timeline required by and as requested by the Department, among other activities.

a. Describe the Vendor's proposed approach to internal monitoring of operations to ensure compliance with this Contract.

WellCare of Kentucky is committed to partnering and exchanging information and ideas with the Department of Medicaid Services in a shared effort to ensure compliance in the Medicaid Program. **WellCare of Kentucky's Chief Compliance Officer, Rebecca Randall, has been with our plan since the launch of the Kentucky Medicaid Managed Care Program in 2011** and serves as the primary contract for and facilitates communications between Contractor leadership and the Department relating to Contract compliance issues. As mandated under Section 9.2, she oversees WellCare's contract implementation of and evaluates any actions required to correct a contractual deficiency or noncompliance with the contractual requirements. Rebecca reports directly to the WellCare of Kentucky's Chief Operations Officer, Ben Orris. Members of our Fraud, Waste and Abuse team and the Special Investigations Unit team also have regular meetings with DMS' Program Integrity Team and have direct access to DMS staff to discuss cases they refer to DMS.

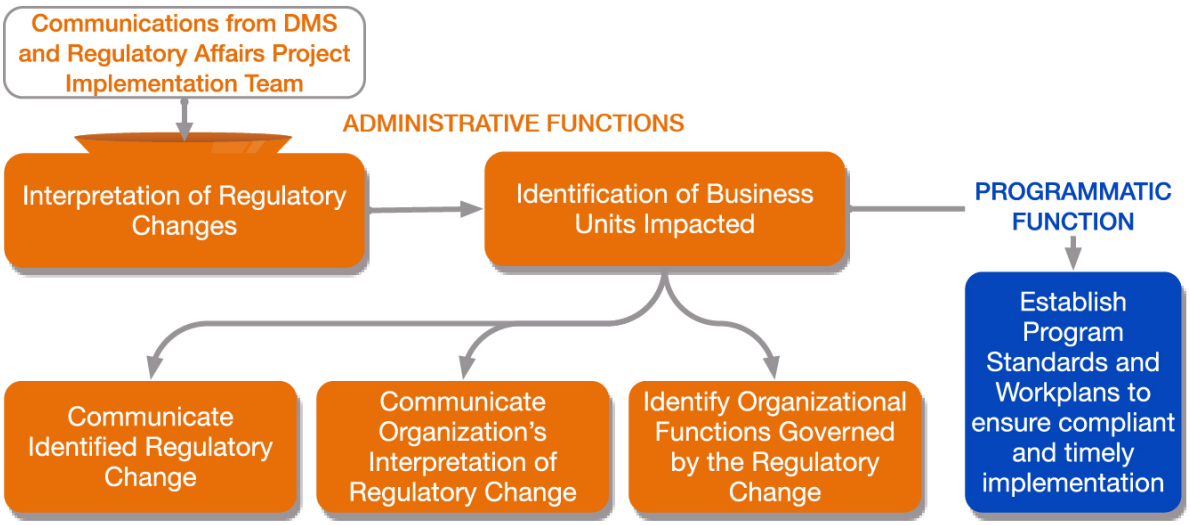


Figure C.11-1 Internal Compliance Monitoring Workflow

ADMINISTRATIVE FUNCTIONS

Our internal compliance monitoring program is closely aligned with the Centers for Medicaid Services (CMS) Model Compliance Program. Administratively, we work towards:

- Establishing a process for distributing and communicating new regulatory changes and contract modifications across the enterprise (including vendors); and
- Creating accountability for receiving regulatory information, operationalizing the regulatory requirements and monitoring performance against established standards (unless otherwise specified).

Examples of this include our established communication channel with DMS (KY_DMS_INQUIRY@wellcare.com) that ensures the regulatory team receives all communications (inquiries, directives, etc.) from the Department. The Regulatory Affairs Staff, led by Rebecca Randall, monitors this email box, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET and is available during this time to respond immediately to any compliance related issues, concerns, complaints and/or inquiries. The Kentucky Regulatory Affairs Staff disseminates the information to appropriate accountable staff as needed. All entries are tracked until completed.

We also have a dedicated Regulatory Affairs Project Implementation Team that interprets regulatory changes and their potential impact to internal operational processes. This local team, led by WellCare of Kentucky's Chief Compliance Officer, Rebecca Randall, determines which business units are impacted and/or governed by the particular regulatory/contract change and provides the following, as depicted in **Figure C.11-1**:

- A synopsis of the identified regulation/contract change/legislation or the regulatory citation;
- the organization's interpretation of the regulation/contract change/legislation; and
- the identification of organizational functions governed by the regulatory change;

PROGRAMMATIC FUNCTIONS

Once new regulatory requirements are provided to impacted business unit(s).,the Regulatory Affairs Implementation Project team works closely with the various business units to establish program standards and work plans in accordance with specific regulations/contract requirements/legislation to ensure compliant and timely implementation.

The Regulatory Affairs team also documents changes through amendments to policies and procedures. New regulatory requirements are added when they become effective. All policies and procedures are reviewed annually (at minimum) by the Regulatory Affairs Team to ensure all regulatory requirements are documented and up to date.

Efforts are already underway to identify and interpret changes to the current contract defined in the RFP for this proposal which will take place upon contract award. Each identified change will follow our already established procedures for analyzing and implementing regulatory changes.

PROGRAM COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS

WellCare's compliance program is based on the seven elements of a compliance program which include:

1. Maintenance of standards and expectations of conduct in the form of a Code of Conduct and Business Ethics (“the Code” or “Code”),
2. Policies and procedures,
3. Education of our associates,
4. Maintenance of communication mechanisms to raise questions or report compliance concerns,
5. Monitoring of associate and company compliance with the internal policies and/or state or federal requirements,
6. Regular auditing, and
7. Use of appropriate discipline for instances of non-compliance.

Our program requires continual compliance with the rules, regulations and laws and encourages associates, members and providers to report suspected non-compliance through the maintenance of a non-retaliation policy.

WellCare of Kentucky has established a comprehensive compliance plan that further details each of the seven elements of our compliance program. WellCare of Kentucky submits its compliance plan as part of the annual EQRO Audit process and will also provide to the Department as needed as part of readiness review activities.

WellCare’s Compliance Department monitors all Board Members, Associates, Vendors, Contractors (Providers) and Subcontractors on a monthly basis. This monitoring includes review of Medicare/Medicaid Sanction Exclusion and Reinstatement reports, the List of Excluded Individuals and Entities, Medicare Opt-Out listings, System for Award Management Exclusions,

professional licensing actions and internal Provider performance monitoring through the collection and review of grievance and adverse event information.

DEDICATED COMPLIANCE PERSONNEL - LOCAL PRESENCE

In addition to Regulatory Affairs personnel, WellCare of Kentucky has a dedicated Market Compliance Director, Aubrey Harmon, who is located in Kentucky. Our Corporate Compliance department is responsible for promoting, executing and maintaining our compliance program and supports the culture of compliance required of all associates. Ms. Harmon functions as the local contact for the CCO and the Corporate Compliance department's functional units, and oversees the identification, tracking, mitigation, and reporting of operational compliance risks.

Ms. Harmon participates in executive team meetings and works with key business owners to develop a Compliance Risk Profile (CRP). The CRP is a continuous risk assessment of contractual and regulatory managed care obligations. Ms. Harmon reviews the risk assessment results and works collaboratively with business owners to determine requirements for which periodic monitoring will be performed by the business owner, and validated by the Market Compliance Officer.

WellCare's Corporate Chief Compliance Officer (CCO) oversees the operation, management, and execution of WellCare's compliance program, ensuring that the program is integrated into all operations of the organization. The CCO has a dedicated team of compliance professionals to provide oversight and monitoring of all activities.

WellCare of Kentucky also maintains a Market Compliance Oversight Committee (MCOC) that meets quarterly to identify and review key compliance risks, issues, and/or concerns related to legislative, regulatory, or contractual requirements, including those risks identified in the CRP. The MCOC promotes business engagement and open communication and coordination of compliance matters, regulatory notices, and compliance changes. Market Compliance Director, Aubrey Harmon chairs the MCOC, which consists of senior WellCare of Kentucky leaders including but not limited to, Bill Jones, State President, Ben Orris, COO, Terri Flanigan, Vice President, Field Health Services, and Bonnie Irvin, Vice President, Field Network Management.

WellCare's Chief Auditor is responsible for leading Internal Audit functions and reports to the Audit, Finance, and Regulatory Compliance Committee and has a dotted line reporting relationship to both the Chief Financial Officer and CCO. 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. Specific to compliance, Internal Audit provides independent, objective assurance designed to add value and improve WellCare's operations by bringing a systematic and disciplined approach to evaluate the effectiveness of the organization's control, risk management, and compliance processes.

COMPANY-WIDE DEDICATION TO COMPLIANCE

Our compliance program also requires that all associates know and understand their individual responsibility to report all suspected incidences of noncompliance. Associates have easy access to numerous Corporate Compliance resources, including trainings, policies and procedures, our anti-fraud plan, our compliance plan and our Code of Conduct. WellCare's compliance reporting and inquiry system ensures efficient and confidential communication between the Compliance

Department, the CCO, associates, officers and directors, agents, first tier, downstream, and related entities, members, and other stakeholders. The Compliance Hotline and Web Portal are central components of WellCare's compliance reporting and inquiry system. By accessing the Compliance Hotline or Web Portal, associates and others can report compliance program violations 24/7. Hotline calls and web entries are reviewed by Compliance department staff and followed through with the assistance of department managers (e.g., Legal, Human Resources and Finance). Consistent with Compliance best practices, an independent third party vendor hosts the Hotline Web Portal, ensuring complete anonymity. Associates are obligated to report actual or suspected violations of the law or WellCare's Code of Conduct or policies. Callers who report violations may remain anonymous upon their request.

b. Describe the Vendor's proposed approach to providing oversight of its Subcontractors, including examples of actions the Vendor takes when a Subcontractor is found to be non-compliant or when performance improvement opportunities are identified.

SUBCONTRACTOR OVERSIGHT

WellCare recognizes and supports the enhanced oversight, transparency and reporting requirements for this new contract. Our Kentucky Subcontractor Oversight Team, led by Ben Orris, is supported by multiple subject matter experts across our company. As part of their negotiating and contracting processes, our National Network Performance Team ensures all required Kentucky-specific contract standards are included in our Kentucky subcontracts, and also aligns these standards with monetary performance incentives and penalties. In addition, our Network Performance Team handles initial subcontractor onboarding, including orientation to WellCare of Kentucky's processes and expectations, completion of pre-delegation documentation, and coordination of pre-delegation audits. Finally, our corporate Oversight Team uses their national purchasing experience to identify best practices from other markets, such as mobile Diabetic Retinal Exams, so that they can be incorporated to improve WellCare of Kentucky's operations and quality of care. They also periodically re-procure our subcontracts to ensure we are partnering with the strongest organizations and obtaining the best value for the subcontracted services.

After onboarding, the team continues to monitor performance. The Delegation Oversight team performs pre-delegation audits, monthly metric monitoring, annual audits, data analysis, and other focused audits of delegated subcontractors. The team uses a suite of audit and monitoring tools that are based on State and Federal requirements and National Committee for Quality Assurance (NCQA) accreditation standards.

Reporting deliverables, complaints and inquiries are tracked within LIONS and C360. In the instance of reports, each month, the Oversight Team generates a report of all deliverables due. If a Subcontractor is responsible for a regulatory report, the Regulatory Affairs team sends a reminder to the Subcontractor contact stating the due date. The report is to be delivered to the plan, with the appropriate attestation to accuracy, by the due date and the Regulatory Affairs team submits it to the Commonwealth. If a Subcontractor fails to deliver the report in a timely manner, they are subject to reimburse the plan for any penalties assessed by the Department. The issue is escalated internally to the Subcontractor management team who will determine if

further corrective action is warranted. Repeated violations of contractual obligations could be justification of contract termination.

Delegation Oversight uses a risk-based approach to determine the scope and frequency of post-delegation review by establishing an annual audit plan, conducting focused audits as needed, and ongoing monitoring activities. WellCare Delegation Oversight completed 781 in 2018; 80 of them specific to Kentucky Medicaid delegates. 88% of these audits were complete by December 31, 2018. Delegation Oversight initiates corrective action plans on delegated subcontractors as necessary and monitors their completion. If a delegated subcontractor fails to remediate the deficiency underlying the corrective action plan, WellCare imposes disciplinary action up to and including termination of the delegation agreement. Delegation Oversight's activities are managed through the company's governance tool, Compliance 360 (C360), which enables accurate tracking and reporting.

In addition to a formal annual audit, WellCare regularly monitors all delegated subcontractors through monthly scorecards. The results of these monitoring and oversight activities are discussed directly with the delegated subcontractors and the Kentucky Regulatory Affairs Team through Joint Operating Committee (JOC) meetings. These meetings include discussions of any performance issues, including outstanding corrective action plans and the status of remediation efforts. More detailed information regarding our subcontractor monitoring and oversight follows.

MONITORING PERFORMANCE

A key component of subcontractor oversight is monitoring the quality of work performed by the subcontractor. We hold regular JOC meetings with our subcontractors to monitor performance level reports and scorecards, identify and address service and quality issues, and design and execute quality improvement initiatives. We typically hold these meetings monthly, but for subcontractors with broader member impact, such as Dental and Transportation, we hold them bi-weekly (and even more frequently if needed, such as during Contract implementation). Key examples of our monitoring approach and its connection to the quality of work performed by our subcontractors include:

- Regular reviews of subcontractor complaint and grievance data, as these can be indicators of quality issues such as inadequate access to care (e.g. inability to find a dentist specializing in sedation treatment in a rural area);
- Analysis of HEDIS results and other measures of population health and quality of care;
- Identification and execution of innovative strategies to close care gaps and improve quality of care such as Mobile Dental and Vision screenings; and
- Sharing these results with our key quality governing committees (e.g. QIC and UMAC) and utilizing the feedback to improve subcontractor performance.

Our quality monitoring through our JOCs is supplemented by our Delegation Oversight Team's independent review of metric driven scorecards. Our Delegation Oversight Team has

established core functional scorecards that include metrics required under our Contract, NCQA standards, and other regulatory guidance. Scorecard metrics reported include, but are not limited to, service levels for utilization management, claims, customer service, case management, credentialing, provider terminations, encounter data reporting, network access and availability, and applicable HEDIS measures (e.g. for dental and vision services).

A total of 173 scorecards were received and reviewed during 2017 for WellCare of Kentucky subcontractors; 179 in 2018. Scorecards are received from subcontractors each month (quarterly for credentialing activities) by the 10th day of the following month. A Delegation Oversight auditor with appropriate subject matter expertise conducts a review to assess compliance. In addition to monthly scorecard reviews, our Delegation Oversight Team audits all of our subcontractors annually, and more frequently if explicit risks or deficiencies have been identified. The results of these scorecard reviews and audits are shared with WellCare of Kentucky's Regulatory Affairs and Compliance teams and if potential noncompliance is identified, an appropriate plan of action is agreed upon, possibly including a formal corrective action plan. The corrective action plan is monitored by the WellCare of Kentucky's Regulatory Affairs and Compliance Teams. For CAPs issued in connection with a scorecard deficiency, the subcontractor is expected to show three (3) consecutive months of compliance before CAP closure is recommended.

TRIGGERS FOR INCREASING MONITORING ACTIVITIES, INTERVENTIONS AND CONTRACT COMPLIANCE ACTION

WellCare of Kentucky's approach to addressing Subcontractor performance issues is based on a progressive escalation process that spans across isolated events that can be quickly addressed by the subcontractor, to repeated issues of a significant nature requiring consequential action by WellCare of Kentucky. The following are the four key phases of our escalation process illustrated in **Figure C.11-2**, along with the "triggers" for increased monitoring activities, interventions and Contract compliance actions.

Figure C.11-2 Escalation Process Phases

Phase 1: Isolated Events that can be Quickly Addressed

As previously described, we have multiple mechanisms for becoming aware of emerging subcontractor performance issues, including metric / scorecard monitoring, complaints and grievances (including those from the Department), regularly scheduled subcontractor audits, member feedback from our Consumer Advisory Boards, JOC meetings with our subcontractors, and our WellCare of Kentucky Quality and Compliance governance meetings. After assessing the issue and confirming its impact, we request the subcontractor to identify and implement a remediation plan and our Compliance team will develop an Internal Action Plan (IAP) to track it to completion.

Example of Oversight and Correction

WellCare began receiving provider complaints in late 2017 regarding inaccurate payments being issued for claims in which the member had primary coverage through Medicare. Upon identifying this trend, WellCare was able to take examples of claims back to our claims department for additional review. Upon further research it was determined that these claims were being manually reviewed by a claim processor employed by one of our vendors. It was determined that the processor was not following the appropriate step action document for proper adjudication. Through additional training and quality assurance monitoring, WellCare was able to address this issue to ensure future claims reviewed by this processor were adjudicated correctly.

Phase 2: Focused Monitoring

For issues with broader impact across our members and providers, we initiate focused monitoring processes to ensure there is a clear plan of action and timeline for resolving the issue. Accordingly, the frequency and intensity of WellCare of Kentucky's oversight will be greater than in Phase 1. In 2018, 75 focused audits were completed at WellCare, with 4 of them specific to WellCare of Kentucky.

An example of a Phase 2 situation was our Dental subcontractor's challenges with collecting appropriate copays for members as the result of a new DMS regulation. After an escalated complaint was received from a dental provider, WellCare performed a focused review of our Dental subcontractor's process for adjudicating claims for members under the age of 19. After completion of this review it was determined that our subcontractor was inappropriately deducting copayment for dental claims for members under the age of 19 years (which is not allowed under the new regulation). We worked with our subcontractor to develop an action plan to remediate this issue and established a daily meeting series to ensure to review 1) the root cause of the issue and 2) develop a remediation plan to ensure future claim adjudication adheres to the regulation. As a result of this focused effort, our subcontractor was able to successfully implement scripting changes within their claims processing system to ensure future claims were not impacted.

Phase 3: Formal Corrective Action Plan

For more widespread and significant situations, we initiate formal corrective action plans (CAPs). One potential trigger for a formal CAP is a subcontractor's performance on their annual audit. We have developed comprehensive audit tools based on State and federal requirements (e.g. HIPAA), specific Kentucky contract requirements, NCQA standards, and Kentucky Medicaid policies. We require annual audits to demonstrate 100% compliance of all elements reviewed. Any annual audit with less than 100% results in a CAP. In 2018, WellCare issued 201 CAPs enterprise-wide with just 4 of them specific to WellCare of Kentucky.

A second potential trigger for a formal CAP is a focused review. Delegation Oversight may initiate a focused review at any time during the year, based on monitoring activities performed, high-risk areas identified (including those by regulatory agencies), or requests from WellCare of Kentucky leadership. Focus reviews are performed to identify the root cause and scope of potential noncompliance on a targeted topic. Examples of focused reviews conducted include,

but are not limited to, UM decision timeliness, UM denial rationales, encounter data completeness, member notifications, and EPSDT services. Findings are shared with WellCare of Kentucky leadership and communicated to the impacted subcontractor. If non-compliance is identified, a formal CAP is initiated and tracked. Evidence required for CAP closure is most often transactional data of at least three (3) consecutive months of compliance demonstrated in a file review, universe of transaction turn-around times, or other evidence of monitoring.

A third trigger for a CAP is a pattern of missed service level agreements on our monthly scorecard monitoring process. In this situation, the subcontractor is placed on a CAP and required to demonstrate three (3) consecutive months of compliance before CAP closure is recommended.

By way of example, in Q4 2017, WellCare became aware of an issue with our subcontractor, eviCore, regarding the notice of adverse benefit determination (NABD) letters. These are letters given to members notifying them that a prior authorization request for services has been denied. The NABD letters generated by eviCore did not contain the appropriate language block (1557 disclaimer) that was approved by the Kentucky Department for Medicaid Services and required by CMS.

WellCare's Delegation Oversight Department performed a focus audit of eviCore's denial letters in Q1 2018. Through the focus audit, WellCare identified that some letters were non-compliant with the 1557 disclaimer. These results were shared with the contract manager who issued a directive for a corrective action plan to have all corrected letters in place within 30 days of the focus audit findings. eviCore confirmed the updated letters were placed into production in July 2018.

WellCare continued to pull random samples to verify that eviCore has completed the corrective steps for full remediation of this issue. Our delegation oversight team also performed a follow up focus audit on the NABD letters in Q4 2018 which yielded no further concerns.

Phase 4: Continued Non-Performance/Material Non-Compliance

Phase 4 is reserved for the most significant situations that call into question whether the subcontractor can continue performing services for members and providers on behalf of WellCare of Kentucky. Examples of such situations include financial insolvency, material compliance findings such as fraud or exclusion from government health care programs, or the continued inability to remediate documented CAPs. If any of these scenarios occur, they will be closely monitored by WellCare of Kentucky leadership and our Delegation Oversight Committee. In the case of failure to remediate a CAP, we will impose disciplinary action, which may include financial penalties, until the issue is remedied. If the disciplinary actions and financial penalties fail to achieve the desired result, the subcontractor's delegation agreement may be terminated or revoked. In the case of insolvency or material non-compliance such as fraud or exclusion, we are required to immediately terminate the contract. We would both identify and implement a new/replacement subcontractor, or insource the delegated services, given careful consideration to the impact on our members and providers. In either scenario, once we determine that the subcontractor will no longer be able to provide the delegated services, we immediately notify the Department of the situation, member impact, and

immediate next steps, as well as establish a process for ongoing communication and updates. To date, we have not had to do this in Kentucky.

TECHNOLOGY SUPPORT OF PHASES AND ESCALATION PROCESS VIA C360

Our approach to addressing subcontractor performance via a progressive escalation process is supported by our compliance management system, C360. C360 manages all elements of the audit and oversight process, including communications, documentation and evidence, and the automatic assignment of CAPs for non-compliant elements. It also provides transparency to all management levels involved in the oversight of subcontractors and enables accurate tracking and reporting. Standard reporting includes monitoring and auditing activities performed, status of audits and monitoring plans, metrics on outstanding CAPs, and trending of subcontractor performance through scorecards.

12. Enrollee Services

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C.12. ENROLLEE SERVICES

a. Describe the Vendor's operation of the Enrollee Services call center including:

i. How the Vendor will monitor and ensure full staffing during operational hours.

ii. Examples of training and resources provided to call center staff.

iii. Approach to using back-up staff to support increased call volumes, how the Vendor ensures such staff are trained and have the correct materials specific to the Kentucky Medicaid managed care program, and location of these staff.

b. Describe the Vendor's approach to Enrollee outreach and education, including the following at a minimum:

i. Overall approach to educating and engaging Enrollees about topics such as but not limited to Covered Services, accessing care, availability of the Population Health Management program, and improving overall health.

ii. Topics the Vendor proposes to be priority areas of focus for Enrollee outreach and education.

iii. Initiatives and education (health literacy) the Vendor will use to drive appropriate utilization and cost-effective health care services.

iv. Collaboration opportunities with other contracted MCOs, CHFS Departments, and community partners to support Enrollee needs through joint outreach and education.

c. Describe methods for communicating with Enrollees as follows:

i. Creative efforts to achieve high levels of Enrollee engagement (e.g., smart phone applications,) to educate Enrollees and to communicate information for their individual health issues.

ii. Approach to identifying, developing, and distributing materials that will be of most use to Enrollee populations, and efforts the Vendor proposes to target distribution to specific populations as appropriate.

iii. Methods of leveraging communications to meet the diverse needs and communication preferences of Enrollees, including individuals with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

d. Provide a summary of innovative methods and the Vendor's proposed outreach plan to assess the homeless population.

e. Describe the proposed approach to assess Enrollee satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends, and use of findings to support ongoing program improvement.

f. Provide the following sample materials:

i. Draft Welcome Packet and Enrollee ID card aligned with the requirements of RFP Attachment C "Draft

ii. Sample Enrollee Handbook meeting the requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

iii. Three (3) sample Enrollee materials with taglines and displaying ability to meet translation, accessibility and cultural competency requirements.

C.12. ENROLLEE SERVICES

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 12 Enrollee Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Leading Enrollee Satisfaction in Kentucky
With the highest Enrollee satisfaction scores of all the Kentucky Medicaid MCOs, our dedicated approach has made WellCare of Kentucky the plan of choice in the Commonwealth—with **over 80%** of Enrollees choosing our health plan as the best option.

Since 2011, we have dedicated our organization and staff to understanding and serving the needs of the people of Kentucky. Through our high-capacity communication channels and a robust staff of dedicated Enrollee Service Representatives (ESRs), we listen to our Enrollees to provide both first-call resolutions and connect those who need it to a deeper level of clinical support that addresses their immediate and long-term comprehensive, whole-person needs. Our outreach channels include a suite of digital smartphone applications connecting Enrollees to easily digestible information and access to our online wellness programs that empower self-sufficiency and healthy behaviors. Enrollee education and outreach extends to the materials we develop in both print and for our digital channels with specific health care needs and guidance in mind.

Lastly, led by our Chief Executive Officer (CEO), William Jones, WellCare of Kentucky has always been a boots-on-the-ground organization. With six regional offices spread across the Commonwealth supporting more than 430,000 Enrollees, our ESRs, coordination staff, community health workers (CHWs), and community engagement team rally our community partners around the Enrollee—creating a collaborative approach to comprehensive support through our Community Connections program that addresses social determinants of health (SDOH) along with their physical, behavioral, and pharmacy needs. The following section describes our Enrollee Services model and the dedicated staff that listen, engage, and follow through every day to help the people of Kentucky with their immediate and long-term healthcare needs.

a. Describe the Vendor's operation of the Enrollee Services call center

Available between the hours of 7:00 a.m. and 7:00 p.m. Eastern Time (ET) Monday through Friday, WellCare of Kentucky's operation of the Enrollee Services call center fully complies with the requirements of Section 22.1 Required Functions. With an average of 38,000 calls per month, our call center serves as a direct line of communication for when Enrollees need help with their questions, want to know how to best access their benefits, and for when they don't know where to turn. Our highly dedicated staff is trained to promptly assist the caller, address

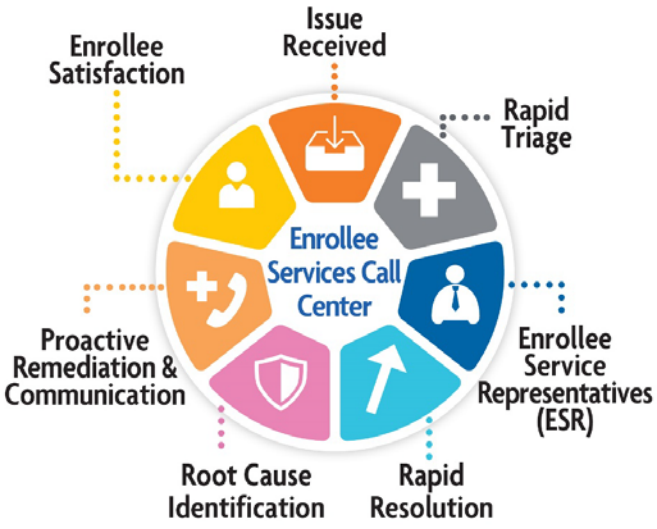
their immediate issues, facilitate follow-up with our care coordination team, and do so while providing superior customer service.

To properly support our Enrollees in the Commonwealth, WellCare of Kentucky's service delivery model for our Enrollee Services call center includes our Work-At-Home- Agent (WAHA) service model staffed by associates located in Kentucky. These Kentucky-based associates are fully trained and supervised virtually using all of our call center tools (i.e., call monitoring, call recording, queue management, etc.). Combined with CAREConnects, our award winning, proprietary agent desktop solution, our WAHA strategy enables us to deliver a localized approach to Enrollee Services through Kentucky-based associates. WAHA allows for rapid deployment during non-forecasted demands, seasonal peaks, hard to staff shifts and crisis management. This approach, supported by an outstanding training model, gives us access to a broad talent pool from which to recruit and hire, with no geographic restrictions. Supporting our team of WAHA staff, we have dedicated more than 170 Kentucky-trained ESRs working together in a single location who have been trained specifically on the Kentucky Medicaid program.

Since the beginning of managed care in the Commonwealth, we have annually exceeded the Health Call Center (HHC) standards set by the Utilization Review Accreditation Commission (URAC). Adhering to the contract requirements, we will continue to report our monthly call center performance, including abandonment rate, blockage rate, and average speed of answer for both our Enrollee Services call center and the Nurse Advice Line (NAL) to DMS.

The following describes the operations of the Enrollee Services call center.

Enrollee Service Representative Responsibilities: Serving as the first line of communication, ESRs are trained and qualified to respond to all inquiries and supply Enrollees with information on a wide range of topics, such as cost-sharing responsibilities, over-the-counter (OTC) medications available free of charge, instructions for changing their primary care physician (PCP), and helping them obtain a new Enrollee identification (ID) card. Following our established workflow process illustrated in **Figure C.12-1**, every ESR is trained to address and resolve the Enrollee's immediate issue or connect them to our internal clinical lines, such as the NAL, for triage and support provided by a qualified healthcare professional. The ESR informs every caller of their rights and responsibilities, collects updated demographic information, facilitates the Enrollee grievance process (and the filing of appeals when requested), responds to questions regarding the Enrollee Handbook and our other communication channels, and



C.12-1 Call Center Workflow

connects the Enrollee to the care coordination team whenever they require access to a specialized provider (e.g., special healthcare needs, long-term complex health conditions).

In addition, ESRs assist with access to services, such as scheduling EPSDT appointments, providing information or referring to support services in the community, such as the local WIC office for food assistance, or community support groups and health education programs associated with our population health program (i.e., tobacco cessation, Alcoholics Anonymous). ESRs inform callers about services they may not be aware they have access to, such as our valued-added services (VAS) for adult vision benefits, the financial incentives of our Healthy Rewards prevention program, home-delivered meals, health coaching for weight loss, and our Safelink smartphone program. In addition, we facilitate Enrollee access to non-emergency medical transportation (NEMT) if they do not qualify for the transportation services maintained by DMS. All callers receive follow-up support when necessary, which may include enrollment in our care coordination and population health programs to address their comprehensive, whole-person needs.

One-Call Resolution Standard: As illustrated in **Figure C.12-2**, our guiding principles drive our mission to provide a best-in-class experience so Enrollees feel comfortable and in charge of their healthcare experience and supported by their MCO every step of the way. Not only do our ESRs assist our more than 430,000 Enrollees in the Commonwealth with their physical health, behavioral health, pharmacy, and SDOH needs, but by working as an integrated unit, the Enrollee Services team resolves Enrollee calls on the first try nearly 90% of the time with no hold time, cold transfers, or additional numbers to call. We attribute this performance to our One Call Resolution standard. We treat every call as another opportunity to inform our Enrollees about how to best access their benefits and covered services and the channels available to do so. For example, we educate them on accessing the secure Enrollee portal and the MyWellCare smartphone application for self-service functions, which includes staying up-to-date with the action steps of their person-centered care plan to maintain health, attend appointments for preventive services, address care gaps with the help of their PCP, and address their SDOH needs through our Community Connections program's Community Connection Help Line (CCHL), which facilitates access to our local social services partners.

Better Access to Self-Service Convenience

In 2018, more than 3,500 Enrollees ordered ID cards online and more than 6,500 Enrollees changed their PCP using either the Enrollee portal or the MyWellCare smartphone application.

Figure C.12-2 Enrollee Services Guiding Principles

In the event that an Enrollee requests an issue be escalated to a supervisor, we have an established escalation process in place to ensure ultimate Enrollee satisfaction and resolution of their issue or question. In rare cases, we take complex issues offline to discuss possible resolutions before calling the Enrollee back in a timely manner with a solution.

Call Center Technology: CAREConnects is our customer relationship management tool that provides ESRs with a 360-degree view of the Enrollee. This data includes open care gaps, previous call history, call resolutions, PCP assignment, demographics, utilization history, claims history, medications and adherence, referrals to address SDOH through our Community Connections program, care coordinator assignment, and other pertinent information that facilitates their ability to resolve calls and connect them to follow-up care. CAREConnects generates guidance scripts and system alerts to help the ESR handle each call efficiently and appropriately. We document all call information into the system, including the purpose and resolution that will be accessible as part of the Enrollee history. CAREConnects helps ensure that our staff engages the right person at the right time for the right answer to assist Enrollees.

In addition, we leverage the Genesys® PureConnect™ Cloud platform, which powers our telephony environment with geographically redundant services connected to our WellCare Health Plan's 28 call centers across the country by dual 10 Gig fiber channel MPLS networks.

Call Routing Procedures: As an integrated call center with a "no wrong door" policy, we assist Enrollees with their comprehensive needs and bring in care coordinators, registered nurses from the NAL, or the licensed mental health clinicians (LMHCs) supporting the Behavioral Health Services Hotline whenever necessary. Our call center staff operates as a unified team, with 90% of calls resolved during the first conversation as part of our One Call Resolution standard. We leverage our high-capacity call center technology—including our award-winning proprietary desktop solution CAREConnects and our hosted Automated Call Distribution (ACD) system Interactive Intelligence (I3)—to ensure **Enrollees receive the right support, from the right specialist or representative, at the right time**. The ACD solution provides intelligent skills-based routing of telephone calls, voicemail, email, and internet-based interactions (e.g., text chats, web callback requests). The ACD solution includes a full-featured interactive voice response (IVR) functionality and speech recognition tools. Enrollees can use the IVR at any time and perform many service-related functions independent of a call center representative. Other key features of our ACD system include:

- *Virtual Hold:* In the event that call volume is high, callers are offered the option to remain on hold for the next available ESR or to receive a call back, without having to remain on the line and without losing their place in queue. This allows callers to go about their busy lives and eliminates the need to be on the line during an “on hold” situation.
- *Reporting Capabilities:* Our ACD system capabilities include generating reports on a daily, weekly, or monthly basis to monitor our call center performance and inform our workforce planning.

Warm Transfers and Escalations: CAREConnects enables our ESRs to add additional members of the Enrollee Services team to assist with a call, whether it be a qualified nurse from the NAL, a

care coordinator, or behavioral health clinician supporting the hotline. In addition, the ESR can add a WellCare of Kentucky patient care advocate (PCA) to the call to help address complaints, or a supervisor when the Enrollee requests that the call be escalated to a member of the management team.

Routing to Behavioral Health Services Hotline: As part of their training, ESRs learn to recognize verbal triggers that may indicate an emergent behavioral health issue. When this occurs, we activate the crisis button in CAREConnects to alert a call center supervisor of the situation and automatically generate a guidance script that directs the ESR to remain on the phone with the caller while simultaneously connecting to a behavioral health clinician supporting the Behavioral Health Services Hotline. Our ESR provides a warm hand-off, including caller background information regarding the purpose of the call. In addition, our Interaction Analyzer software performs call analysis to identify specific word and phrase combinations that indicate a serious emergency or potentially life-threatening situation. The hotline provides Enrollees with 24-hour support with drug and alcohol abuse and behavioral health concerns. Applying a person-centered approach to service, hotline representatives provide crisis triaging to assess the Enrollee's need for crisis services, urgent care, or connection to their care coordinator and multidisciplinary team (MDT) for immediate engagement.

Routing to the Nurse Advice Line (NAL): Our centralized NAL provides Enrollees with medical advice and direction twenty-four hours a day, seven days a week from qualified physicians, physician assistants, licensed nurse practitioners, and registered nurses. In addition to triaging, NAL staff educate Enrollees about appropriate utilization of services; **in 2019, NAL staff diverted 68% of Enrollees to a lower, appropriate level of care who were initially inclined to seek ED services. In 2019, 99% of calls were answered within 30 Seconds (80% or greater is required) with only 1.39% abandoned calls, much lower than the required 5%.**

Enrollee Engagement - Outbound Calls: Our Care Center located in Hazard, Kentucky is an outbound call center dedicated to contacting Enrollees with open care gaps and alerting them of upcoming recertification deadlines so they do not lose their eligibility and access to health services. The Care Center was born out of an innovation that was originally intended to support Kentucky HEALTH Enrollees who required assistance with navigating the obstacles of the 1115 Waiver program.

We took this opportunity to go on the offensive, and developed a proactive customer service approach that performs outbound calls to Enrollees at risk of a suspension. As a result of the delay and eventual suspension of Kentucky HEALTH, this team now focus on member outreach calls to address health needs of our most vulnerable and at risk members.

Language Access: We comply with all the requirements of 42 C.F.R. 438.10(d) and translate all materials, including digital content, to Spanish and other languages upon request, including Braille. The Enrollee Services call center is staffed with English and Spanish speaking representatives. We provide telephonic interpretation at no cost through our dedicated language line, which supports over 200 languages, including American Sign Language. On-demand, trained, and experienced interpreters provide a seamless language experience

addressing our Enrollees' courses of treatment, medical history, and health education. **The year-to-date average speed of answer for the language line is 6.6 seconds, meeting or exceeding the target 100% of the time.** We also arrange for in-person interpreters to support Enrollees at their medical appointments. In Bowling Green, for example, we have responded to the recent demand by our Somali-speaking Enrollees, providing interpreters and ensuring that language is not a barrier to accessing care.

i. How the Vendor will monitor and ensure full staffing during operational hours

WellCare of Kentucky continuously monitors our Enrollee Service call center staff and forecasts when we may need to increase staffing to ensure we exceed our service standards during operational hours. **Chief Operating Officer Ben Orris, is responsible for the oversight and monitoring of the call center to ensure DMS's standards are being met**, including ensuring staffing levels to meet the call volume needs. He has real time access to WellCare's Command Center, to monitor the service levels at any time. Additionally he is provided dashboard reports that detail the Kentucky call center's service levels five times throughout each day. Our operational Command Center is staffed by a centralized team of analysts who continually monitor the Kentucky call center volume capacity and performance. We invest in industry leading call center technology and tools to ensure we will always have a Kentucky-trained ESR available to assist Enrollees at this critical touchpoint. We also have cross-trained staff available to assist Enrollees.

PRECISE FORECASTING: NICE WORKFORCE MANAGEMENT TOOL

Our Command Center workforce analysts leverage the capabilities of our **NICE Workforce Management (NICE WFM)** platform which forecasts precise

daily staffing models and individual staff schedules based on historical call volumes including seasonal cycles such as enrollment periods, population size, call handling times, time of day, and other data to meet all contract requirements and deliver best-in-class customer service. To ensure we can absorb any unanticipated spikes in call volume, we add an additional 10% staffing capacity to our forecasts. We also monitor the average speed of answer, abandoned call rate, blocked call rate, average hold time, timely response to inquiries, accurate response to inquiries, and phone etiquette - all intended to provide first call resolution.

MONITORING PERFORMANCE: GENESYS WORKFORCE OPTIMIZATION TOOL

The Genesys Workforce Optimization tool generates service level data in 30-minute intervals, such as number of callers on hold, average speed of answer, abandonment rate, blockage rate, and other metrics against the number of ESRs available to assist Enrollees. When our performance measuring tool alerts the command center analysts of dips in service levels, they deploy a load-balancing action plan consisting of progressive step actions to return performance within service levels. A detailed description of this plan is included in our response to 12.a.iii. With an experienced team operating the call center combined with industry-leading technology, we have not only met the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for each of the past three quarters, but have

significantly exceeded these requirements. For example, the average rates over the past three quarters are as follows:

- Blockage rate=0% (10% is the requirement)
- Abandonment rate=1.5% (5% is the requirement)
- Average speed of answer=16 seconds (30 seconds is the requirement)

AFTER-HOURS SUPPORT

For Enrollees requiring assistance outside of our normal business hours, they can access the NAL and the Behavioral Health Services Hotline 24/7. We include these phone numbers on all printed materials, online, and via the MyWellCare smartphone application. Through our self-service Enrollee portal, which is available 24/7, Enrollees can order ID cards or handbooks, search for providers, and find information about benefits, covered and non-covered services. Our language line is available 24/7 with 2,000 interpreters, on call, capable of translating 200 languages including American Sign Language. Finally, Enrollees can leave a voicemail message, and an ESR will respond by the next business day.

ii. Examples of training and resources provided to call center staff.

We believe the first call is the only call a WellCare of Kentucky Enrollee should have to make to get the right answer or be connected to the care coordination team to help address their whole-person needs. To achieve and maintain our first-call resolution standard, ESRs begin training on their first day of hire and build upon their knowledge and skills through ongoing training courses related to both customer service skills and knowledge of Medicaid covered benefits. The rigorous training requirements through our learning and education hub—WellCare University— include more than 160 training hours and a score of 85% or higher on all assessments to successfully become a certified ESR supporting our Enrollees in the Commonwealth.

As a result, our comprehensive training curriculum transforms ESRs-in-training into Kentucky Medicaid experts capable of resolving calls while providing the highest level of customer services.

CALL CENTER STAFF TRAINING

The training provided to our call center staff includes the following foundational Kentucky Medicaid program modules:

Foundational Training. These training topics align our ESRs with WellCare's Enrollee-centered culture, federal rules and regulations, and compliance requirements. Topics include our code of conduct and business ethics; compliance policies and procedures; fraud, waste, and abuse (FWA); HIPAA compliance; quality performance; cultural competency (unconscious bias); and Enrollee rights and responsibilities. All WellCare of Kentucky staff members receive cultural competency training, including disability awareness, to effectively communicate with Enrollees based on their cultural and ethnic backgrounds, disabilities, genders, sexual orientations, and

gender identities. In addition, we require our providers to take a cultural competency course, available through our provider portal.

Functional Training. We educate ESRs on our call center technology and tools for assisting Enrollees with their various needs. We provide intensive training on our customer service management tool, CAREConnects—the core call center technology guiding ESRs through each call to a successful resolution. ESRs learn to identify care needs and schedule provider appointments during the same call; change an Enrollee's PCPs; order new ID Cards and handbooks; connect to the NAL and Behavioral Health Services Hotline; and activate the language line.

Kentucky Medicaid Program Training. We educate ESRs on the Kentucky Medicaid program, including the covered services and benefits. Topics include eligibility requirements; covered and carved-out services, such as non-emergency medical transportation; access to value-added services; our pharmacy program and medication assistance; the Department for Aging and Independent Living (DAIL) clients; and the future SKY program.

Table C.12-1 describes the additional training delivered through a blend of WellCare University modules and in-person instruction.

Table C.12-1 Additional Training

Component	Description
Instructor Training	Trainers lead in-person classroom and virtual instruction on enhancing the Enrollee experience through Kentucky Medicaid program expertise, mastering desktop technology, and effective engagement with individuals who are economically disadvantaged and culturally diverse. Skilled ESRs transition an Enrollee, regardless of their background, from call resolution to care gaps and schedule an appointment with a PCP.
E-Learning	WellCare University provides computer-based training modules for programmatic topics such as covered services, carved-out services, and EPSDT schedules. ESRs-in-training must score at least 85% on the knowledge and skills assessment as a condition of employment and to advance to the practical component of the training curriculum.
Supervised Experiential Training	Training leaders supervise in-person the ESRs-in-training as they begin assisting Medicaid Enrollees. They become certified and can take calls on their own after meeting production goals such as scoring 92% or higher on Customer Satisfaction Surveys and a 90% or higher on call quality.
Continuous Training	Annual training courses and scored assessments on Fraud, Waste, and Abuse, HIPAA, Cultural Competency, Compliance Policies and Procedures, and other topics. Supervisors also provide "on the floor" training to guide ESRs through more complex calls and provide in the moment feedback.

Component	Description
Cross Training	Our highest-performing ESRs are cross-trained with provider call-center curriculum, giving them the depth of knowledge to increases their skill level to resolve more complex calls.

CALL CENTER STAFF RESOURCES

As every contact with an Enrollee is an opportunity to educate and engage them in their health, ESRs assess Enrollee needs and provide them with the core managed care services listed in Section 22.1 Required Functions to meet those needs. For example, when a mother-to-be from Paducah calls searching for a provider, the ESR informs the Enrollee that an OB/GYN provider can serve as the PCP, completes the assignment, schedules an appointment, and orders a new ID card. The ESR transitions to informing the Enrollee about our Healthy Rewards program for pre-and postpartum incentives and refers her to the nearest WIC (Women, Infants, and Children) Program office. Before ending the call, the ESR assists the Enrollee with completing the Health Risk Assessment (HRA).

To successfully deliver these in-the-moment services, we provide ESRs with the following resources:

- *Knowledge Management Platform:* Our knowledge management platform guides ESRs through a response algorithm to address caller requests and provides easy to access program information about Kentucky Medicaid as well as the future SKY program, when implemented. For example, when a Perry County Enrollee calls with transportation needs, the ESR quickly identifies our Region 8 community partner, Pennyrile Allied Community Services (PACS), which provides transportation vouchers to assist Enrollees who do not qualify for NEMT services with their transportation needs to medical appointment, the grocery store, or community events.
- *CAREConnects:* Our premier customer service tool provides ESRs with guided scripts to manage a call from beginning to resolution, providing them with a complete view of the Enrollee's needs and the capabilities to meet them.
- *Integrated Platforms:* Our integrated system platforms with bi-directional information feeds enable coordination of Enrollee needs across all domains, providing all Enrollee-facing staff with the comprehensive, holistic view of their medical, pharmacy, behavioral health, and social needs. This includes Enrollee demographics, medical history, as well as clinical and behavioral health information comprising of diagnosis codes, claims, and authorization history.
- *Interaction Analyzer:* This tool recognizes word and phrase combinations signaling a possible crisis situation, and alerts the ESR to take appropriate action such as keeping the caller on the line, alerting a supervisor, and engaging the NAL or Behavioral Health Services Hotline.

In addition, our call center performance auditors monitor at least eight calls for each ESR per month to ensure optimal performance. For new staff, the auditors monitor three calls per ESR per week for the first 30 days. ESRs must demonstrate Kentucky Medicaid program knowledge, skill in navigating call center technology, and deliver exceptional customer service. Our supervisors recognize high-performing ESRs and facilitate their professional development with mentoring, coaching guidance, and opportunities for career advancement. We report all audit reports to the Customer Service Quality Improvement Workgroup for analysis and trending. Each quarter, our Quality Improvement Committee (QIC) reviews the reports and recommends corrective actions if necessary.

iii. Approach to using back-up staff to support increased call volumes, how the Vendor ensures such staff are trained and have the correct materials specific to the Kentucky Medicaid managed care program, and location of these staff.

As we described in Section a.i above, we leverage the capabilities of the NICE WFM platform to monitor call volumes throughout the day to ensure we maintain adequate staffing levels. For instances of unanticipated call volumes, our call center leaders activate a load-balancing action plan to prevent or quickly remediate any impacts to our performance. The plan consists of the following step actions:

- All call center supervisors and team leads log into the call center software and take calls.
- If needed, ESRs and community-based WAHAs (Work At Home Agents) flex their offline time, such as lunch breaks, to receive calls in queue.
- If further action is required, we activate call rollovers to the approximately 1,000 on-demand back-up ESRs who are cross-trained on the Kentucky Medicaid program and tested to Kentucky call center standards.
- Concurrently with these actions, call center analysts research, remediate, and restore the Kentucky call center to full strength and disable call rollovers.

With our investments in call center technology and our rapid response processes, we meet or exceed our service requirements and assist our Enrollees with their needs.

BACK-UP STAFF, TRAINING, MATERIALS, AND LOCATION

We have approximately 1,000 on-demand, Kentucky-trained, back-up staff located in the 28 WellCare enterprise call centers across the country to support our Kentucky call center during periods of unanticipated high call volumes including extreme situations such as natural disasters. Our back-up staff are cross-trained on the Kentucky Medicaid program and have successfully met all training requirements to expertly assist Kentucky Enrollees. Since back-up staff operate from the same CAREConnects system, leverage the same Kentucky Medicaid knowledge platform, follow the same guidance scripts and other Kentucky-specific reference materials, Kentucky Enrollees receive similar high quality levels of service and consistently accurate information as they do from our Kentucky ESRs.

b. Describe the Vendor's approach to Enrollee outreach and education, including the following at a minimum.

WellCare of Kentucky's approach to Enrollee outreach and education began even before the launch of managed care in 2011. Before the enrollment of a single Kentucky Enrollee, we were deeply rooted in the communities learning about the culture of the people, the geographic diversity of the regions, and the local social support organizations they trusted. Through learning about the people in the diverse regions across the Commonwealth, we developed the comprehensive Enrollee outreach and education program described in the following section.

i. Overall approach to educating and engaging Enrollees about topics such as but not limited to Covered Services, accessing care, availability of the Population Health Management program, and improving overall health.

For more than eight years, we have been helping Enrollees learn to eat healthier, exercise more, visit their providers for screenings, and seek care in appropriate settings and cost-effective ways—operating under the belief that all healthcare is local. Today, our education and engagement approach is driven by our conviction that all healthcare is also personal, and therefore, particular to an Enrollee's culture, language, beliefs, community, as well as their health conditions, co-morbidities, and SDOH needs.

Through multiple Enrollee touchpoints, we discuss covered services, accessing care, enrolling in our population health programs, and improving their overall health and quality of life. The following section describes our overall approach to education and engaging our Enrollees.

FACE-TO-FACE ENROLLEE ENGAGEMENT AND EDUCATION STAFFING ROLES

When managed care in the Commonwealth began in 2011, it was evident that reaching our Enrollees to engage them in their health was not going to be achieved through traditional outreach methods or mailing campaigns; it would be accomplished through very personal, face-to-face interactions, feet-on-the-street style education, and the co-location of our associates within the community. Through the following WellCare of Kentucky staff roles, we engage in multiple Enrollee touchpoints to provide education and guide their healthcare experience.

Patient Care Advocates: We staff eight Patient Care Advocates (PCA) who travel onsite at many of our high-volume practices throughout the regions of the Commonwealth to engage Enrollees at the primary care provider's office. As part of the education process, PCAs reinforce health and wellness, schedule follow-up appointments and annual exams, escalate complex issues until resolution, and connect the Enrollee to local partners to address their SDOH through the Community Connections program. For example, if the Enrollee has diabetes, the PCA educates them on the importance of glucose monitoring and retinopathy exams, schedule the follow-up needed and remind them about our value-added benefit offering a pair of eyeglasses for adults.

Community Engagement Team: Our Community Engagement team engages Enrollees at our sponsored health fairs, back-to-school events, and other community events throughout the Commonwealth to educate them about their benefits, covered services, population health programs, and community resources. Often we learn at these events that Enrollees do not have

a comprehensive understanding of the services they are entitled to, including access the Community Connections Help Line (CCHL), available health and wellness programs, or coordination support with non-covered services such as NEMT or state-run programs such as the Health Access Nurturing Development Services (HANDS) program or First Steps early intervention programs.

Enrollee Outreach Coordinators: As part of our field-based team dedicated to supporting Enrollees in rural areas of the Commonwealth, our Enrollee outreach coordinators work with providers, community organizations, and homeless shelters to locate our high risk and disengaged Enrollees for enrollment in our care coordination and population health programs. Our outreach coordinators have located thousands of our Enrollees that cannot be engaged through phone calls, mailings, or text messages. Upon identification, we enroll them in care coordination and address their SDOH through our Community Connections partners.

Health Coaches: Our Health Coaches conduct continuous telephonic outreach to our most vulnerable Enrollees to coach and educate them on recommended critical screenings and preventive services, helping to bring awareness to Enrollee health needs and transform Enrollee lives since the program's inception in February 2019. In addition, we will expand our program to include two additional Health Coach teams comprised of local experts, focusing on smoking cessation, obesity and pre-diabetes/diabetes.

COMMUNITY ENGAGEMENT

Making a Local Impact on SDOH

Since launching the Community Connections program in Kentucky, we have connected more than 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in emergency department visits, and a 53% decrease in inpatient spending.

Now a national model implemented at all our health plans across the country, the Community Connections program was developed specifically for the Kentucky market in 2011. We leverage this proven model with the unique innovations put forth by the Commonwealth to evaluate and improve Enrollee health and well-being. Our WellCare of Kentucky field-based community engagement team is responsible for continuing development of our grassroots, data-informed community partnerships throughout the Commonwealth that help our Enrollees address their SDOH. The team proactively works alongside local organizations to address social barriers and increase the strength of the local safety net infrastructure for each region. Our team members live locally in the communities they serve, many who have lived experience and understand the needs of our Enrollee population firsthand. Using social service data, the team identifies when and where services are needed and then mobilizes resources to develop the needed service.

TELEPHONIC OUTREACH

Within the first 30 days of enrollment, our ESRs call new Enrollees to conduct a brief HRA, confirm they have received their Welcome Kits, inquire about their present health concerns, and provide information about accessing their covered services, value-added services such as

the Healthy Living program, enrollment in population health programs based on their medical conditions, and offer to make their first PCP appointment. The following WellCare of Kentucky staff roles engage our Enrollees in ongoing telephonic outreach to provide education on their healthcare services.

Field Outreach Coordinators: The field outreach coordinators exclusively outreach to Enrollees with the purpose of enrolling them into our care coordination program. This dedicated team of staff is solely committed to connecting with Enrollees by using multiple data systems and connecting with an array of providers associated with the Enrollee's care. In 2018, the field outreach team reached more than 3,600 unable to contact Enrollees, of which 1,652 were enrolled into our care coordination program to better manage their physical, behavioral, pharmacy, and SDOH needs, co-morbidities, and chronic conditions.

Care Needs Coordinators: Our team of six care needs coordinators focuses on Enrollee engagement through telephonic outreach by leveraging our data analytics platform to identify those most in need of support. Care needs coordinators outreach Enrollees who are disengaged from medical care, have chronic conditions, and need of preventive services. Through this engagement process, we can bring Enrollees back into the managed care environment to better coordinate their services between all providers, including the MDT, and remove their barriers to care, while also providing vital education that places them back on a path toward wellness. Through careful guidance, care needs coordinators help non-compliant Enrollees previously disengaged with the healthcare system schedule and attend their PCP and specialty provider appointments and build trust that empowers them to improve their health.

Care Needs Coordinator Impact

An Enrollee, who was homeless, was identified as having a care need related to his medication adherence and recommended screenings and connected with a QI Care Needs Coordinator. Numbers to available resources were shared by our QI Care Needs Coordinator in addition to offers for a referral to Care Management. The Enrollee refused a referral to Care Management but he did have access to a telephone so our QI Care Needs Coordinator would call him periodically to check on him. Through the resource numbers provided, the Enrollee was able to find a stable place to live. On a subsequent call, the Care Needs Coordinator was able to help him get an appointment with his PCP, connect with Member Services to update his new address, and to obtain an insurance card. The Enrollee expressed that he felt he was now on a path to get his life on track.

Care Coordinators. Care coordinators use advanced clinical judgment and critical thinking skills to facilitate appropriate physical and behavioral healthcare and social services for Enrollees. They coordinate the care and services of selected Enrollee populations across the continuum of care and place Enrollees in the appropriate population health program based on their health conditions and personal goals. The care coordinator ensures that Enrollees receive appropriate, quality care that is cost-effective, working directly with the Enrollee while collaborating with the MDT to assess, plan, implement, coordinate, monitor, and evaluate services and outcomes to maximize the health of the Enrollee.

Health Coaches. An Enrollee-dedicated coach guides the Enrollee along the path to better health while providing education on healthy behaviors. Coaches use motivational interviewing techniques to engage the Enrollee and develop trust. We focus on motivating the Enrollee to receive consistent care from their PCP to avoid more costly services, providing education on appropriate prevention services, and maintaining the appointment adherence for chronic conditions. They work closely with Enrollees who have health literacy barriers to ensure they understand their care needs and assist with other barriers to care through referrals to our care management team and the Community Connections program. They have made nearly 5,000 outreach calls with more than 2,000 of them successful.

Care Center. In 2018, WellCare launched a dedicated Care Center in Hazard, Kentucky to perform outbound calls to Enrollees in the Kentucky HEALTH waiver program. This team was created to assist Enrollees who were at risk of losing their benefits for failure to pay premiums, not meeting the community engagement requirements, or were potentially eligible for medically frail status. With the suspension of Kentucky HEALTH, this team has been performing outreach to Enrollees who are approaching their recertification date or have unmet care needs.

Peer Support Specialists. Our peer support specialists support the Community Connections Help Line (CCHL) as a vital component of the Community Connections program. Specialists refer Enrollees (and non-Enrollees) to our community partners to address their SDOH. We identify needs based on resources accessed through the model, proactively designing programs to close care needs. **In Kentucky in 2019, WellCare of Kentucky completed 1,409 community activities, reaching 37,509 community stakeholders.**

DIRECT MAIL EDUCATION CAMPAIGNS

We recognize that the traditional process of mailing educational information to our Enrollees is still an effective component of a well-rounded engagement strategy. As such, we send the following printed Enrollee education materials by direct mail: New Enrollee Welcome Kit, Enrollee Letters, Wellness Exam Reminders, Birthday Cards, EPSDT Calendars, Periodicity Letters, Quarterly Newsletters, and Disease Education.

DIGITAL CHANNELS

We maintain a secure, Enrollee portal and the MyWellCare smartphone application to provide Enrollees with simple, modern channels of communication that allow us to easily engage them through education materials and self-service functions from the convenience of any web-enabled device. These applications enable the following functions:

- Enrollees can access the information distributed through our direct mailing campaigns, such as covered services, preventive care, and our Healthy Rewards program. They can easily replace an ID card, change their PCP, or find a provider based on specialty and location
- For immediate services in their community, Enrollees can identify the nearest urgent care center, order OTC health-related products, or learn more about employment opportunities through the WellCare Works program

- Leveraging text messages, we send notifications that alert our Enrollees to opportunities in the community to address their SDOH and preventive care educational information
- Our social media channels, including Facebook and Twitter, pushes out education information, stories, and tips via the web

ii. Topics the Vendor proposes to be priority areas of focus for Enrollee outreach and education.

We believe the topics proposed by DMS are the most critical and prevalent issues that we should continue to address through proactive outreach and education. By continuing to teach our Enrollees about the topics of population health, access to care, covered services, and improving overall health we can help them prevent the onset of health issues and connect them to the best resources for the management and treatment of existing conditions.

TOPIC #1: POPULATION HEALTH

Our primary goal is to identify and engage Enrollees in their own health using a variety of innovative outreach approaches described above, including face-to-face, telephonic, print materials, and through our digital channels like the MyWellCare smartphone app. We engage Enrollees in each population health program through personal health coaching, face-to-face meetings, peer support, and education on their value-added services that support healthy lifestyle changes. For example, our Healthy Rewards program provides financial incentives for Enrollees who complete preventive health, wellness, and PCP engagement milestones to promote better health outcomes and develop healthy behaviors. We teach Enrollees about accessing our innovative programs, such as MyStrength's online behavioral health coaching platform and the Pacify smartphone application that guides new and expecting mother's on a week-to-week basis with tips and education. The foundational elements of each population health program include access to health education on our public website, the Enrollee portal, the MyWellCare smartphone application, traditional health informational mailings, text messaging programs, and social media. Table **C.12-2** illustrates our population health programs and the associated outreach and education resources for each.

Table C-12.2 Population Health Programs Outreach and Education

Population Health Programs	
Asthma	Our Breath of Life Asthma Program embodies a holistic, comprehensive approach to promoting wellness, improving chronic condition management, and improving population health through collaboration with communities. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on appointment reminders, online self-management tools, available peer support access, our Asthma app, and health coaching. Education materials include a guide for living an active, healthy lifestyle; understanding environmental factors; explanation of health conditions; and the importance of compliance with maintenance medications,

Population Health Programs	
Heart Disease	Our Heart Disease Program supports Enrollees' condition management through education, guidance, and support to learn more about their unique health concerns and to increase their ability to self-manage in accordance with their provider's treatment plan. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on our self-management tools, peer support access, the importance of attending medical appointments with their PCP and specialists, and nutrition and activity guidance.
Diabetes	Our Diabetes Program aims to prevent diabetes from occurring through diet, exercise, medication adherence, and lifestyle changes, helping empower them to achieve positive health outcomes. We refer Enrollees to local resources through our Community Connection model, which can connect them to local partners for physical activity and healthy eating opportunities, and to community prevention programs. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on our diabetes coaching solution which provides personal care through human interaction and technology. Health coaches teach Enrollees about diabetes symptoms, treatments, and tests.
Health Management	Our Obesity Program embodies a holistic, comprehensive approach to addressing one of the most common chronic diseases in Kentucky and is a major risk factor for development of debilitating diseases, such as diabetes and cardiovascular disease. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate and enroll them in our six-month program working with a health coach. The health coach teaches them how to cook healthy meals and develop healthy lifestyle habits. Enrollees receive education materials on healthy eating choices, the benefits of exercise, and identifying diabetes symptoms. We also provide education about financial incentives for completing preventive care and A1C testing, as well as leveraging the MyStrength platform for online coaching and support at they learn new, healthier habits.
Tobacco Use	Our ACT for Tobacco program encourages Enrollees to actively commit to healthy lifestyles and supports those who are ready to quit tobacco. We integrate anti-tobacco education into programming for adolescent Enrollees and continue to offer options for all our young people to make the ongoing decision to stay tobacco-free. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on MyStrength's self-directed online therapy to assist with anxiety, depression, or other substance use disorders that may be related; and the Healthy Rewards program for attending preventive appointments and screenings, as well engaging in healthy behaviors. We also inform Enrollees about accessing the Kentucky Tobacco Quitline for telephonic support and resources in their community. We also offer health coaching, motivational text messaging, and education information on our public website and the Enrollee portal.

Population Health Programs	
Cancer	Our Cancer Program approach includes interventions, goals, and expected outcomes that vary based on diagnosis, risk level, and various other factors. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on the importance of following recommended treatment plans, managing side effects of treatment, taking medications, the impact of mental health, and general tips and guidance. We provide access to cancer education materials specific to their conditions and the care gaps they need to address.
Infant Mortality and Low Birth Weight	Our WellCare BabySteps program improves maternal health and birth outcomes through the delivery of services by multidisciplinary, integrated care coordination and care management services team. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on our incentive program to encourage attendance at recommended prenatal and postpartum care appointments. We provide education materials on pregnancy, postpartum care, as well as access to the Pacify smartphone applicate where they can access the NAL, video chat with a lactation consultant or pediatric nutritionist.
Behavioral Health and Substance Use	Our comprehensive Opioid Misuse Prevention Program is for Enrollees who are over-using opioid medications or appear to be at risk of doing so. Our outreach and education methods are facilitated by our care coordinators who connect with Enrollees to educate them on access to treatment programs and local support groups, the MyStrength behavioral health platform, and peer support access.

TOPIC #2: ACCESSING CARE

We never assume our Enrollees know what services they have access to through their benefits or how to access those services. We use every in-person and telephonic touchpoint, as well as our direct mailings and digital communication channels, to teach and guide Enrollees about accessing their available services for medical issues and to address their SDOH. We consistently educate them on the importance of prevention visits, the role of a PCP, and how to distinguish a medical emergency from a routine visit to promote appropriate utilization of services.

From day one, we start with a Welcome Call, where we can connect Enrollees with a live service representative to schedule their first PCP visit. Enrollees receive our Welcome Kit, which includes the Enrollee Handbook and information on accessing providers in their community. We strive at all times, to maintain a consistent and thorough education process that drives Enrollee engagement and brings information to their fingertips in a simple to understand, digestible format. All of our Enrollee education materials can be directly mailed or accessed online through the portal, website, or smartphone application. In addition to engaging Enrollees to take advantage of the services available, we target specific issues, conditions, and populations with tailored education materials and discussions, such as the following:

- *OB/GYN:* We identify and provide early engagement education for our pregnant Enrollees that include prenatal and postpartum guidance. Identification occurs through the HRA, review of the premium file or examination of claims algorithms, all of which leads to assistance scheduling their first appointment with an OB/GYN provider. We promote our digital programs, including the Baby's First text messaging program and the Pacify smartphone application to provide additional guidance and prenatal support and coaching throughout the pregnancy and postpartum stages. Pacify includes 24/7 video access to certified dieticians and lactation consultants.
- *Appropriate ED Utilization:* Our emergency department (ED) Diversion program serves to educate and empower Enrollees to make the most informed decisions about their health, lower health care costs, and ensure that emergent medical care is available for individuals who are experiencing a physical or behavioral emergency. The Enrollee Handbook and ESRs help our Enrollees learn about the proper utilization of the ED and more appropriate alternatives for non-emergency care, such as local urgent care centers or accessing the NAL or Behavioral Health Services Hotline for triage and guidance. Our Enrollee Outreach Coordinators engage high-utilizers to enroll them in care coordination, teach them about accessing their PCP and prevention appointments, and how to locate alternatives to the ED in their community. The MyWellCare App also provides Enrollees with an easy-to-use search and mapping function that allows them to find the urgent care centers open at the time they are searching nearest to them.

TOPIC #3: COVERED BENEFITS AND OTHER SERVICES

Enrollees who learn about the benefits and services available to them are more likely to use them to get healthy and stay healthy. For example, we inform them about core benefits and our value-added services, such as eye glasses, OTC health and hygiene products, and our Safelink mobile phone program at every in-person, telephonic, digital, and print communication. Our communications team will continue to reinforce Enrollee education through outreach calls from the Care Center, our patient care advocates, and health coaches, while focusing on specific benefits our Enrollees may not be aware of, including the following:

- *Dental Care:* We recognize that dental care is a critical element of whole-person care, playing an important role in the overall health of an Enrollee. We proactively identify those Enrollees who require dental services and who have not received an annual exam or cleaning. Once identified, we work with our dental vendor, Avesis, by sending them a notification of the care gap and perform outreach to encourage service utilization.
- *WellCare Works:* Our community engagement team educates Enrollees about the WellCare Works program—an innovative platform that assists Enrollees in preparing for the workforce and finding a job suited to their experience. We provide one-on-one trainings, including webinars, summits with workforce agencies, and train community partners in an effort to increase education about the program at various Enrollee touchpoints.
- *Value-Added Services (VAS):* We educate Enrollees about not only their covered services and benefits, but also their value-added services that supplement our support through

additional benefits free of charge. These services help our Enrollees fill in critical gaps and not typically covered under the umbrella of traditional benefits that improve health outcomes. Our education topics include discussing access to home-delivered meals, the Healthy Rewards program, health coaching services, access to vision and dental care, job training, and financial education, to name a few.

TOPIC #4 IMPROVING OVERALL HEALTH

We focus on educating Enrollees about the benefits of preventive behaviors for staying healthy and preventing illness. From day one, we provide education on the importance of the PCP and maintaining a consistent relationship with their provider to address their needs while adhering to appointment schedules, treatments, and medications. ESRs and Enrollee-facing staff teach all Enrollees about the role of the PCP, what providers can be selected as a PCP, how to change their PCP using the call center, online portal, or smartphone application, how to schedule appointments, obtain referrals, and understand authorizations. As we auto-assign a PCP upon enrollment, we discuss these topics at the initial Welcome Call and provide clear instructions and education about the importance of maintaining PCP relationships in our print materials.

We tailor materials to our Enrollee populations, such as EPSDT calendars for child and adolescent health maintenance, and annual reminders for adult wellness exams. Enrollee outreach coordinators, health coaches, and care needs coordinators frequently engage with Enrollees one-on-one to provide information about prevention services and our Healthy Rewards incentive program, which rewards individuals for healthy behaviors like seeing their PCP. Enrollees receive a gift card for accessing preventive health screenings, PCP visits, Well-Child visits, prenatal care visits, well-women visits (including mammography, cervical cancer, and chlamydia screenings), diabetes HbA1c screenings and eye exams, and preventive dental care among others.

iii. Initiatives and education (health literacy) the Vendor will use to drive appropriate utilization and cost-effective health care services.

WellCare of Kentucky's Enrollee Services model includes initiatives and education (health literacy) that drive appropriate utilization and cost-effective healthcare services. Our general strategy focuses on implementing the following methods across all our communication channels to teach Enrollees how to properly utilize their managed care services and benefits, as depicted in **Figure C.12-3**:

Figure C.12-3 Components of Health Literacy

- Improving health literacy so that Enrollees feel empowered to access appropriate services and preventive services across the entire spectrum of care guided by our staff engagement, education materials, and communication channels.
- Teaching Enrollees to engage in self-care through adherence to PCP and specialty appointments, as well as through our digital apps and population health

programs that provide one-on-one and online health coaching to guide and support the Enrollee as they manage specific conditions.

- Empowering Enrollees with information that gives them the confidence to navigate the health system, address their comprehensive SDOH needs, and know when and how to contact us through their preferred communication channel whenever they need help.

The following initiatives are examples of how we achieve proper utilization and cost-effective healthcare services.

PROJECT IMPROVEMENT PLAN INITIATIVES

One of the biggest challenges in managed care is finding a way to effectively apply improved health literacy to make sure Enrollees understand how to properly use their services in a cost-effective manner. Through our project improvement plans (PIP), we identified the need to increase health literacy on the following topics:

- Proper use of urgent care centers, local health departments, and PCPs for vaccines
- Risks associated with tobacco use for an unborn child
- Importance of postpartum and dental care
- Appropriate management of COPD
- Available resources to assist with ongoing disease management
- Non-emergent ER utilization

Without knowledge on how to properly manage their health care, Enrollees are unlikely to make informed decisions to improve their health. To address this, we developed and distributed Enrollee-specific informational material, including targeted letters and newsletters for Enrollees to improve health literacy as part of the PIPs. Through telephonic outreach, our care needs coordinators educated Enrollees regarding dental, postpartum, and COPD care, and our care coordinators educated Enrollees with serious mental illness (SMI) on managing their behavioral health issues. We also implemented a 24/7 BabyLine staffed with nurses and available to offer support and answer questions through telephonic interactions with Enrollees. To support tobacco cessation, we referred Enrollees to the Kentucky Quit Line to access support resources in their community. Lastly, we expanded the Healthy Rewards program to include financial incentives for attending dental appointments, well-child visits, and adolescent well-care visits.

HEALTH LITERACY INITIATIVES

Enrollees cannot change inappropriate patterns of seeking care—or may not seek care at all—if they cannot understand healthcare concepts, know how to navigate the system properly, or access education materials and support in their preferred language. To prevent the onset of health disparities caused by low health literacy or jargon-filled materials, we implemented the following measures:

- *Health Literacy Advocate:* Trained in population health and disparities, our health literacy advocate trains associates on the correlations between health literacy and health disparities, and the influence of culture on Enrollees' attitudes about health and treatment.
- *Language Interpretation/Translation Services:* To ensure that speaking a language other than English, including American Sign Language, is never a barrier to understanding their health care, we provide certified oral and ASL interpretation as well as materials translation for all our Enrollees in Spanish and other languages upon request.
- *Accessible Education Materials:* In addition to ensuring materials are written at a sixth (6th) grade reading level, we use Krames easy-to-understand materials. Conveniently located in the Enrollee Handbook, the WellCare of Kentucky Dictionary educates Enrollees on common healthcare terms.
- *Cultural Competency:* All WellCare of Kentucky staff members are required to take cultural competency training to develop skills enabling them to interact effectively with diverse populations. We hire our Enrollee outreach coordinators from the same rural communities as our Enrollees and, combined with our community partners whom our Enrollees trust, we are able to educate them on how to access services appropriately. We also require providers to take cultural competency training accessed from the provider portal.
- *Kentucky Homeplace.* This University of Kentucky program, and a WellCare of Kentucky rural partner, consists of community health workers providing health literacy education to Enrollees (and non-WellCare Enrollees) so they can learn to navigate the healthcare system.

ENROLLEE ENGAGEMENT INITIATIVES

Our mix of engagement initiatives consist of phone calls, mail-outs, and push notifications to mobile devices encouraging Enrollees to follow discharge orders from a hospital or ED, educating them on alternative, cost-effective care sites such as nearby walk-in clinic or urgent care center, promoting preventive care through EPSDT calendars and tying in annual exams with health awareness months (e.g., mammograms in October during Breast Cancer Awareness month). Other initiatives include the following:

- *EOC Program (Enrollee Outreach Coordinators).* An intervention-based initiative, the EOC program consists of field-based outreach coordinators engaging high-utilizing Enrollees and enrolling them in care coordination. Through data sharing agreements, hospitals and other providers furnish reports of Enrollees who have presented for services including their most recent contact information for follow-up by our coordinators. They also notify us of admissions for coordinators to engage at the Enrollee bedside, educate on utilization, and enroll in care coordination. EOC's successful engagement and care coordination enrollment of high-utilizers has resulted in a **22% decline in admissions, a 20% decline in ED use, and a 17% reduction in medical expenses.**
- *Health Coaching.* Our care coaches, specialty-trained in engagement techniques, guide Enrollees towards appropriate utilization by encouraging medication adherence, promoting

appointment adherence for PCP and prevention visits, and providing lower-level, cost-effective alternatives to EDs such as walk-in clinics or urgent care centers.

- *Healthy Rewards Program.* Our incentive program reinforces proper utilization such as well-visits and annual screenings, with reward cards redeemable at local retailers. **In 2019, WellCare of Kentucky closed more than 43,500 care gaps through this program and distributed over $1,018,000 in rewards.**

iv. Collaboration opportunities with other contracted MCOs, CHFS Departments, and community partners to support Enrollee needs through joint outreach and education.

WellCare of Kentucky is a community-anchored, managed care organization (MCO) that values collaboration with our partners in the Commonwealth to support Enrollee needs through joint outreach and education. Since 2011, we have accepted every invitation to participate on state or local community taskforces and workgroups with other MCOs, the Cabinet for Health and Family Services (CHFS) departments, and our community partners. We have seen firsthand how these joint efforts have helped develop a more efficient, unified approach to managed care and we look forward to collaborating on future initiatives.

The following section includes examples of our collaborative efforts to support Enrollee needs through joint outreach and education and proposed initiatives for future discussion.

COLLABORATION WITH MCOs IN THE COMMONWEALTH

Our leadership and community relations teams maintain contact and communication with the other MCOs in the Commonwealth and participate alongside our MCO colleagues through community engagement events and through the Project Improvement Plans (PIP) organized by DMS. In addition, we also contribute alongside the other MCOs on nearly 60 different local coalitions, workgroups, and councils, including the Safety Net Alliance of Northern Kentucky, the Kentucky Coalition for Health Communities, and the Trimble County Health and Wellness Coalition. The following are just a few examples of collaborations that focused on developing education and engagement initiatives to support Enrollee needs:

Foster Care Training Presentation: Navigating Managed Care

As a leader in the development of innovative services and programs for our Enrollees in the foster care system, we led the development of a key training presentation with the other MCOs to help teach foster parents about the managed care environment and accessing their covered services. The training teaches common healthcare terminology, how to access help and support, the available benefits and specialty providers, and how to work with WellCare of Kentucky or other MCOs on any issues they may have while supporting their foster child. Prior to attending the presentation, many foster parents are unaware of the services available to them and appreciate help with learning how to navigate the system. A truly collaborative effort, our Senior Manager of Foster Care, LeAnn Magre (and potential SKY Provider Services Liaison) initiated a workgroup that included participants from each of the MCOs in the Commonwealth. The workgroup met on a monthly basis for more than a year, working together to develop the

curriculum and foster care tip sheet for parents and workers at the Department of Community Based Services (DCBS).

To maximize our engagement and spread this knowledge, we attend regional conferences and parent training sessions organized by the DBCS and other community-based organizations across the Commonwealth. In 2019, we served as the lead presenter for this training at four parent conferences held twice a year, as well as four parent support group trainings throughout Kentucky. Additional examples of collaboration include the following:

- *Passport Health Plan.* We teamed up with Passport Health Plan to support the FARMACY Program at the Letcher County Farmer's Market in Whitesburg. The program features local health providers educating Enrollees on healthy nutrition and writing prescriptions for the market's fresh fruits and vegetables. Together, our combined support enabled **more than 650 individuals from more than 220 families to obtain local produce.**
- *Kentucky HEALTH Forum.* Along with our MCO counterparts, we participated in the 2018 Kentucky HEALTH forum to provide information about how MCOs will support our Enrollees in the program.
- *MCO Joint Flyer.* Led and developed by DMS, we contributed our benefits information and distributed the MCO Benefits Flyer at events and provider offices. This one-stop-shop benefits document displays the benefits provided by each of the five MCOs in the Commonwealth, enabling Enrollees to easily and quickly grasp information regarding their particular MCO.

PROPOSED COLLABORATIONS

Our leadership and community relations team is proposing the following ideas for future MCO-driven collaborative efforts focusing on joint outreach and education to support Enrollee needs.

- *Rural Collaborative Health Fair.* We attend and participate at events across the Commonwealth to meet our Enrollees and share information while meeting them face-to-face in their community. Along with many of the other MCOs, we attend events such as the Kenton County Open Enrollment Health Resources Fair, the Readiness Health Fair in Spencer County, and the Eastern Kentucky University Health Fair in Clay County. Expanding on this engagement opportunity, we propose the development of a Collaborative Health Fair with the other MCOs that we that would enable us to bring information, screenings, and services to rural areas as a cohesive group. At times, each MCO attends local events and provides the same types of redundant services. Through collaboration, we could streamline this approach by pooling our resources together, with each MCO providing different type of clinical service or preventive screening at the Collaborative Health Fair. We would also include the help of the local health departments and any community partners that can contribute to the road show in each of the regions.
- *Mental Health First-Aid.* We propose working with the other MCOs to fund and host evidence-based Mental Health First-Aid training presentations at community events and

facilities in each region of the Commonwealth. This type of training is geared toward the lay-person to help them identify signs of behavioral health issues and crises.

- *Streamlined Crisis Services Access.* We recognize that DMS is seeking to streamline the disjointed mobile crisis support system in the Commonwealth. In addition to financial contributions, we would propose working with the MCOs to develop a single, accessible hotline capable of routing all Enrollees to the appropriate MCO Behavioral Health Services Line. This would eliminate the confusion sometimes caused by multiple numbers, and simplify the system down to a single, easily identifiable number to support Enrollees behavioral health needs and crises.

COLLABORATION WITH CHFS DEPARTMENTS

As stated, we regularly participate in workgroups and PIPs alongside the various departments of the CHFS, including DCBS and the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DHBDID). The following includes just a few examples of our collaborative efforts on joint outreach and education initiatives to support Enrollee needs:

- *Smoking Cessation Guide.* In an effort led by DMS, we worked with the other MCOs over a period of six months to develop a smoking cessation guide based on a related collaborative PIP. As a result, all MCO network providers are provided with an easily digestible guide that includes the available tobacco cessation benefits and medications that each of the five MCO's offers on a single page. The guide also includes simple reminders, such as asking every Enrollee about tobacco use and instructions for providing the Quit Now Kentucky phone line information for telephone counseling, or contacting Quit Now Kentucky directly to have them contact the Enrollee. The provider guide also includes useful tips for applicable diagnosis codes and billing information.
- *Enrollee Newsletters.* Over the years, our thought leaders and clinical directors have participated in various PIPs with the CHFS departments and other MCOs to help advance the care and support for all the Enrollees in the Commonwealth regardless of the MCO providing that care. Examples include PIPs for antipsychotic medication use in children and adolescents, prenatal smoking, and reducing hospitalizations and ED visits. As an offshoot of these collaborations, we have taken some of the most important lessons, tips, and ideas from these meetings and incorporated them into useful information in our quarterly Enrollee newsletters. As an example, one of our 2019 newsletters includes educational information on the importance of annual checkups, skin cancer, asthma and allergy awareness, healthy recipes, information on our Community Connections resources, and advice for navigating managed care in the Commonwealth.
- *Behavioral Health Resource Provider Packets.* While not a direct Enrollee-facing material, our behavioral health resource provider packets were developed in collaboration with the other MCOs and DBHDID as a result of a PIP focused on addressing the physical health risks in the SMI population. Today, MCO providers, specifically PCPs, have a better understanding of how to screen, treat, refer, and manage SMI for our Enrollees. Providers can bring the

packet to appointments, and apply the targeted behavioral health screenings to identify physical and behavioral health risks with guidance on the appropriate next steps.

PROPOSED COLLABORATIONS

While we look forward to continuing all our collaborations with the various CHFS departments and other MCOs, we also propose adding a new outreach and education component to the PIP process. In the past, most of the PIP collaborations have been provider-focused, and include ideas, initiatives, and solutions to help our providers better serve our Enrollees. By adding an Enrollee-facing component to the PIP process, the MCOs can work with the various departments to develop a cohesive Enrollee engagement and education outreach approach focused on improving Enrollee health and quality outcomes.

Collaboration with Community Partners

We have developed creative partnerships for Enrollee outreach and education throughout the Commonwealth, including schools, homeless centers, youth service centers, family resource centers, public health departments, and other community and faith-based organizations. Since 2011, we have created and maintained hundreds of valuable relationships, and hold leadership positions on more than 20 local boards, including the Homeless and Housing Coalition of South Central Kentucky, Northfork Local Foods, the Housing Development Alliance, the Kentucky Faith-Based Coalition, and Pathfinders of Perry County, to name a few.

Our leadership and community relations team regularly develops and proposes new Enrollee-facing outreach and education initiatives in the local communities with our partners. The following includes just a few examples of some of our most exciting collaborations that support Enrollee needs.

- *Public Health Departments and County Schools.* WellCare of Kentucky provided a financial grant to expand the Marshall County Health Department's Team Ultra program to promote youth health and fitness. Through this program, we helped make it possible for more elementary and middle school children to participate in after-school activities that promote exercise, healthy behaviors, and nutrition. We refer school age Enrollees to the program, which increased PCP visits by 98% and decreased ED visits by 35%.
- *Kentucky Homeplace — Rural Access.* We supported and funded the Kentucky Homeplace initiative—an extension of the University of Kentucky's Center for Excellence in Rural Health. Through this support, we enabled community health workers to engage individuals with chronic diseases across 30 counties. The program provided health coaching, health literacy, and disease self-management combined with gas cards and transportation vouchers to help Enrollees attend medical and social services appointments. **As a result, the program experienced a decrease in ED visits and inpatient admissions resulting in a $1,615 PMPM reduction and an estimated total savings of more than $850,000 since 2016.**

PROPOSED COLLABORATIONS

In addition to the current collaborative efforts currently underway with our community partners, we are also proposing the following new initiatives for joint outreach and education that supports Enrollee needs:

- Green River District Health Department — smoking cessation
- Faith Community Pharmacy — better access to medications
- Northern Kentucky Independent District Health Department — oral health
- The Healing Place — behavioral health and SUD treatment support
- Family Health Centers — personal safety
- County Health Departments (Todd, Graves) — diabetes
- North Central District Health Department — baby showers for pregnant Enrollees
- True Up Louisville — foster care transitions
- Marshall County School District — behavioral health support
- Kentucky Faith-Based Coalitions — suicide prevention

c. Describe methods for communicating with Enrollees as follows:

i. Creative efforts to achieve high levels of Enrollee engagement (e.g., smart phone applications,) to educate Enrollees and to communicate information for their individual health issues.

To achieve high levels of Enrollee engagement, we develop creative solutions that educate our Enrollees and communicate information for their individual health issues in a format that is easily digestible and accessed using familiar, mobile technology right from the phone. Our digital communications team is dedicated to the ongoing development of new mobile solutions that keep pace with our Enrollees' adoption of new technology. The following suite of mobile applications and text messaging programs enable Enrollees to participate in their healthcare experience through the convenience of familiar mobile functionality.

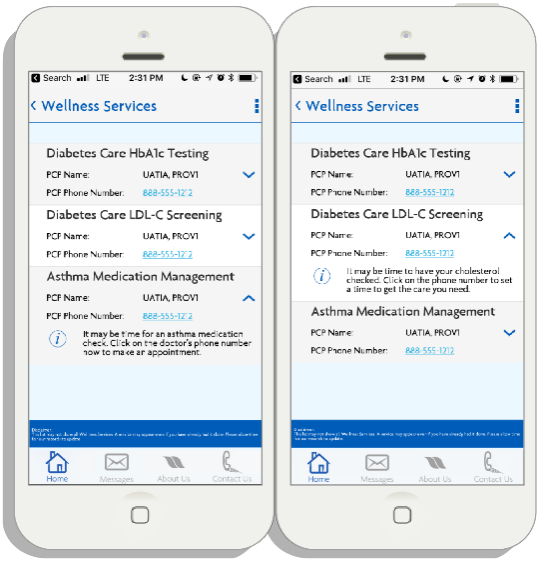


Figure C.12-4 MyWellCare App

MyWellCare Smartphone Application. Compatible with iOS and Android, and depicted in **Figure 12-4**, our mobile smartphone application helps Enrollees locate nearby urgent care centers, switch PCPs, and email their ID cards to providers. Enrollees with diabetes can opt-in to receive HbA1c test reminders

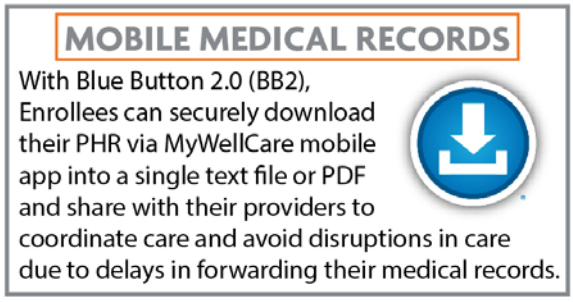
with their provider's phone number hyperlinked for a tap-to-dial appointment setting. **In 2018, there was a 200% increase in downloads of the MyWellCare smartphone app—the most popular functions include the provider search, Enrollee ID card, and PCP change.**

Text-to-Health. Text messaging empowers Enrollees to actively participate in improving their health through direct interactions received on their phone. Our Enrollee texting program increases engagement by conducting outreach through short message service (SMS) or text messaging. Enrollees, the parents of Enrollees (ages 3-20), and caregivers receive messages reminding them to schedule services, including well visits, breast cancer screenings, and medication reminders. Follow-up reminders are sent for Enrollees who continue to need their care needs addressed. Enrollees can contact us for assistance with scheduling appointments based on the texting outreach. **To date, we have launched nearly 1,000,000 text messages enterprise-wide since our texting campaign launched.**

Baby's First Text Messaging Program. Baby's First is our text messaging program offered to Mothers, who can easily sign-up with the help of their care coordinator or by texting BABY1 to 52406. Enrollees receive up to six text messages per week that provide guidance from birth to 15 months postpartum. Program guidance includes links to videos, questionnaires, and other resources that cover topics such as child development, daily care tips, vaccinations, wellness visit reminders, breastfeeding instructions, home safety measures, nutrition and healthy eating, developmental milestones, to name a few.

JOOL Health Coach. Last year, we collaborated on a new program for our foster care youth with JOOL Health Coach, a personal coaching smartphone application that encourages youth to check in with their peers and engage in healthcare services. With tailored program tracks specific to different populations, Enrollees have access to a transition-aged youth pathway for those with opioid use disorder/substance use disorder (OUD/SUD). JOOL includes OUD/SUD assessments, resources, and referral information to help youth and their families easily learn about their conditions and the local treatment options available in their community.

Mobile Medical Records. Blue Button 2.0 (BB2) technology enables Enrollees to securely store their health records and download to a file through the MyWellCare mobile app to coordinate care with providers.



Pacify Smartphone Program. At the touch of a button, Pacify offers expecting and new mothers unlimited 24/7 video access to certified dieticians and lactation consultants. Enrollees receive breastfeeding support and guidance from these specialized providers for any health issues their babies may be experiencing, such as colic, digestion, and transitioning to solid foods, to name a few. As part of our ongoing focus on continuous quality improvement and ensuring Enrollees receive the care they need, Pacify aims to improve health outcomes while also reducing costs to the healthcare system. Push

notifications include helpful alerts for health and safety tips beneficial to both mothers and their babies.

MyStrength. An online, evidence-based behavioral health therapy platform, MyStrength provides Enrollees with interactive clinical programs empowering them to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges, while also supporting the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care. MyStrength's integrated model includes computerized cognitive behavioral therapy (cCBT), mindfulness, motivational interviewing and Assertive Community Treatment (ACT) protocols with personalized pathways that facilitate user interaction, mood trackers, and additional tools to measure effectiveness and improvement, depicted in **Figure C.12-5**.

MyStrength has shown the following benefits upon implementation: a 43% rapid symptom reduction within the first two weeks of engagement, 83% as effective as face-to-face therapy at a fraction of the cost, and a 70% cost reduction in medical expenses for Enrollees.

Figure C.12-5 MyStrength Behavioral Health Therapy Platform

Enrollee Portal. Enrollees can access our secure portal from any device to access their personalized health care experience and self-service functions. For example, within the portal, Enrollees can complete an HRA, change PCPs, or check on the status of service authorizations. **In 2018, more than 6,500 Enrollees changed their PCP using either the Enrollee portal or the MyWellCare smartphone application.**

WellCare of Kentucky Website. Our mobile responsive website provides all the information in the Enrollee Handbook plus interactive functions such as the find-a provider tool for Enrollees to search by languages, gender, accessibility considerations, and more. Enrollees can download the Enrollee Handbook, learn about preventive care, locate a specialist or PCP using the find-a-provider tool, change their PCP, order a new ID card, or read our FAQs in the Enrollee Quick Tips section, which we developed from our experience transitioning Enrollees to managed care. Based on health literacy principles, the tool enables Enrollees to use non-medical terminology

to find physicians, such as "heart doctor" for a cardiologist. **In 2019, WellCare of Kentucky's public website received more than 178,541 unique views, and since 2018, more than 3,500 Enrollees have ordered ID cards online.**

New Enrollee Welcome Video: Our captioned, dynamic welcome video (based on location and Enrollee needs) is a recent innovation our team developed to engage Enrollees through a multi-media experience accessed from a new Enrollee welcome text (SMS) message. The four-minute video on WellCare's YouTube channel educates Enrollees about accessing information regarding their benefits and covered services, the role of a PCP (with a prompt to schedule an appointment), the purpose of the NAL, and accessing the CCHL to address their social resource needs.

AbleTo: The AbleTo program is a virtual CBT solution providing weekly coaching sessions with a coach and professional therapist to handle the behavioral health components of co-morbidities. The team helps the Enrollee set goals and build a program tailored to their personal needs. Coaching sessions occur twice a week at a time convenient to the Enrollee.

Fit4D: Supporting youth and adolescents with Type 1 and Type 2 diabetes, Fit4D is a support tool that includes chat messaging and push notifications. Through personalized education and coaching services, Fit4D supports Enrollees by teaching self-management behaviors and guidance for following treatment and care plan recommendations, as well as participating in preventive services. Health coaches speak to both the guardian and the Enrollee, or for older participants, help supplement diabetes treatment and education as Enrollees learn to manage treatment on their own.

MAP Health Management: This tool provides mobile peer support for SUD. MAP is a national vendor that matches Enrollees with a peer with the same lived experience as they go through detox and need support for their triggers. Addiction is a chronic disease—MAP's peer recovery support services extend the care continuum to match the chronic nature of the disease.

- Improve long-term engagement across SUD Enrollee populations to facilitate early intervention, motivate Enrollees to seek treatment when appropriate, reduce the impacts of relapse, and direct care needs such as readmission when appropriate
- Reduce out of network utilization for SUD treatment
- Capture and report on longitudinal outcomes data, including social determinants of health, on SUD populations and treatment programs

We understand that Enrollee engagement is key to recovery success, which is why providing this real-time, 24/7 access to support and the ability to triage for additional services is critical. This connectedness helps Enrollees feel less alone and isolated.

ii. Approach to identifying, developing, and distributing materials that will be of most use to Enrollee populations, and efforts the Vendor proposes to target distribution to specific populations as appropriate.

Our approach to identifying, developing, and distributing materials that will be of most use to our Enrollee populations includes both general materials that cover accessing basic services; and targeted education materials for specific Enrollee populations. The following information describes our approach:

- *Identify.* WellCare of Kentucky's health literacy advocate works with our Enrollee Services team to discuss the impact that our education materials have on increasing health literacy and improving Enrollee well-being and quality of life, as well as how it affects their decisions about seeking care and meeting with their PCP. Our Enrollee materials account for the various levels of health literacy to ensure they are culturally appropriate and inclusive of healthcare guidance, information, and instructions for accessing their benefits.
- *Develop.* We develop materials to educate Enrollees on how to navigate the managed care system so they can access benefits and services and learn to practice self-care. Our materials are written at the sixth-grade level in English and Spanish and are translated into prevalent non-English languages with short turnaround times. Our health literacy advocate (with training in health disparities) works with the Enrollee communications team to produce not only visually engaging materials but ones that are culturally accessible.
- *Distribute.* We distribute materials through print mailings, online information—including the public website, MyWellCare smartphone app, Enrollee portal, and social media—in-person, and by telephone. Knowing that many of our Enrollees prefer to engage with materials online through the portal, website, mobile application, we provide the following content to guide their healthcare experience: Instructions for what to do in a behavioral health emergency; Preventive health guide; Covered services; Free OTC products; SafeLink phone program; WellCare Works; Healthy Rewards program; Pharmacy services; Enrollee rights and policies; Helpful tips and information; Flu shot information; and How to access the NAL and Behavioral Health Services Hotline.

GENERAL ENROLLEE MATERIALS

We recognize that the traditional process of mailing educational information to our Enrollees is still an effective component of a well-rounded engagement strategy, which is why we make all materials available in print mailings and online through the public website, Enrollee portal, and the MyWellCare smartphone app. For new enrollees, we distribute an Enrollee Handbook, a Quick Start Guide, and ID card letters within the first five days of enrollment. These materials educate Enrollees about their covered services, the role of the PCP, how to access care that meets their whole-person needs, and enrolling in our population health programs. In addition, we send the following printed Enrollee education materials by direct mail:

- *New Enrollee Welcome Kit* — Mailed within the first five days of enrollment, the welcome kit includes the Enrollee Handbook, provider directory, and Enrollee ID card

- *Enrollee Letters* — Includes notifications of changes to the Kentucky Medicaid program, information about our Healthy Rewards program, and incentives that we provide for participating in prevention appointments and activities
- *Wellness Exam Reminders* — Highlights the importance of preventive care for children, adolescents, and adults
- *Disease-Specific Education* — Regarding conditions, such as asthma or juvenile diabetes that can be improved through self-directed care and maintaining a good relationship with the PCP, as well as attending appointments consistently
- *Quarterly Newsletters* — Covering a broad range of health-related topics, our quarterly newsletter includes information about our population health programs, alignment with monthly national health themes, such as asthma awareness, and information on the importance of accessing services, attending annual checkups, and sustaining a trusting relationship with PCPs. It also includes healthy recipes, health and exercise tips, local Community Connections resources, and contact information for WellCare of Kentucky and the NAL

TARGETED ENROLLEE MATERIALS

We develop and distribute materials promoting overall health and educating Enrollees on the importance of prevention and the programs we offer. These materials include the following:

- *Prevention Education* — Include brochures and booklets from the public domain, such as those produced by local health departments, the Commonwealth, or the Centers for Disease Control and Prevention (CDC). We also produce proprietary materials, such as our Healthy Rewards brochure that includes information on how to earn rewards for health behaviors and attending health check-ups with their PCP
- *Child and Adolescent Health* — Materials include EPSDT schedules, birthday cards that provide well-child visit reminders, individualized periodicity reminder letters, newsletter articles, and other materials
- *Maternal Health* — Education materials promoting maternal and child health include booklets such as Mommy and Baby Matters, Taking Care of Yourself and Your Baby, and Start Healthy Birth Outcomes
- *Adult Preventive Health* — Materials that promote adult preventive services include individualized periodicity reminder letters, newsletter articles, and brochures explaining the various annual preventive screenings, such as cervical cancer screenings

iii. Methods of leveraging communications to meet the diverse needs and communication preferences of Enrollees, including individuals with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

WellCare of Kentucky's Enrollee Services staff and call center have established methods of leveraging communication to meet the diverse needs and communication preferences of our

Enrollees across the eight regions of the Commonwealth. The methods listed below support individuals with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities regardless of gender, sexual orientation, or gender identity. We train all Enrollee-facing staff to confirm and document the Enrollee's preferred language at each interaction, ensuring their preference is available for all staff to adequately communicate with the Enrollee.

INTERPRETATION AND TRANSLATION RESOURCES

The Enrollee Services call center is fully staffed with both English and Spanish speaking ESRs. To support Enrollees with limited English proficiency, we also provide interpretation and translation resources that facilitate healthcare support and guidance in the comfort and familiarity of the Enrollee's preferred language. Our language line supports more than 200 languages through more than 2,000, on-demand, qualified interpreters experienced in healthcare language and terms. We translate all Enrollee materials into Spanish and can provide materials in large print, Braille, or DVD for Enrollees with a low level of literacy. For medical appointments, we provide an in-person interpreter to ensure the Enrollee can understand their physician and adequately communicate their concerns and questions. We train ESRs to seamlessly participate in three-way calls with American Sign Language interpreters using the Video Relay Service so that Enrollees who are deaf or hard of hearing will never be at a disadvantage when accessing information or services.

PERSONALIZED ENROLLEE EXPERIENCE

To personalize the healthcare experience for our Enrollees, we ensure cultural and diversity inclusion by documenting their language preferences and language needs where the native language is available and using this information across all channels (phone, print, materials). We note the preferences and needs in CAREConnects, and this information is visible to all Enrollee-facing staff, including care coordinators. For outbound communications, these needs and preferences are automatically absorbed into the logic of our system, which organizes the production of Enrollee communications. If an Enrollee’s language preference is Spanish, for example, we would send a letter about a Medicaid program change to the Enrollee already translated in Spanish; an Enrollee who opted-out of mailed, written materials would receive the communications about a Medicaid program change in the Enrollee portal if they had selected this option. For Enrollees needing oral or ASL interpretation, a pop-up alert informs ESRs that the Enrollee calling requires an interpreter, and they are able to respond quickly to meet their communications needs from the moment the Enrollee contacts us.

CULTURAL COMPETENCY: MEETING THE NEEDS OF OUR ENROLLEES

Our approach to meeting our Enrollees' needs considers their diverse cultural and ethnic backgrounds, disabilities, genders, sexual orientations, and gender identities. Our commitment to engaging Enrollees on their own cultural or personal terms begins with our leadership team who annually approves our cultural competency plan, which aligns with the national standards for Culturally and Linguistically Appropriate Services (CLAS). The plan is reviewed, updated, and approved by the Quality Improvement Committee (QIC) on an annual basis.

The following components of our approach support both diversity among our Enrollee population and our workforce:

- *Cultural Competency Training*: We require new associates to participate in cultural competency training within 30 days of hire, and annually thereafter, and pass an assessment as a condition of employment. ESRs, care coordinators, and other Enrollee-facing staff are prohibited by policy from direct Enrollee contact until they have demonstrated cultural proficiency. Market-specific training for Kentucky-facing associates includes learning how to pronounce names and surnames for the various Kentucky populations such as the Somalis in Northern Kentucky. Currently, all Enrollee Services staff have passed the requirement to recognize and respect our Enrollees' cultures, religions, primary languages, sexual orientation, and any other means of self-identification.
- *Unconscious Bias and Conscious Inclusivity Training*: In 2018, Senior Directors and above trained for a total of 2,000 hours on Conscious Inclusivity. Dr. Kellie McElhaney, Founding Director of the UC Berkeley Center for Equity, Gender, and Inclusion (EGAL), delivered the training which challenged our leaders to discover their biases while providing solutions to overcoming them.
- *CEO Action for Diversity and Inclusion*: In 2017 WellCare Health Plans CEO joined more than 650 CEOs in signing the CEO Action Pledge—the largest CEO-driven business commitment to advancing diversity and inclusion within the workplace. We celebrate diversity and inclusion in our work place through our growing number of affinity groups.
- *Associate Resource Groups*: WellCare supports six Associate Resource Groups (ARG), which are voluntary, staff-led groups united around a common affinity or personal identity. WellCare Health Plans currently has seven ARGs: African-American, Asian, Hispanic, LGBTQ, Persons with Disabilities, Women, and Veterans workgroups representing a powerful resource leveraged across the organization in various ways, such as:
    - Informing Enrollee communications to ensure relevance and understanding
    - Supporting recruiting and retention efforts to realize a diverse, high-performing and engaged workforce
    - Highlighting shifting trends that enable us to be of greater value to our provider partners
- *Diversity and Inclusion Achievements*: Our dedication to the diversity of our staff and the care for our Enrollees has garnered significant achievements that we celebrate, including the following examples:
    - *Corporate Equality Index*: WellCare scored a perfect 100% on the Corporate Equality Index—the national benchmarking tool for corporate policies and practices pertaining to lesbian, gay, bisexual, transgender, and queer employees.
    - *Best Places to Work*: WellCare of Kentucky was named "A top 10 Best Places to Work" in 2017 and 2018 by the Kentucky Chamber of Commerce, the Kentucky Society of Human Resource Management, and Lifestyle Health Plans.

- *Enrollee Satisfaction*: WellCare of Kentucky continues to lead all other MCOs in Enrollee satisfaction with eight out of ten new Enrollees actively choosing our health plan as their MCO over our competitors.

- *Health Literacy Training*: Our Health Literacy Advocate, with expertise in population health, provides intensive training for staff members on the correlations between health literacy, health disparities, and the role that culture plays on Enrollees' attitudes about health and treatment.

d. Provide a summary of innovative methods and the Vendor's proposed outreach plan to assess the homeless population.

A Path Forward: Housing Stability

Over 6,660 enrollees with WellCare of Kentucky have been connected to nearly 22,000 services through our homeless initiatives including 828 referrals for housing and 537 for education and employment assistance.

WellCare of Kentucky's grassroots Homeless Outreach Plan was established in 2011 to assess the homeless population, connect them to local organizations that address housing instability and domestic violence, and enroll them in our care coordination program to guide their healthcare experience.

In an effort to continually enhance and evolve our Homeless Outreach Plan, WellCare implemented our Homeless REACH program. The Homeless REACH program builds off of existing programs and weaves in new partnerships by combining high-powered, data-driven search engines with our call center and feet-on-the-street outreach activities to assist in rare cases where we cannot locate an Enrollee experiencing homelessness. We also utilize the collaborations with our grassroots partnerships in the community. The compassionate Homeless REACH program encompasses three key characteristics—**Partner-Locate-Connect**—to best serve our Enrollees.

The partner, locate and connect concepts flow throughout many of our successful homeless outreach initiatives.

- *PARTNER:* **Leveraging our local partnership and relationships to identify Enrollees experiencing housing instability facilitated by our Community Connections program and the deep community partner connections we have developed throughout the Commonwealth.**

- *LOCATE:* Utilizing a powerful data warehouse to integrate information from our internal sources, state enrollment files, the Community Connections database, external vendors, public records, and the Homeless Management Information System (HMIS) developed by the Department of Housing and Urban Development (HUD) to help locate Enrollees.

- *CONNECT:* Using the partnerships that we have developed, our Community Engagement partners implement solutions that resolve housing instability with help from our local partners and the members of the community we work with every day to assist the most vulnerable individuals in need of care, support, and guidance.

PARTNER: COMMUNITY PARTNERSHIPS

WellCare of Kentucky maintains a local presence throughout the Commonwealth with the work of our Community Engagement Partners responsible for developing and maintaining local partnerships that address our Enrollees SDOH needs, such as housing permanency. **In 2018, our dedicated community engagement team spanned the Commonwealth participating in more than 260 homeless and domestic violence-related activities across all eight regions and working side-by-side with over 50 front-line organizations.**

Through our partnerships with homeless coalitions, local shelters, and homeless organizations, it is possible for WellCare of Kentucky to keep our finger on the pulse of the challenges our homeless Enrollees face and in turn better serve our Enrollees and the communities in which they live. Through these efforts, the Community Connections program drives the continual development of our partnerships, allowing us to connect Enrollees to help when and where they need it most. Our partners include the following organizations:

- Westcare Homeless Shelter
- House Abuse Shelter
- Boulware Mission, Inc.
- BRASS (Barren River Area Safe Space)
- Children Exposed to Violence Coalition
- Chrysalis House
- Coalition for the Homeless
- Community Assistance & Referral Service, Inc. (CAReS)
- Community Connect Stand Down (HUD Continuum of Care)
- Community S.H.I.E.L.D.
- Daniel Pitino Shelter
- DOVES of Gateway
- East Kentucky Dream Center
- Emergency Shelter of NKY
- Family Nurturing Center
- Father Bradley Shelter for Women and Children
- Greenhouse17
- Homeless and Housing Coalition of South Central Kentucky
- Bethany
- Hope House
- HOTEL INC
- Housing Development Alliance
- Kentucky Coalition Against Domestic Violence
- Letcher County Homeless Council
- Lexington-Fayette Domestic Violence Prevention Board
- Over my Head
- Paducah Cooperative Ministries
- Safe Harbor of Northeast Kentucky, Inc.
- Salvation Army Richmond Corps
- SecondChance Mission
- The Dressing Room
- The Gentry House
- The Hope Center
- Turning Point Domestic Violence Shelter
- Welcome House
- Women’s Crisis Center, Inc.

To strengthen our local partnerships and expand access to resources for our Enrollees, the Community Connections program actively participates in the development of community programs by accepting and maintaining leadership positions on the boards of local organizations. Our internal Community Engagement Partners are active members of the following boards:

- *Chairperson of the Board* —The Homeless and Housing Coalition of South Central Kentucky
- *Secretary of the Board* —Housing Development Alliance
- *Board Member* — Coalition for the Homeless
- *Board Member* — Continuum of Care Advisory Board

FUNDING FOR LOCAL ORGANIZATIONS TO COMBAT HOMELESSNESS

As illustrated in **Table C.12-3**, WellCare of Kentucky recognizes that funding for community organizations is often limited and we provide investments that help sustain and provide capacity for those organizations that assist Enrollees with overcoming social barriers.

Table C.12-3 Funding for Community Organizations that Address Homelessness

Organization	Program	Description
Homeless and Housing Coalition of South Central Kentucky	Room in the Inn	WellCare provided a sponsorship to the Homeless and Housing Coalition of South Central Kentucky to begin the first season of Room in the Inn Bowling Green, which is a winter shelter program where homeless guests are housed for the night in area churches. Funds were used to purchase initial cots and needed supplies to get the program started. HOTEL INC, a member of the Homeless and Housing Coalition of South Central Kentucky, acted as fiscal agent. Room in the Inn is now operating as a stand-alone non-profit organization.
Community Connect Stand Down (HUD Continuum of Care)	Healthcare Screenings for the Homeless	Agencies and volunteers from throughout Warren County came together at the Salvation Army to explain their services and provide screenings and assistance to homeless and precariously housed individuals. WellCare Community Engagement Partner served on the planning committee and arranged for a variety of healthcare screenings to take place that day.
Coalition for the Homeless	Multiple	A variety of Coalition for Homeless Events over the years including “Stand Down” and “Give-a-Jam to End Homelessness!”

Organization	Program	Description
WestCare	Outreach	In 2015, WestCare men and women's shelters and connected WellCare Enrollees with case management through WellCare. WestCare notified a WellCare case manager by phone when an individual requested case management. This was an effort to assure healthcare needs are met for our Enrollees and reduce the Unable to Contact rate.
Welcome House	Northern Kentucky Street Medicine	WellCare provided funding to the Street Medicine program beginning in Kenton County. The program connected homeless individuals where they are to provide basic services. Funding provided means for technology, mentoring/training, and pharmacy costs. This was a new initiative for the organization.
The Dressing Room	Homeless Outreach	The mission of The Dressing Room, operated by Federated Charities, is to serve as a community clothing closet, collecting donations of gently used and new clothing and redistributing to low and moderate-income families, including those experiencing homelessness, at no cost.
Over My Head	Financial Assistance and WellCare Works	Over My Head is a Homeless Shelter and community organization providing services and supports to low income and homeless individuals. This funding is for financial support programming and administrative costs for the Enrollee level data exchange. They provide monthly data for all WellCare Enrollees accessing WellCare Works.
Daniel Pitino Shelter	Financial Assistance	The Daniel Pitino Shelter provides emergency and transitional housing, and primarily serves the GRADD region (Daviess, Henderson, Union, Webster, McLean, Ohio, and Hancock).
The Gentry House	WellCare Works	The agency's front line staff is trained on platform functions, in order to support our Enrollees in their employment and/or volunteerism search.
Brighton Center, Women's Crisis Center, Kenton County Library, Covington Schools, Targeted Assessment,	Community Impact Council	Through a WellCare facilitated Community Impact Council, these organizations are creating an awareness project around homelessness in the area.

Organization	Program	Description
Emergency Shelter of NKY, Erlanger Schools		
Boulware Mission, Inc.	Bus Tokens	Funding was to support transportation for homeless to decrease the barrier of limited affordable transportation for homeless individuals needing access to other service organizations and employment opportunities.

LOCATE: FINDING ENROLLEES THROUGH A DATA DRIVEN APPROACH

Accessing our internal data, WellCare of Kentucky has been able to identify Enrollees that have addresses listed as a shelter or as "homeless." Our team is then able to partner with these shelters to locate our Enrollees and connect with them in real time. This allows us to meet Enrollees where they are, ensuring they receive needed medical, behavioral, and social services support.

WellCare of Kentucky has identified more than 2,400 Enrollees experiencing homelessness or unstable housing situations. Today, nearly 800 Enrollees have been located and enrolled in our care coordination program.

Another data-driven method we use is partnering with homeless organizations to analyze Homeless Management Information System (HMIS) data. The purpose and impact of collaborating with HMIS agencies is multifold. Through data sharing with HMIS systems, we can identify our Enrollees who are experiencing homelessness or are at risk of homelessness. Often, these individuals are our Unable to Contact (UTC), Unable to Engage (UTE), or Loss to Care (LTC) population. In addition, this segment of Enrollees tends to be among our highest utilizers of ED services, whose needs could be better addressed in the PCP office. Often these Enrollees do not know who their MCO is, or how to navigate the health system.

Our current Kentucky HMIS partner is the Coalition for the Homeless. They have been the voice for the homeless in Louisville for the past 25 years and bring together thirty different agencies that address the issues facing the homeless through three approaches: (1) educating, (2) advocating, and (3) coordinating. Our Community Connections program began our partnership with the Coalition in 2014 to discuss the impact of social service accessibility for the homeless and its overall impact on the health of the most vulnerable citizens of Louisville.

Working in partnership with HUD, the Coalition is responsible for coordinating care, delegating HUD funding, and overseeing and coordinating the use of the HMIS to organize data regarding the homeless in Louisville and the resources available. Our Community Connections team plays an active role in the Coalition's efforts through attending the Continuum of Care (CoC) monthly meetings to continue learning about the HMIS process. In 2018, WellCare of Kentucky provided additional funding to the Coalition that contributed to their Point in Time (PIT) Count and Rx:

Housing Fund initiatives, and provided a match for the Youth Homelessness Prevention Demonstration Grant.

Data collection efforts of the HMIS database have shown that between November 2018 and October 2019, more than 200 WellCare of Kentucky Enrollees were referred to more than 600 services—with 350 of those service referrals made to a homeless day center and more than 170 for housing assistance. We are able to use this specific data in real time to assist our homeless enrollees.

CONNECT: CONNECTING ENROLLEES WITH AVAILABLE SERVICES

We recognize that homelessness is often a result of complex behavioral health conditions and co-morbidities that, when left untreated, may worsen due to the effects of housing instability. We also know that Enrollees experiencing homelessness have specific challenges such as accessing services, cycling between homelessness, shelters, hospitals, and correctional and mental health facilities, and may be victims of domestic violence. Upon successful outreach, a WellCare of Kentucky care coordinator works with the Enrollee to refer them to Section 8 housing and connect them to community programs and resources that provide housing-related assistance and address their comprehensive SDOH needs.

We use the HUD definition to define homelessness, which includes individuals in emergency shelters or residing in transitional housing, those discharging from a mental health or substance abuse treatment facility or prison who previously had no residence, and those fleeing a domestic violence housing situation. Through the following methods of the REACH program, we identify and connect our Enrollees to available resources within the community:

COMMUNITY CONNECTIONS HELP LINE (CCHL)

The Community Connections Help Line (CCHL) is our empathy-based call center staffed by Peer Coaches and Peer Liaisons who guide and assist Enrollees in removing social barriers. These peer-support coordinators, hired through workforce innovation programs, represent many diverse cultures, including individuals with disabilities, seniors, caregivers, students, veterans, and military families. They have first-hand experience navigating social services or have "lived" experience, such as being a former Medicaid Enrollee.

Using a database of 330,000 resources, these experts help Enrollees achieve independence by connecting them with organizations that offer a variety of benefits. We refer Enrollees to social resources that can assist them with everything from housing and transportation to child care and clothing. Powered by the My Family Navigator database, **the CCHL provides access to more than 200 local organizations with homelessness-related services and more than 130 organizations providing support for victims of domestic violence.** To assist individuals fleeing a domestic violence situation and prevent homelessness from occurring, our network includes more than 1,100 organizations providing transitional and permanent housing support and shelter.

As former Ticket-to-Work and Welfare-to-Work beneficiaries, peer coaches leverage their lived experience to skillfully identify primary causes of Enrollee SDOH-related issues. For example, a peer coach could uncover that the mother calling for housing support is actually experiencing domestic violence and should be referred to a domestic violence shelter, such as Turning Point

in Eastern Kentucky that covers Floyd, Johnson, Magoffin, Martin, and Pike Counties. As many individuals experiencing domestic violence require basic housing items and necessities for their fresh start, we provided a grant to this organization that assisted individuals with new cookware supplies.

Since launching, more than 6,450 Enrollees have been referred to nearly 19,000 services in Kentucky through the CCHL. **In 2018, we made more than 14,000 service referrals to assist individuals with housing and housing-related needs.**

COMMUNITY PARTNER STORY - HOTEL INC: STREET MEDICINE OUTREACH

One of our longest-standing partnerships is with HOTEL INC, a community-based non-profit organization that provides the citizens of Warren County with pathways to stable housing, community resources, and quality food. Since we began funding the HOTEL INC program in 2013 to support outreach efforts focused on homelessness, the organization has expanded to four teams that perform "Street Medicine" outreach multiple days per week to provide basic health assessments and follow-up care. The program connects individuals and provides transportation to local clinics and care coordination services for further engagement.

The HOTEL INC team remains a key strategic partner for identifying and referring WellCare of Kentucky Enrollees experiencing homelessness. Our combined data sharing efforts provide us with insight on the health conditions of our Enrollees, including the following:

- Individuals have an average of 3.1 chronic conditions (46% diagnosed with hypertension, 35.4% diagnosed with asthma, 22.5 % diagnosed with diabetes, and 61.9% diagnosed with obesity)
- Individuals have an average of 1.6 behavioral health diagnoses (43.4% depression, 55.3% some other mental illness, 7.6% SMI, 17.9% bipolar disorder, and 31.1% SUD)

In 2017, HOTEL INC opened their first respite home program, with funding assistance from our Community Connections program. The home helps bridge the gap from an inpatient hospital discharge to permanent housing with the goal of preventing readmissions and re-occurring visits to the ED. Supporting the program, the Street Medicine team provides health checks and medical care as needed. The respite program provides a safe location for pre-op, pre- and post-recovery for colonoscopies, and respite for an individual who has a virus that is contagious to others or may cause additional health problems if not properly addressed.

HOTEL INC Street Medicine Team
Since 2013, WellCare of Kentucky's Community Connections program has invested more than $80,000 in HOTEL INC, ensuring that continued care and attention is given to some of the most at-risk populations throughout the Commonwealth and among our Enrollee membership.

Our partnership includes a HIPAA-compliant data sharing agreement in which we track our Enrollees' utilization of HOTEL services (e.g., food, housing, or a second referral to a domestic violence shelter), and correlate these services with decreased ED utilization and increased PCP visits to quantify the medical cost savings of providing social supports. We automatically upload Enrollee data into our predictive analytics tool to proactively identify a potential social or

clinical crisis and coordinate the resources and services to stabilize the Enrollee before it becomes an issue.

From August of 2016 through July of 2019, HOTEL INC has provided 883 WellCare of Kentucky Enrollees with more than 16,800 services to address housing instability and other SDOH needs. From 2017 to 2018, these Enrollees experienced a 10.5% reduction in ED costs, an 18.4% reduction in flu-related encounters, and a 5.8% reduction in total costs amounting to $560-PMPY.

Enrollee Story: A Place to Call Home

A 63-year old Enrollee with hypertension and paralysis due to stroke was referred by the utilization management team to transitions care management because of his frequent admissions and ED utilization, which were the result of COPD and pneumonia. The Enrollee was homeless and living on his cousin's porch for two years because of cramped housing conditions inside the residence. He slept in his wheelchair, which caused fluid to build up in his right leg. He is estranged from his other family, a sister and brother who live in Nicholasville. He was not interested in going to a skilled nursing facility and was deemed competent to make his own decisions. Immediately upon assignment, the transitions care coordinator, Susan, began calling to find local housing options to help with the Enrollee's urgent housing needs. The search was extensive. Susan used a housing resource guide she had gathered from her time as a care coordinator. Susan found an opening at Emerson Center Apartments and assisted him in completing the application paperwork. She also helped order him a birth certificate required to complete the application process. He was approved for a handicapped unit with amenities.

At the time of hospital discharge, Albert's apartment was not ready. The UK Hospital CATS program, Bluegrass Care navigators agreed to pay for hotel stay until he was able to move in. For an electric wheelchair to help his mobility, Susan contacted HDI CATS (Center for Assistive Technology Services) that aids individuals with assistive devices, who donated an electric wheelchair. The company also donated a grabber to help the Enrollee pick things up off of the floor and a tool to help take off clothing. A hospital bed was provided through New Moon Medical. Emerson Center donated a transfer bench to get in and out of the shower. The community service, Paramedical program, department of the local fire department, also Susan to assist with the Enrollee's move to the new residence and with transportation. Home Depot in Lexington donated wood that would be used to build a ramp on his porch to help Albert get his electric wheelchair from the porch to the sidewalk. Other donations were made from various people locally, including two WellCare of Kentucky care coordinators, to ensure that Albert had furniture, dishes, utensils, glasses, towels and washcloths, sheets and comforters. His assigned field case manager, Lowell set him up with Bluegrass Mobile, a local primary care physician that can come to the home for visits and with a home health agency for skilled nursing and physical therapy. He was also enrolled in the frozen meal program with GA foods in addition to his food stamps. Susan helped arranged deliveries from God's Pantry. He was provided a free phone from the phone assistance program.

The Enrollee has been able to turn his life around. With the stability and the independence he desired, the assistive medical equipment, healthy food options, and accessible medical care he has been able to succeed in managing his health and has truly found a place to call home.

e. Describe the proposed approach to assess Enrollee satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends, and use of findings to support ongoing program improvement.

WellCare of Kentucky is an MCO intently focused on listening and responding to the voice of the Enrollee to drive program improvements, enhance the Enrollee healthcare experience, and increase their satisfaction. Through our feedback capture tools, such as surveys, we assess Enrollee satisfaction at each point of contact: the call center, online, and in-person. We believe Enrollees having a positive experience with their MCO are more likely to engage in their health. Through our Enrollee-centered approach, we have earned the highest Enrollee satisfaction scores of all Kentucky Medicaid MCOs as measured by the CAHPS surveys in 2017 and 2019 and the highest rated MCO in Quality since 2016 according to NCQA scores. In addition to having the highest quality rating, we also have the highest percentage of ratings of a 4 or higher in the 2019 – 2020 report, see **Figure C.12-5**. We believe this level of satisfaction is reflected in the improvement of 91% of our HEDIS measures year-over-year from 2013 to 2019 and in the fact that we lead the Commonwealth in 24 out of 70 HEDIS measures for 2019.

#1 MCO for Enrollee Satisfaction
As a result of our tailored hands-on approach to empowering Enrollees, we have improved our CAHPS scores from 86.51% in 2014 to 88.89% in 2019 while experiencing significant growth, and have the highest Enrollee satisfaction in the Commonwealth as measured by the CAHPS survey in 2017 - 2019.

WHAT WE MEASURE IN OUR SURVEYS

We vary our feedback capture tools to measure Enrollee satisfaction via the methods they interact with us, as the following examples illustrate: *Call center*- We deploy surveys calibrated to measure their experience contacting our call center using a scoring methodology from 1– Very Dissatisfied to 5 – Very Satisfied; *In-person*- Also using a 5-point scale, these surveys enable Enrollees to evaluate their experience engaging us in-person. Their level of satisfaction would encompass interpersonal factors such as body language, active listening, and even cultural competency if, for example, avoiding direct eye contact signals respect for the Enrollee. We will be implementing this survey tool in Kentucky under the new contract; *On-line*- Our online survey, accessed from the Find-a-Provider search feature, gauges Enrollee satisfaction with a search tool to find providers via an online channel. In addition to this survey, we are developing survey tools for all online channels such as live chat, MyWellCare mobile app, the Enrollee portal and other methods for implementation under the new contract.

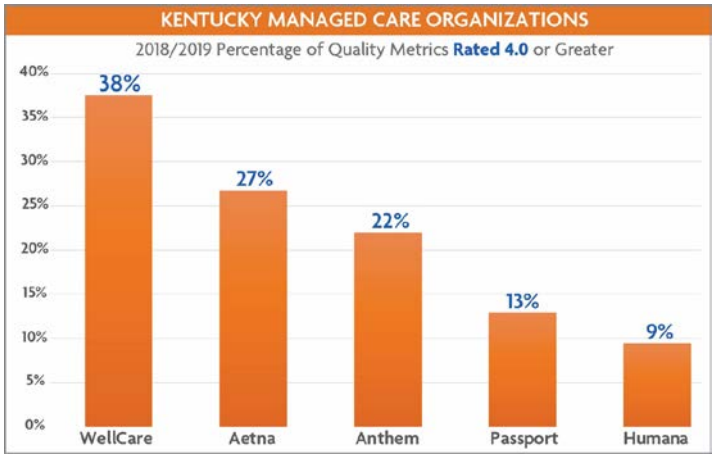


Figure C.12-5 *WellCare Percentage of Quality Metrics*

In response to these surveys, we identify areas of improvement and implement solutions corresponding to the method of interaction. Solutions for call center and in-person interactions include remedial training of ESRs including cultural competency refreshers or simplifying the IVR navigation process to connect with a live ESR. Corresponding solutions with their online experience center on ease of use, accuracy, and functionality. By varying the feedback capture methods, we gain a broad vantage point into the Enrollee experience, their satisfaction, and align appropriate solutions. For all surveys, Enrollees can submit verbatim messages if they wish to elaborate on the experience as well as express their willingness to recommend WellCare of Kentucky to others (Net Promoter Score).

To be sure, in addition to these surveys, Enrollees can use any communications channel they prefer to express their satisfaction, and they have more choices than ever to make their voices heard. In addition to the survey tools described above, Enrollees can:

- Contact our call center at any time during operating hours, reach us through live chat, or call their Care Coordinator, our local Grievance Coordinator, or their provider.
- Send us letters or contact us through the MyWellCare mobile application, send emails or text messages, or use the secure Enrollee portal.
- Speak in-person with their Care Coordinator, provider, or visit us at any one of our 6 community-based offices located throughout the Commonwealth.

We act on Enrollee feedback via these channels with same urgency and rigor as through our survey tools.

HOW WE USE THE INFORMATION GATHERED

Our data analysts aggregate the satisfaction scores, gather the verbatim feedback, and provide monthly reports to the Customer Service Quality Improvement Committee (CSQIC). The CSQIC, which includes Kentucky market leaders, reviews summaries of actual Enrollee feedback as well as trends, overall satisfaction, and net promoter scores. This information is reported to the Quality Management Committee quarterly for root cause analysis and resolution. Additionally, the Executive Leadership Team listens to live Enrollee calls to hear the voice of the Enrollee first-hand and support solutions which drive a positive Enrollee experience and increase their satisfaction. Please see **Table C.12-4:** Approach to Assessing Enrollee Satisfaction for an illustration of our feedback capture processes.

PROGRAM IMPROVEMENTS

Through our committees and workgroups, we design solutions aligned with Enrollee feedback as these examples illustrate:

- *Call center authentication.* In late 2019, Enrollees expressed concern that our up front, verification screening prompts were too onerous. In response, we implemented a new tool (ANI Match) that enables Enrollees calling from a “known number” to bypass the HIPAA protection screens and proceed directly to one final verification screen/query. As a result, authentication rates have increased two-fold, and we have seen a three-fold increase in our Enrollees' use of self-service functions.

- *Balance billing.* When Enrollees made us aware that providers were balance billing them, we launched a dedicated Enrollee Services team to personally assist Enrollees with balance billing issues and educated the providers, resulting in reducing balance billing-related grievances by 91% in three months.
- *Find-a-provider search tool.* Based on Enrollee feedback captured through our online survey regarding the find-a-provider tool, we expanded the number of radius miles for providers in rural areas and enhanced the tool functionality to identify providers, such as Internal Medicine providers or specialists, who also serve as PCPs.
- *Communications preferences.* Enrollees told us that they want options regarding how we communicate with them. Some prefer direct mail or phone calls or communications via their handheld devices. Consequently, we launched an initiative to capture every Enrollees' preferences and engage them based on their selection. We know that Enrollees who make affirmative decisions on how they want to be contacted are more likely to respond to communications received through their preferred method.

Our extensive focus on listening to our Enrollees and driving operational improvements elevates our performance and leads to more satisfied Enrollees. For example, **our 2018 Medicaid Enrollee post-call satisfaction rate was 94.8%.** In addition, from 2016-2018 we experienced the following Enrollee satisfaction quality improvements:

- Obtaining Enrollee information increased by 4.8%.
- Ease of reaching health plan call center over the phone increased by 15.5%.
- Overall satisfaction with health plan's call center services increased by 11.3%.
- Helpfulness of WellCare of Kentucky's Enrollee Services associates in obtaining referrals increased by 7.4%.

Hazard Care Center Enrollee Satisfaction

By going the extra step with helping Enrollees maintain Medicaid eligibility and connect them to needed services, our call center has earned a 99.3% Enrollee satisfaction rate.

ENROLLEE FOCUS GROUPS

The more opportunities we offer Enrollees to communicate their experience with us, the more we learn how to better serve them, even beyond their health to their everyday living needs such as food or housing. To provide yet another channel for feedback, we are organizing Enrollee focus groups throughout 2020 led by our newly-hired Director of Enrollee Experience. These forums will enable us to continue learning about our Enrollees' experience and needs, ensuring we invest in resources and drive operational improvements to provide the best managed care environment leading to happier, healthier Enrollees.

Table C.12-4: Approach to Assessing Enrollee Satisfaction

Point of Contact	Method	Feedback Tool/Frequency	Process
Call center: Inbound and outbound calls	Telephonic	Post call surveys offered after each inbound/outbound call	• Our "live after survey" tool consists of Enrollee Services Reps (ESR) contacting, within one business day, Enrollees with scores of 1 or 2 reflecting high dissatisfaction. • The CSQIC analyzes monthly reports that flow up the Quality Improvement Committee (QIC) for trending, root cause analysis, and solutions development. • Under the new contract, Enrollees will have an option to connect live with an ESR at end of the survey for additional feedback.
Online	Enrollee website provider search, live chat, mobile app, text/email, Enrollee portal, etc.	• Find-a-provider survey tool offered to Enrollees after each search transaction. • For the new contract, we are developing surveys for all other digital channels (live chat, mobile app, Enrollee portal etc.) to be offered to Enrollees after each online interaction.	• After each search transaction, Enrollees are offered a survey to evaluate their satisfaction with the provider search tool. • Results for all digital channels flow through CSQIC, QIC and the Digital Communications team to implement solutions enhancing Enrollees' digital experience.
In-person	Face-to-face	We will be implementing a survey tool under the new contract to be offered to Enrollees after each in-person interaction with our staff.	• Staff logs each in-person interaction in CAREConnects (CRM) that generates an outbound follow-up call to survey Enrollees about their in-person experience. Survey results flow through CSQIC and QIC.
Additional Methods of Measuring Enrollee Satisfaction			
CAHPS	Telephonic, in writing	CAHPS Survey Tool	CSQIC, QIC, and Kentucky market leaders review customer service results

Point of Contact	Method	Feedback Tool/Frequency	Process
			for trending, analysis, root cause, and develop PIPs, if needed.
Grievances and Appeals process	Telephonic, in writing, online, in-person, or through providers.	Our Grievances and Appeals platform enables systematic processing and issue resolution within the required deadlines.	Quarterly, the UMAC, CSQI, and QIC review and discuss trends, barriers, and opportunities for improvement and assign workgroups to conduct root cause analysis and drive process improvements.

f. Provide the following sample materials:

i. Draft Welcome Packet and Enrollee ID card aligned with the requirements of the Draft Medicaid Managed Care Contract and Appendices
ii. Sample Enrollee Handbook meeting the requirements of the Draft Medicaid Managed Care Contract and Appendices.
iii. Three (3) sample Enrollee materials with taglines and displaying ability to meet translation, accessibility and cultural competency requirements

WellCare of Kentucky has provided the following attachments as requested by DMS:

- **Attachment C 12.f.i-1 Draft Enrollee ID Card**
- **Attachment C 12.f.i-2 Draft Enrollee ID Card Letter**
- **Attachment C 12.f.i-3 Draft Provider Directory (provided electronically)**
- **Attachment C 12.f.ii-1 Sample Enrollee Handbook (provided electronically)**
- **Attachment C 12.f.ii-2 Sample Enrollee Handbook in Spanish (provided electronically)**
- **Attachment C 12.f.iii-1 Sample Enrollee Material Quick Start Guide Brochure**
- **Attachment C 12.f.iii-2 Sample Enrollee Material OTC Catalogue (provided electronically)**
- **Attachment C 12.f.iii-3 Sample Enrollee Material Healthy Rewards Brochure**

C.12 Enrollee Services

- Attachment C.12.f.i-1 Draft Enrollee ID Card
- Attachment C.12.f.i-2 Draft Enrollee ID Card Letter
- Attachment C.12.f.i-3 Draft Provider Directory (Provided Electronically)
- Attachment C.12.f.ii-1 Sample Enrollee Handbook (Provided Electronically)
- Attachment C.12.f.ii-2 Sample Enrollee Handbook in Spanish (Provided Electronically)
- Attachment C.12.f.iii-1 Sample Enrollee Material Quick Start Guide Brochure
- Attachment C.12.f.iii-2 Sample Enrollee Material OTC Catalogue (Provided Electronically)
- Attachment C.12.f.iii-3 Sample Enrollee Material Healthy Rewards Brochure

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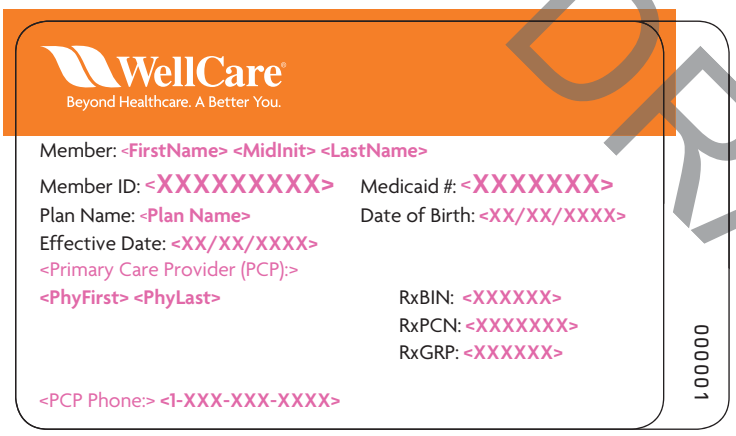

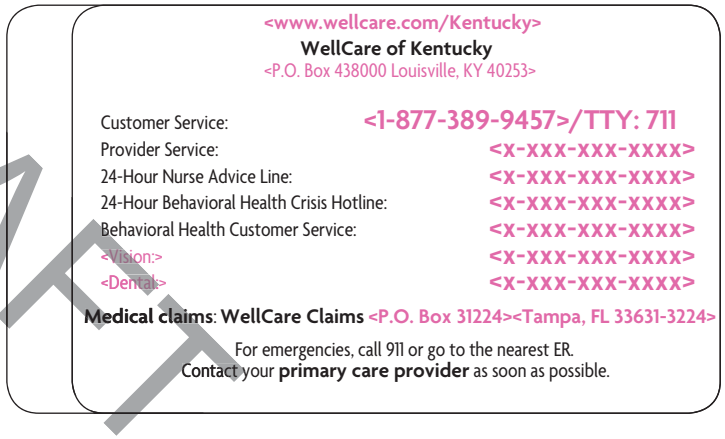

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123 Main St
Lexington, KY 40502

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Member: <FirstName> <MidInit> <LastName>
Member ID: <XXXXXXXXX> Medicaid #: <XXXXXXX>
Plan Name: <Plan Name> Date of Birth: <XX/XX/XXXX>
Effective Date: <XX/XX/XXXX>
<Primary Care Provider (PCP):>
<PhyFirst> <PhyLast>
RxBIN: <XXXXXX>
RxPCN: <XXXXXXX>
RxGRP: <XXXXXX>
<PCP Phone:> <1-XXX-XXX-XXXX>

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Dear Member:

We're glad you're with us. We want you to have everything you need to make sure you get the care and attention you deserve. Helping you get the most out of your plan is our number one priority. Attached is your member identification (ID) card, the key to accessing your plan benefits.

- Keep your card safe and carry it with you at all times;
- Please check to make sure the spelling of your name is correct; and
- See important phone numbers on the back of the card.

What's Next? Take Charge Of Your Health

Visit www.wellcare.com/Kentucky to:

- Register/Log in to your Member Portal;*
- Review benefit information
- Find a provider or pharmacy; and
- View your Member Handbook and Provider Directory.

On the Member Portal you can:

- View/Print your ID card;
- Request your plan materials;
- Find info about your Primary Care Provider (PCP)
- Chat live with a Customer Service representative.

*New Members – allow 24 hours after your coverage starts to register on the Member Portal.

Things to Remember:

- Call the Kentucky Department for Medicaid Services at **1-800-635-2570** to let them know if:
  - Your address or phone number change
  - You get other health insurance
  - Your income changes
  - Your family size changes
- In a true emergency, go to the nearest emergency room or call **911**.

Have questions? We have answers!

Here are just a few things our Customer Service representatives can help with:

- Choose or change your PCP;
- Info about benefits
- Order a paper copy of your Member Handbook or Provider Directory

Do you have questions or would you like to receive materials in Braille, audio, large print or another language? If so, call Customer Service at **1-877-389-9457** (TTY **711**) and we'll send them to you at no cost. We can help you Monday–Friday, 7 a.m. to 7 p.m.

Sincerely,
WellCare of Kentucky

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WellCare
Beyond Healthcare. A Better You.

WellCare
Beyond Healthcare. A Better You.

WellCare of Kentucky complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-877-389-9457**. For TTY, call **711**.

Si el español es su lengua materna, podemos brindarle servicios de traducción. También podemos proporcionarle información en otros formatos, como braille, audio y letra de imprenta grande. Simplemente, llámenos sin cargo al **1-877-389-9457**. Para TTY llame al **711**.

如果中文是您的母語，我們可以為您翻譯。我們也可以用其它格式為您提供資訊。這些格式包括布萊葉文、音頻及大字體。僅需撥打我們的免費電話。您可以撥打 **1-877-389-9457** 聯絡我們。TTY 用戶請撥打 **711**。

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KEEP THESE HANDY:

With the WellCare of Kentucky app, you can access benefits info and more! Available in the Apple and Android stores.

Just visit www.wellcare.com/Kentucky

Customer Service 1-877-389-9457 (TTY 711)

Our friendly staff can help with ID cards, OTC orders and much more.

24-Hour Nurse Advice Line 1-800-919-8807

Speak with a live nurse 24 hours a day, 7 days a week.

Community Connections Help Line 1-866-775-2192

They can help you find local, community-based services if you need help with things like food, transportation, child care and more.

24-Hour Behavioral Health Crisis Hotline 1-855-661-6973

If you or a family member is having a behavioral health crisis, call us for help.

WellCare
Beyond Healthcare. A Better You.

We want you to have all the information you need. We can send you the complete Member Handbook at no charge. Please call WellCare of Kentucky toll-free at **1-877-389-9457** (TTY **711**) to ask for one. You can also request a copy at **www.wellcare.com/Kentucky**.

You must recertify your Medicaid every 12 months to keep your benefits. Do you know when it's time to recertify your coverage? Visit **www.KYNECT.KY.GOV** to learn more.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-877-389-9457**. For TTY, call **711**.

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CAD_25310E State Approved 02202019

2019 WellCare of Kentucky

Quick Start Guide

WellCare
Beyond Healthcare. A Better You.

KY9CADBRO25310E_0000

Attachment C.12.f.iii-1 Sample Enrollee Material Quick Start Guide Brochure

Ready to take charge of your healthcare but aren't sure where to begin? Try starting with these steps:

Check your member ID card.

Your member ID card has information you'll need:

- Your member ID number
- Your primary care doctor's (PCP's) name and contact information
- Important phone numbers

Be sure to carry this card with you at all times.

Get to know your doctor.

Your PCP is your partner in health. See your PCP during your first 90 days as a member to be on top of your health. You can also request to change your PCP on our website. It's easy! Visit **www.wellcare.com/Kentucky**.

If you need help choosing a PCP, we can help. Call us at **1-877-389-9457** (TTY **711**).

Sign up for OTC.

Our most popular extra benefit is the OTC or over-the-counter benefit. Every month you can order $10 worth of items and have them sent right to your home. Choose things like diapers, vitamins, cold remedies, toothbrushes and more. We'll send monthly shipments to your home totaling as much as $120 each year. Ways to order:

- Call us toll-free at **1-877-389-9457** (TTY **711**) and talk to one of our team members or use our automated service
- Go to our website at **www.wellcare.com/Kentucky** and log in to our member portal

Covered Benefits

With WellCare of Kentucky, you get benefits like:

- ☑ **Physician office visits**
  $3 co-pay
- ☑ **Pharmacy services**
  $1 co-pay preferred and non-preferred generic
  $4 co-pay preferred brand name
- ☑ **Behavioral health services**
  $3 co-pay
- ☑ **Family planning services**
  $0 co-pay for:
  - Annual visit
  - Contraception and supplies
  - Family planning and HIV counseling
  - Lab tests and pregnancy testing
- ☑ **Vision (adults 21 and over)**
  - 1 exam per year
  - 1 pair of eyeglasses per 24 months

Healthy Rewards

The Healthy Rewards Program rewards you for taking steps that help you live a healthy life. To learn more about WellCare of Kentucky's Healthy Rewards Program, or if you have questions, give us a call or go online. Our toll-free number is **1-877-389-9457** (TTY **711**) and our website is **www.wellcare.com/Kentucky**.

Would you like to see the full list of healthy behaviors that earns rewards? Just visit the Healthy Rewards Program section on our website. Go to **www.wellcare.com/Kentucky** in the Medicaid section.

Did You Know?

If you're pregnant, let us know. Call us at **1-877-389-9457** (TTY **711**) so we can let you know about WellCare of Kentucky's great extra benefits such as:

Birthing Center and Licensed Midwife Services

Giving mothers options when it comes to childbirth.

Unlimited Visits for Maternity Care

Unlimited prenatal visits and unlimited postpartum visits for the first 4 weeks after your child is born.

Healthy Pregnancy

Complete one prenatal physician visit within your first trimester and receive your choice from the following: stroller, car seat, playpen or diapers.

Attachment C.12.f.iii-1 Sample Enrollee Material Quick Start Guide Brochure

WellCare® Beyond Healthcare. A Better You.

Healthy Rewards Program

We want to reward you for joining our Healthy Rewards Program and taking steps to improve or maintain your health!

How preventive health checkups improve long-term health

Your healthcare provider is your best partner in keeping you healthy. He or she will test you for things like high blood pressure and diabetes. If they find a problem, they can treat you before your symptoms get worse. When a problem is found early, treatment could be as simple as a small change in your diet! Want some more good news? Just by completing those checkups, you earn more on your Healthy Rewards card!

What is the Healthy Rewards Program?

The Healthy Rewards Program recognizes your efforts in taking small steps that help you live a healthy life. By seeing your provider and completing health checkups detailed in the chart, you can start earning rewards.

Prepaid Debit Card or Gift Card

You can use your Healthy Rewards Prepaid Debit Card or Gift Card to buy healthy items you use every day.

How to Get Your Rewards

To start earning rewards, please go to **www.wellcare.com/Kentucky** and log in to the secure member portal. Once you are logged in, click on the *Healthy Rewards* link to notify us that you've completed an activity.

You can also call Customer Service to notify us or if you have questions about the program. You can reach us at **1-877-389-9457** (TTY **711**). We're here for you Monday–Friday, 7 a.m. to 7 p.m. Visit us any time at **www.wellcare.com/Kentucky**.

WellCare of Kentucky complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-877-389-9457**. For TTY, call **711**.

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Healthy Rewards Program

WellCare®
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Attachment C.12.f.iii-3 Sample Enrollee Material Healthy Rewards Brochure

WellCare® Beyond Healthcare. A Better You.

Healthy Rewards Program	Focus Area	Activity Criteria	Incentive Type	Incentive Value
New Members	PCP Visit	Initial PCP Visit within 90 days of enrollment	Visa® Debit Card, or Gift Card	$25
Member Information	Updated Member Information	Members get an annual reward for keeping their information current: phone number, address, and e-mail address	Visa® Debit Card, or Gift Card	$10
Children's Health	0–15 Months	Well child visit per periodicity schedule (6 visits)	Visa® Debit Card, or Gift Card	$10 per visit for a total of $60
Healthy Pregnancy	Prenatal Care Visits	Members must complete a prenatal visit during their first trimester or within 42 days of enrollment (age 12 and up)	Visa® Debit Card, or Gift Card	$25
	Completion of Prenatal Visit	Members who complete a prenatal visit will have the choice to get one of the reward options listed	Bonus Reward	Choice of a stroller, portable playpen, car seat or six (6) packs of diapers.
	Postpartum Care Visit	Attend 1 postpartum visit 21–56 days after the birth of the baby (age 12 and up)	Visa® Debit Card, or Gift Card	$25
Chronic Care Management	Diabetes	Complete an annual eye exam (members with diabetes ages 18–75)	Visa® Debit Card, or Gift Card	$25
		Complete an annual HbA1c lab test (members with diabetes ages 18–75)	Visa® Debit Card, or Gift Card	$25
		Blood Pressure Control (members with diabetes ages 18–75)	Visa® Debit Card, or Gift Card	$25
Well Women	Cervical Cancer Screening	Complete office visit for an annual Cervical Cancer Screening (pap test) (ages 21–64)	Visa® Debit Card, or Gift Card	$25
	Mammogram Screening	Complete an annual Mammogram Screening (ages 50–74)	Visa® Debit Card, or Gift Card	$25
	Chlamydia Screening	Complete an annual Chlamydia Screening (ages 16–24)	Visa® Debit Card, or Gift Card	$25
Adult Health	Annual Adult Health Screening	Complete a annual Adult Health Screening (Wellness Visit - members age 20 and older)	Visa® Debit Card, or Gift Card	$25
Dental Care	Preventative Dental Visit	Any preventive Dental visit for all members (ages 2–20)	Visa® Debit Card, or Gift Card	$25

Attachment C.12.f.iii-3 Sample Enrollee Material Healthy Rewards Brochure

WellCare® Beyond Healthcare. A Better You.

13. Enrollee Selection of Primary Care Provider (PCP)

C.13. ENROLLEE SELECTION OF PRIMARY CARE PROVIDER (PCP)

a. **Describe the Vendor's proposed approach to helping Enrollees to identify and make voluntary selections of PCPs, within specified timeframes, who meet their needs, ensure continuity of care. Include information about differences in the Vendor's approach, if any, to supporting Enrollees without Supplemental Security Income (SSI), Enrollees who have SSI and Non-Dual Eligible, and Enrollees under Guardianship through the selection process.**

b. **Describe the Vendor's PCP auto-assignment algorithm for Enrollees who do not make a voluntary selection, including how the Vendor will ensure an Enrollee's continuity of care.**

c. **Describe the Vendor's approach for processing provider change requests, to include:**
   i. Enrollee request after initial assignment,
   ii. For cause,
   iii. When Enrollees regain eligibility,
   iv. When the Provider is terminated, and
   v. For a Provider request.

d. **Describe the Vendor's approach to identifying, outreaching to, and educating Enrollees who do not receive services from their PCP within one (1) year of enrollment with the PCP. What information and support will the Vendor provide to Enrollees to obtain services?**

C.13. ENROLLEE SELECTION OF PRIMARY CARE PROVIDER (PCP)

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 23.0 Enrollee Eligibility, Enrollment, and Disenrollment of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix,** provided electronically.

Helping our Enrollees identify and select PCPs is a WellCare of Kentucky core competency we have been delivering successfully since 2011 yet never stop trying to improve. Our process for Enrollee-PCP alignment prioritizes Enrollee choice made in the most streamlined and efficient way possible. We are at 100% of network adequacy, so there is a high-quality PCP for every Enrollee who needs one. When Enrollees do not make a voluntary selection at the time of applying for Medicaid, our algorithm generates the best possible matches based on criteria most important to Enrollees' health and continuity of care such as prior PCP relationship, family members assigned to the PCP, the time and distance standards and other factors. Our Enrollees need strong patient-provider relationships to help them understand and navigate complex medical needs within a trusted environment, and we maintain those existing relationships or facilitate new ones. We believe that our network in general, and our PCP network in particular, are reasons why more Enrollees choose WellCare than any other MCO in Kentucky.

a. Describe the Vendor's proposed approach to helping Enrollees to identify and make voluntary selections of PCPs, within specified timeframes, who meet their needs, ensure continuity of care. Include information about differences in the Vendor's approach, if any, to supporting Enrollees without Supplemental Security Income (SSI), Enrollees who have SSI and Non-Dual Eligible, and Enrollees under Guardianship through the selection process.

WellCare of Kentucky's policies and procedures governing the PCP assignment process aligns with Section 23.0 Enrollee Selection of Primary Care Provider.

WellCare of Kentucky empowers our Enrollees to make voluntary PCP selections because voluntarily selecting a PCP is an affirmative decision to take charge of one's health. When processing enrollment files, we preserve Enrollees' PCP choices if they are in network. The majority of our PCPs are Board Certified in Family and Internal Medicine, General Practice, Pediatrics, and Geriatrics. However, Enrollees may select as their PCP an Advanced Practice Registered Nurse, Physician Assistant, or specialized in Obstetrics and Gynecology. Enrollees with chronic illnesses or with long-standing relationships with providers may choose other specialists as PCPs.

If the Enrollee does not make a voluntary PCP selection during the application process, our standard practice is to auto-assign a PCP within 24-Hours. This assignment is a preliminary selection designed to begin facilitating the Enrollee-PCP relationship quickly.

Despite the practices employed by other Managed Care Organizations, our **preliminary PCP assignment does not inhibit or limit the Enrollee** in any way. Enrollees are free to receive care from any provider they choose, even if that provider is not their assigned PCP. Our preliminary PCP assignment does not limit Enrollees from seeing any PCP they choose, including PCPs they are not assigned to. Our goal is that every Enrollee have an assigned medical home they have chosen and providers they have strong relationships with. Our commitment to unfettered choice empowers us to make initial PCP assignments immediately upon enrollment and then educate Enrollees about their options for changing PCPs if they are unsatisfied in any way. We communicate this information in our handbook and other materials specifying Enrollees' right to change PCPs at any time without a 30-Day or 90-Day restriction for changing a PCP selection. This process applies to all Enrollees who are required to have a PCP, whether they have SSI, or are enrolled in a non SSI eligibility category. However, Medicare Dual eligible Enrollees, Foster Child Enrollees, or Guardianship Enrollees are not assigned a PCP through this process.

If an Enrollee requests a reassignment after being preliminarily assigned a PCP, we acknowledge that the reassignment is retroactively effective to the date of the Enrollee's assignment to us. Changes requested after 30 days are effective on the first of the following month. Our DMS-approved algorithm prioritizes previous PCP relationships in its logic as well as other rules described later in our response to 13.b.

GUARDIANSHIP CLIENTS (DAIL)

Our enrollment systems identify adult guardianship clients on the HIPAA 834 transaction file, and we understand that DAIL staff are authorized to make PCP selections on their behalf. These **Enrollees can change PCPs at any time** with or without cause, and our process allows for PCP

changes without limitations. Furthermore, because these Enrollees frequently move from one placement to another, brief absences for medical services outside their county of residence not exceeding one month do not constitute a change in the county of residence.

REPORTING

In accordance with our policies and procedures, we submit a quarterly report to DMS with the number of eligible individuals assigned a PCP. We notify Enrollees, in writing, of PCP assignments, including Providers' names and office telephone numbers. In addition, on the first day of each month, we furnish our PCPs with a roster of Enrollees who have selected or been assigned to his or her care.

PCP ASSIGNMENT NOTIFICATION

Within five (5) days of a PCP assignment, whether self-selected or assigned, we send an ID card and letter with the PCP name, address, and phone number as well as instructions to contact us if they wish to change PCPs. New Enrollees also receive an Enrollee Welcome Kit within five (5) Days consisting of an Enrollee Handbook and Provider Directory, which contain information about the PCP assignment process and how to establish the PCP relationship.

RESOURCES FOR PCP IDENTIFICATION

To help Enrollees understand the PCP assignment process soon after enrollment, we provide Enrollees with a handbook detailing the importance of maintaining a PCP relationship and informing them of their right to change PCPs at any time. In addition, we also furnish a Provider Directory listing all participating providers in their region by county and specialty. Through our public website, Enrollees can use the find-a-provider tool to get the most current information on providers by location, name, specialty, or other keywords.

ASSISTED, VOLUNTARY PCP SELECTION

WellCare of Kentucky's new Enrollee Welcome Calls provide Enrollees an option to connect with a live Enrollee Services Representative (ESR) for PCP selection. The ESR conducts a new Enrollee onboarding needs assessment consisting of a Health Risk Assessment to identify any immediate clinical needs, capturing communications preferences (mail, phone, text) including language needs, previous PCP relationships, and other criteria. In this manner, new Enrollees learn that making voluntary PCP selections within the broader context of their health needs, background, and circumstances ensure a better match. In addition, ESRs educate Enrollees on continuity of care considerations in the PCP selection process, advising Enrollees to avoid disruptions in care by changing PCPs during a course of treatment, and they also assist Enrollees with scheduling an appointment to establish the relationship.

SELF-SERVICE, VOLUNTARY PCP SELECTION

Offering self-service options for voluntary PCP selection encourages Enrollee self-sufficiency. We empower Enrollees to take charge of an important health care decision by providing PCP selection via the secure Enrollee portal and the MyWellCare mobile application. Enrollees who self-select their PCPs are more likely to access them.

b. Describe the Vendor's PCP auto-assignment algorithm for Enrollees who do not make a voluntary selection, including how the Vendor will ensure an Enrollee's continuity of care.

When an Enrollee does not make a voluntary PCP selection during the Medicaid application, we activate our algorithm which prioritizes previous PCP relationships at the very top of the logic hierarchy for continuity of care purposes. Our proprietary auto assignment algorithm also includes a preference for Providers receiving the highest quality scores and our processes ensure that PCPs are willing to accept new Enrollees before they are assigned. Enrollees with certain health conditions also have the option to select a specialist or subspecialist as their PCP.

Our DMS-approved auto-assignment algorithm is aligned with Section 23.3 Enrollees without SSI:

- Review of previous PCP history using both internal claims and claim history provided by DMS for new enrollees
- The PCP is active, participates in the Medicaid program, and has an open panel
- Time/distance logic: 30 miles or 30 minutes aligned with accessibility standards as outlined in Section 28.4 Provider Network Access and Adequacy
- Needs of children and adolescents to be under the care of a pediatric/adolescent specialist
- Needs of children from the same household will be assigned to have a common medical home
- Special medical needs such as pregnancy
- Language needs
- Area of residence – access to transportation

Finally, we apply quality, cost efficiency, and Patient Centered Medical Home status and generate scores to ensure we assign Enrollees to high quality PCPs as follows:

- Scores of 3.75-5 (first preference)
- Scores of 3-3.75 (second preference)
- Scores of 2-3 (third preference)
- Scores of 0-2 (fourth preference)

ALGORITHM PERFORMANCE

Enrollee and provider satisfaction scores can indicate an effective PCP selection process. **We earned #1 NCQA Customer Satisfaction in 2016-2019 among all Medicaid MCOs. We also scored the highest of all MCOs on 24 key HEDIS measures**. Our performance in these areas validate strong Enrollee-PCP alignment and a good algorithm match. We apply rigorous quality control analysis to identify trends and flow reports to the Quality Improvement Committee for recommendations on algorithm improvements, if necessary.

c. Describe the Vendor's approach for processing provider change requests

Our approach to provider change requests begins with following all contract requirements and federal regulations. Our policies and procedures as stipulated in policy C6EN MD-006 governing the PCP assignment process aligns with this section and Section 23.0 Enrollee Selection of

Primary Care Provider. We maintain an open access network and believe that not restricting Enrollees' abilities to choose or change PCP assignments results in Enrollees being served by providers they have a positive relationship with and receiving the care necessary to improve their health outcomes. Even though the contract permits us to limit Enrollees from changing PCPs in certain scenarios, we value the Enrollee-PCP relationship and accordingly, our guidelines for changing PCPs are less restrictive than those outlined in Section 23.6 Primary Care Provider Changes.

The tools we use to process change requests are designed to process information promptly and accurately with no administrative burden for the Enrollee or PCP. We process Enrollee change requests in writing, telephonically through our customer service agents or digitally through our online Enrollee portal or MyWellCare mobile app.

During any change in PCP, the initial PCP is responsible for the Enrollee's care until the effective date of the new assignment. To ensure Enrollee continuity of care, we assist with the transition of Medical Records to the new PCP in accordance with applicable contract requirements and federal regulations. Our process is time-tested and frequently evaluated for efficiency and accuracy. Our process, as described above, is consistent for all the change requests below.

i. Enrollee request after initial assignment,

As previously discussed, we honor Enrollees' right to change the PCP at any time for any reason; therefore, our approach is to accept all change requests following initial assignment.

ii. For cause,

We process Enrollee change requests after the initial assignment at any time for any of these for cause reasons. We assign a new PCP according to contract requirements and our criteria noted above to make the best possible match.

- Enrollee was denied access to needed services
- Poor quality of care
- PCP is not qualified to treat condition

We recognize that negative experiences with a PCP can lead an Enrollee to disconnect from their care. When we become aware of these situations, our trained staff encourages Enrollees to create a primary care relationship with their new PCP and important points to consider in their new selection.

iii. When Enrollees regain eligibility,

Our Enrollment and Eligibility System (EES) recognizes on the incoming 834 enrollment file Enrollees who have been reinstated following a minor interruption in coverage; in these instances, we assign back to the original PCP for continuity of care. As always, we will process a change request at any time if the Enrollee desires a different PCP.

iv. When the Provider is terminated

We assist Enrollees in selecting new PCPs in cases of provider terminations. A termination triggers a letter to Enrollees notifying them of the termination, according to the below

timeframes, and provides Enrollee guidance on the options available to them to facilitate a PCP change including live agent call, MyWellCare App or through the Enrollee portal

- For voluntary terminations, we notify within 30-Days prior to the effective date or as soon as the Provider notifies WellCare of Kentucky if fewer than 30-Days.
- For involuntary terminations, within 15-Days prior to the effective date

To avoid disruptions in care and Enrollee abrasion we brief our Enrollee Services Reps to prepare for increased call volumes and provide them with information to better transition our Enrollees seamlessly.

v. For a Provider request.

PCPs have the right to request an Enrollee's disenrollment from their practice (request must be in writing) under the following circumstances:

- Incompatibility of the PCP/patient relationship
- Non-utilization of services within the past year of enrollment in the PCP's practice provided the PCP furnishes documentation of six unsuccessful attempts by mail and phone on six separate occasions during the year
- Inability of PCP to meet Enrollee's medical needs

We acknowledge that Federal regulations protect Enrollees from being reassigned by their PCP on the basis of the following:

- Change in health status or need for treatment
- Utilization of services
- Diminished mental capacity
- Disruptive behavior resulting from special health care impairing PCP's ability to furnish services to Enrollee or others
- Race, gender, disability, color, national origin, age, or gender

Enrollees have the right to file grievances regarding transfer to a new PCP.

d. Describe the Vendor's approach to identifying, outreaching to, and educating Enrollees who do not receive services from their PCP within one (1) year of enrollment with the PCP. What information and support will the Vendor provide to Enrollees to obtain services?

PCP REASSIGNMENT

Because we are committed to facilitating the relationship between Enrollees and their PCPs, we regularly employee algorithms to identify whether Enrollees are receiving their regularly scheduled preventive care and whether they are receiving it from their assigned PCP or another provider within the provider group or organization the PCP belongs to. In the event that an Enrollee is identified as not having received services within the past year, or not having received them from their assigned PCP or his/her peers, WellCare employs a reassignment process. When an Enrollee has not received services for a year, we conduct a claims analysis with a 24-month look-back period to identify if the Enrollee has received services from the assigned PCP, a PCP within that practice, or if the Enrollee has received services from any other provider who is eligible to serve as a PCP. We will reassign the Enrollee to the PCP providing the services to

ensure that, moving forward, their assigned PCP is reflective of the providers they have implicitly been using as their PCP, even if they had not formally requested a PCP change.

For Enrollees who have not engaged with their assigned PCP, or any other PCP, we will perform telephonic outreach to address the importance of having a medical home, and will work with the Enrollee to schedule the first appointment.

Our primary goal in all of this is not to enforce an original PCP assignment, but to ensure the Enrollee has the freedom to receive care from the provider of their choice, and we will pro-actively alter our initial assignment to conform to the demonstrated preferences of the Enrollee.

14. Enrollee Grievances and Appeals

C.14. ENROLLEE GRIEVANCES AND APPEALS

Describe the Vendor's proposed Enrollee Grievances and Appeals process, including a summary of methods for the following:

a. **Compliance with State and Federal requirements.**

b. **Process for Expedited Review.**

c. **Involvement of Enrollees and their caregivers in the process.**

d. **Tracking grievances and appeals received by type and trending results for use in improving operations.**

e. **Reviewing overturned decisions to identify needed changes.**

C.14. ENROLLEE GRIEVANCES AND APPEALS

a. Compliance with State and Federal requirements

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 24.0 Enrollee Grievances and Appeals of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

In Kentucky, WellCare has been successfully resolving grievances and appeals for Enrollees for eight years. We rank first in Enrollee satisfaction and we have an overall Enrollee choice rate of nearly 80%. Our philosophy is that grievances and appeals provide valuable feedback about our operation, so we review them each month in our executive team meeting. This gives management direct access to any new or potentially troubling trends.

From 2017 to 2019 WellCare of Kentucky saw a 3% improvement in first call resolutions

Our **Enrollee-friendly process** leverages our Medicaid experience across the nation resolving grievances, appeals, and state fair hearings in compliance with NCQA, state, and federal Medicaid requirements using a process designed for rapid and thorough resolution. The program protects Enrollees' rights and employs industry-leading technology to capture, log, document, track, resolve, report, and trend every grievance and appeal from beginning to end.

We define a grievance and appeal using the 42 C.F.R. § 438.400(b) definitions and cited in the MCO contract. Our Enrollee grievances and appeals system enables us to track a grievance, a plan level appeal, and access to a State Fair Hearing. We offer a **"no wrong door"** approach to filing Enrollee grievances and appeals, and train all associates on how to correctly receive and manage them. Providers and subcontractors receive similar training.

Highly qualified and experienced locally based Enrollee grievance and appeal coordinators comprise the WellCare Kentucky Enrollee Grievance and Appeal Team, overseen by Enrollee Services Manager Elizabeth Starr, LCSW. To ensure timeliness standards, a team of other full-time coordinators, clinicians, and operational leads support the coordinators within our

corporate headquarters in Tampa. WellCare of Kentucky executives, including Medical Director Howard Shaps, MD, MBA, further support the process, with full authority to initiate any action necessary to address Enrollee grievances and appeals.

Nationally, WellCare has a team of 380 highly qualified staff who handle grievances and appeals. This staffing includes coordinators, intake specialists, quality auditors, clinical experts, operational team leads, and managers. Because we offer an in-house pharmacy, behavioral health, and physical health program, our clinical experts include pharmacy medical directors, staff psychiatrists, registered nurses and medical directors of varied specialties. If necessary, we have external physician advisors for a similar specialist review that is arranged to ensure our Enrollees have unbiased access to the care they need.

Locally, our WellCare of Kentucky staff includes seven full -time Kentucky-based grievance and appeals coordinators who manage and adjudicate Enrollee issues; and work in tandem with full-time clinical experts who have the clinical expertise in treating Enrollees to resolve grievances and appeals in accordance with Kentucky contract requirements and Commonwealth and federal laws.

TIMELY PROCESSING OF ENROLLEE GRIEVANCE AND APPEAL REQUESTS

WellCare of Kentucky views every inbound Enrollee call as an opportunity to interact and collect valuable feedback for improving our internal processes and achieving high Enrollee satisfaction. Our goal is efficient issue resolution with minimal burden to Enrollees, parents, and caregivers. We review issues as they arise and make every effort to prevent them from reoccurring. We never discourage our Enrollees from exercising their rights to file formally, but work hard to resolve issues at the point of contact.

In 2017, WellCare of Kentucky exceeded Department requirements, averaging 20.4 calendar days to close standard Enrollee appeals

In accordance with section 24.2 of the Draft Contract, WellCare of Kentucky has a timely and organized Grievance and Appeals Process with written policies and procedures for resolving Grievances filed by Enrollees. We follow all regulatory timeliness guidelines for routine and urgent grievance and appeal processing in accordance with 42 C.F.R. 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. Our process allows identification of access-to-care grievances (e.g., appointment or prescription delays) that come through standard channels and prioritize them for a rapid response. **We are currently compliant with Enrollee grievance and appeals timeliness standards in Kentucky and all of our Medicaid states.**

Strategy One: Resolving Calls in "One Touch"

Industry-leading technology supports our Enrollee grievance and appeals process, ensuring each grievance and appeal is appropriately documented and resolved with root cause analysis of both the individual issue and emerging trends. Using this continuous loop, WellCare of Kentucky **"Solves the Cycle"** to reduce grievances and appeals and improve Enrollee satisfaction, depicted in **Figure C.14-1**. Our Enrollee Service Representatives (ESRs) are specifically trained on Kentucky Medicaid Managed Care program requirements and empowered to resolve each Enrollee contact at the **first point of escalation 100% of the time**

with escalation teams who receive an additional 80 hours of training on the resolution of Enrollee issues. We use a tiered escalation process and word recognition software to automatically flag and route escalated calls to this team for resolution. For example, if an Enrollee mentions a word indicating severe displeasure, the system generates a flag and a supervisor joins the call, as it is happening to prevent a grievance. The success of our "one-touch" Enrollee process is demonstrated by our **2019 first call resolution rate of 86% across all of our Medicaid plans**. We also use machine learning and artificial intelligence solutions to predict the likelihood that an action will result in a grievance or appeal and take proactive measures to address the matter at that time.

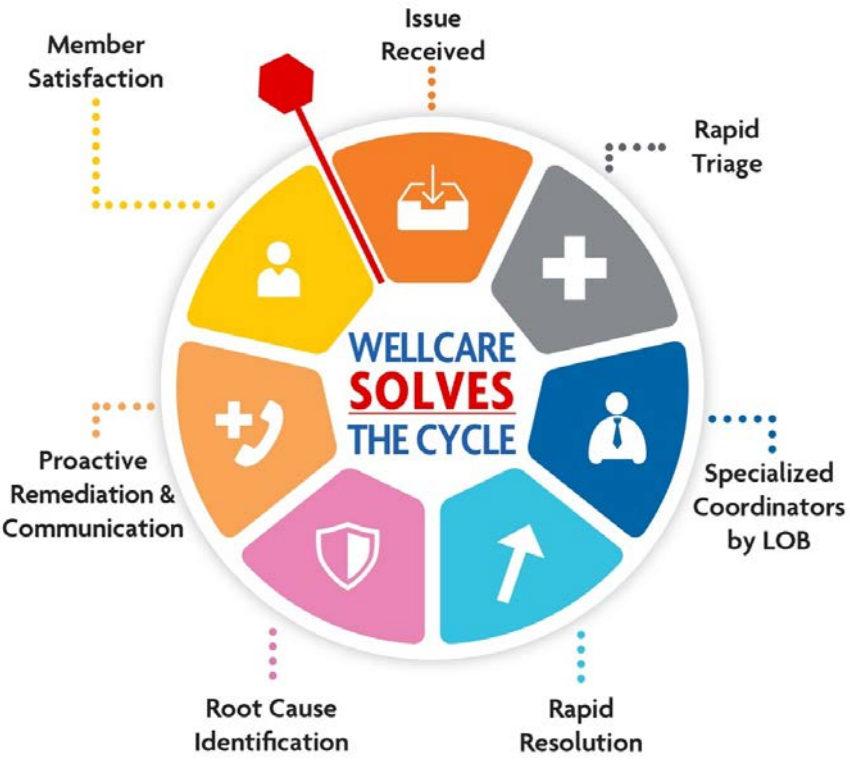


Figure C.14-1 Continuous "Solve the Cycle Process

Strategy Two: Proactively Engaging With Enrollees to Address Issues

We also resolve Enrollee issues at the lowest level of escalation through active in-person engagement where the ESR helps resolve issues before they become a grievance or appeal. Proactive engagement efforts involve care managers who are Enrollee advocates empowered to resolve or escalate issues and community partners (e.g., advocates) who have direct links to WellCare subject matter experts to resolve Enrollee issues.

Strategy Three: collaboration across WellCare

The Grievance and Appeals department collaborates across our organization using our grievance and appeal system to resolve Enrollee grievances and appeals quickly and at the lowest level of escalation. We make every attempt to diffuse issues by resolving them in a timely, efficient, and effective manner at the first point of escalation. In the rare case that a request is reviewed and overturned through the State Fair Hearing proceedings, Dr. Shaps collaborates with our utilization management team, and appeals and grievance staff to review the determination and assess the underlying reason that WellCare of Kentucky's position was not accepted. They use this assessment to address the need for any changes to our policies, procedures, reference materials, and communications, to ensure the remediation of issues, and to eliminate the need for future similar reviews.

Our ability to meet and exceed timeliness standards is the result of the well-defined processes we have developed in Kentucky. These include:

- Mining historical data to understand the volume of grievances and appeals we can expect. This intelligence informs the number of associates we employ to perform WellCare KY grievance and appeals functions.
- Staffing accordingly, training our dedicated Kentucky associates, and cross training others on Kentucky-specific requirements so we have trained staff for unexpected increases in enrollee grievance and appeal volume.
- Establishing Service Level Agreements (SLAs) based on Kentucky timeliness requirements and setting team and individual goals aligned to those requirements
- Reporting to Quality Improvement Director, Laura Betten, the Utilization Management Medical Advisory (UMAC) Committee, Customer Service Quality Improvement (CSQIW) Committee, Quality Improvement (QIC) Committee, and DMS the volume, nature, and resolution status of grievances and appeals
- Conducting independent, internal audits to identify and cure deficiencies
- Collaborating with DMS on Kentucky audits and external quality review audits
- Embedding Kentucky requirements into our grievance and appeal system with workflow requirements and business rules to reduce the reliance on manual processing instructions. For example, the system generates the acknowledgment letter automatically, improving our ability to comply with acknowledgement contractual requirements.

WellCare of Kentucky operates a single platform for complaint resolution - both grievances and appeals. This integrated workflow management system delivers real-time monitoring for each step in the process from intake to resolution, allowing grievance and appeals coordinators in Kentucky to resolve cases according to established standards. The system processes grievances and appeals using a standardized approach. It incorporates automation, machine learning, and artificial intelligence, reading context and sentiment and employing standardized and automated communication throughout. Our grievance and appeal system automation facilitates:

- Case creation and assignment
- Real-time case tracking
- Reminders for aging cases
- Supervisor dashboard alerts and escalation for expiring cases
- Production of regulatory reports and audits
- Integrated document and image storage
- Acknowledgment and resolution letters, requests for information, and case status letters
- Root cause classification and tracking for identification and process improvement

Process for Acknowledging Receipt of Enrollee Appeals and Grievances

We acknowledge the receipt of each grievance and appeal (including oral appeals) in accordance with the Section 24.2 of the Draft Contract and 42 C.F.R §§ 438.406(b)(1) and 438.228(a). Upon receipt of a grievance or appeal, one of our Kentucky-based grievance and appeals coordinators triages the case within our grievance and appeal system for rapid resolution. Our intake coordinators receive comprehensive training on how to recognize and categorize requests as grievances, standard or expedited appeals. Grievances and appeals may

come from multiple sources, including a primary care provider or care manager that submits them on behalf of the Enrollee, with his or her consent. The system automatically issues an acknowledgement letter with a copy going to the provider or other representative acting on the Enrollee's behalf, and updates the grievance or appeal record. Within that letter, we encourage Enrollees to submit additional information to support their request for appeal, and inform them of their right to review the case file during the appeals process. For standard requests, we provide written acknowledgement within five calendar days of receipt. We acknowledge expedited requests via trackable mail within 24 hours.

Our acknowledgment letters use easy-to-understand language that meets grade level plus industry health-literacy levels. We create them in the Enrollee's language with instructions on alternative languages and formats and the availability of an Enrollee advocate to assist. Our acknowledgement letters also encourage the enrollee to submit any additional information they feel can support their case, and of their right to review their case file at any time.

Protocols, Procedures, Staffing Levels, and Requirements for Appeals and Grievance Review

Protocols and procedures for reviewing Enrollee appeals and grievances are as follows:

- Individuals that make decisions on grievances and appeals, including the Kentucky-based grievance and appeal coordinators and clinicians, must not have been involved in any previous level of review or decision-making; they also cannot be a subordinate of any such individual.
- Grievance or appeals involving clinical issues must be reviewed by individuals who have the appropriate clinical expertise in treating the Enrollee's condition or disease
- Persons reviewing the grievance or appeal must take into account all comments, documents, records and other information submitted by the Enrollee/representative without regard to whether such information was submitted or considered in the Adverse Benefit Determination
- An authorized representative (including provider) or legal guardian may request an appeal or file a grievance on behalf of the Enrollee, with the Enrollee's consent
- Correspondence will be conducted in a manner that meets applicable notification standards using Department templates for all Enrollee grievance and appeal notices

In accordance with Section 24.2 of the Draft Contract, we maintain a copy of every grievance or appeal file for a minimum of 10 years, and have a strict policy that prevents retaliation for providers requesting a grievance or appeal, or assisting Enrollees through the grievance and appeal process.

Enrollee Grievance Process

Figure C.14-2 Enrollee Grievances Process Milestones

Figure C.14-2 highlights the grievance process flow**.** Enrollee grievances include dissatisfaction with any aspect of care, outside of an Adverse Benefit Determination. The Enrollee, or their representative with written consent, may file a grievance at any time. Multiple avenues exist for submission of grievances orally or in writing, illustrated in **Figure C.14-3**. These include our call center, website, care managers, PCP or other provider, subcontractors, community partners, and advocates. Grievances are initially triaged by the associate who received the issue, such as the ESR, to determine if it is service-related (i.e. accessibility, Enrollee education) or clinical-related in nature. The grievance and appeal platform integrates with our CAREConnects platform. The ESR enters the ticket using CAREConnects and then the grievance and appeal system picks it up as a grievance. We strive to resolve issues at this step if we can, for example if an Enrollee is calling about obtaining a timely specialist appointment, ESR will resolve it by calling the specialist and scheduling an appointment.

Our Kentucky-based grievance and appeals coordinators record the date and time of call, the Enrollee's contact information, and a detailed explanation of the grievance into our grievance and appeal system. Entry into the system serves as a timestamp for tracking final resolution of the grievance. If the issue is not resolved at time of the contact, the associate forwards it on the same day to the grievance department, along with all supporting documentation, for review, referral, resolution, and reporting. Written grievances go directly to the grievance department. In accordance with Kentucky Medicaid guidelines, WellCare acknowledges grievances within five calendar days.

The grievance coordinator takes responsibility for reviewing and resolving the grievance. If it requires research or input by another department, the coordinator collaborates to research and collect facts from all parties in accordance with our Enrollee Grievance Policy and Procedure. Facilitated by our grievance and appeal system, we ensure that resolution of grievances involves the appropriate staff (or clinical professional with appropriate expertise in treating the Enrollee's condition or disease for clinical grievances), that they or their subordinate have not been involved in prior levels of review or decision-making, and that grievances are resolved as expeditiously as the Enrollee's health requires. If the grievance involves a Medical Necessity determination, Denial or expedited resolution or clinical issue, the coordinator contacts the local Kentucky Quality Improvement department, overseen by Quality Improvement Director Laura Betten, RN. There, it is heard by health care professionals who have the appropriate clinical expertise to make a determination, forwarding it to Dr. Shaps if necessary for final decision. If the QI department determines a grievance requires immediate medical review, a clinical professional with appropriate clinical expertise reviews and resolves it as expeditiously as the Enrollee's health requires.

Our grievance coordinators uses the **automatic alerts and dashboards in our system to track open grievances and ensure resolution** in a timely manner. Depending on the nature of the grievance, provider relations, network management, and population health management teams work collaboratively to resolve each issue. Upon resolution, the assigned coordinator notifies the Enrollee in writing as to the resolution and notifies him or her of the opportunity to submit an appeal to WellCare if dissatisfied with the resolution of a grievance. The grievance coordinator updates the grievance and appeal system, which maintains a dated summary of the grievance including reason, resolution at each level, who conducted the review, key dates associated with the request (e.g., receipt date, date acknowledged, date resolved), and final resolution. We will submit a policy noting any new requirements to DMS for review and approval and update it at least annually.

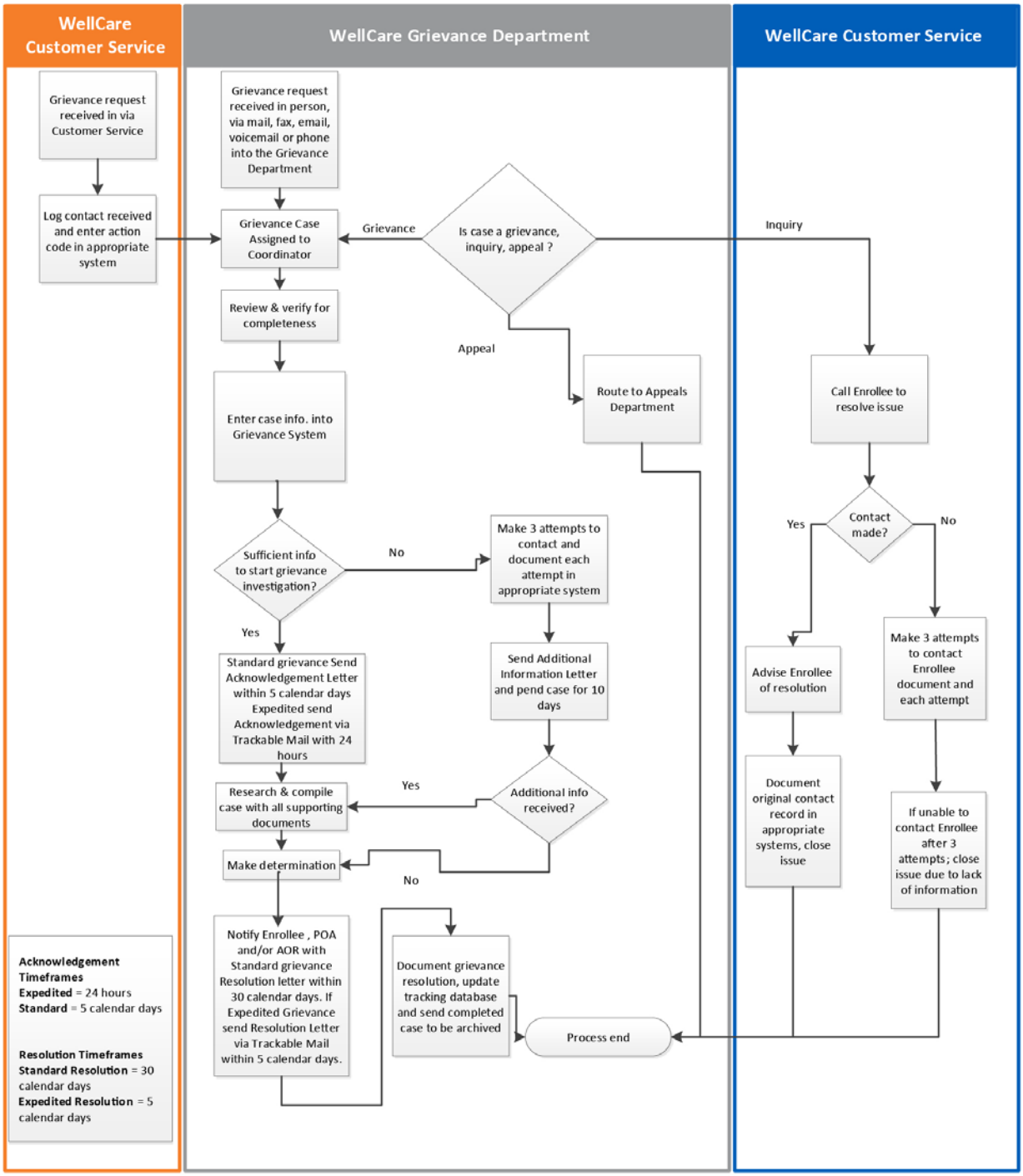


Figure C.14-3 Enrollee Grievance Process

Figure C.14-4 depicts the Enrollee Standard and Expedited Appeals process flow described below.

Enrollee Standard Appeals Process

Enrollee appeals result from a disagreement about service denial, reduction, suspension, or termination through a Notice of Adverse Benefit Determination (NABD). WellCare receives

appeals submitted by Enrollees in writing and via fax. We are also in the process of implementing functionality to accept appeals through our website. Enrollees or their authorized representatives have 60 calendar days from the date on the NABD to file an appeal request. In accordance with our Enrollee Appeal Policy and Procedure, **we track, acknowledge, route, and resolve all appeals in our grievance and appeal system, which fully integrates with our care management system.**

To ensure timely and appropriate resolution of an appeal, Kentucky grievance and appeal coordinators have the support of dedicated enterprise-level appeals RNs and coordinators, quality assurance staff, and department leaders. They complete reviews for clinical cases, and all cases of children under the age of 21, in collaboration with a board-certified physician, psychologist, therapist, or other approved clinical professionals as appropriate, based on the type of appeal. Our reviewers may provide peer-to-peer review support, upon request from an Enrollee's provider prior to the final appeal decision; or they may initiate outreach to the provider to discuss supporting documentation. In accordance with federal and Kentucky regulations, our internal review process allows providers to present new or additional information about the Enrollee's health at any time during the review so we can evaluate previously denied, reduced, or suspended services. Enrollees receive a copy of their complete case file upon request at no charge. WellCare of Kentucky will continue services while an appeal is pending, in line with federal requirements.

Reviewers have the option to have cases reviewed by our Appeals Committee, in which case Dr. Shaps will engage the committee to evaluate whether the determination is in the best interests of the Enrollee.

If the original adverse action is overturned in part or in whole, we authorize the services as rapidly as the Enrollee's health condition requires We also provide for continuation of services, in accordance with 42 C.F.R. 438.420, while the Appeal is pending. In accordance with Section 24.2 of the Draft Contract, WellCare of Kentucky ensures that a grievance or appeal is addressed and notice is given as expeditiously as the Enrollee's health requires. We resolve all cases no later than 30 calendar days from the date of the request. The reviewer enters the resolution in the grievance and appeal system, verbally notifies the Enrollee and the provider when the request is pre-service in nature, and sends formal written notification as to whether the original decision was approved or upheld. The written notice includes the date the review was completed and the reason(s) for the determination in easy to understand language, as required in 42 CFR 438.10. Our grievance and appeal system shares this information with our CareCentral clinical platform to automate the authorization process.

Upon completing the review, the reviewer updates the grievance and appeal system, which maintains a dated summary of the issue or request including who conducted the review, who made the final determination, key dates associated with the request (i.e., receipt date, date acknowledged, date resolved), and final resolution. We will submit a policy noting any new requirements to DMS, and will continue to submit our Enrollee Appeal Policy to DMS for review and approval, in accordance with Section 24.2 of the MCO contract.

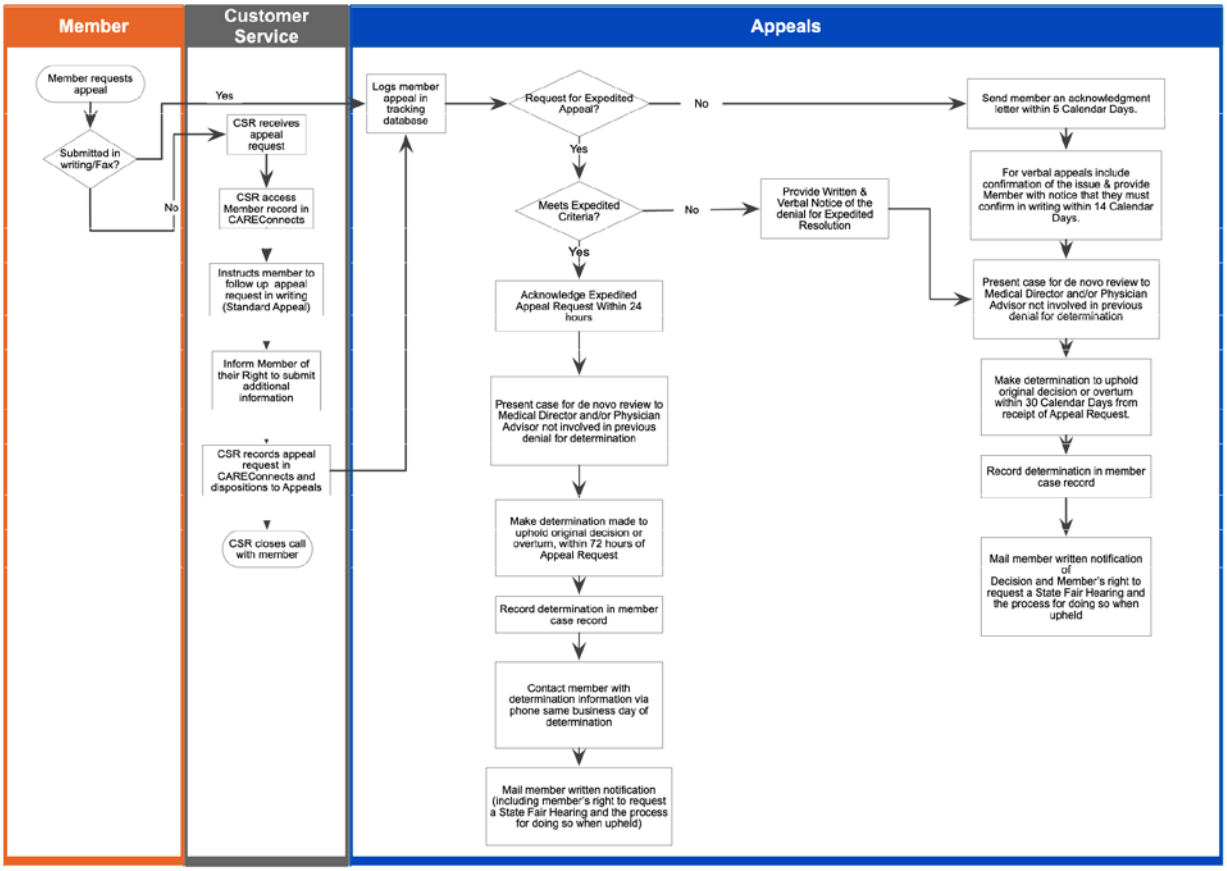


Figure C.14-4 Enrollee Standard and Expedited Appeals Process

b. Process for Expedited Review

If a medical director determines that allowing the time for a standard resolution, described above, could seriously jeopardize the Enrollee's health, life, or ability to attain, maintain, or regain maximum function, we expedite the appeal review. In addition, upon request of the Enrollee or Enrollee's provider, we carefully track these appeals to ensure that we meet the Commonwealth's timeliness standard of three business days using the grievance and appeal system alert flags. A qualified health professional makes the determination to expedite processing. If the expedited request is denied, the Appeals Department attempts to notify the Enrollee immediately by phone and issues a decision in writing within 24-hours of receipt. The case is presented for review to the medical director or a physician advisor not involved in previous denial for determination. Following this review, the medical director or physician advisor determine whether to uphold or overturn the original decision within 72 hours of the appeal request. The same day that this determination is made, it is documented in the Enrollee case record, and the Enrollee is notified by phone. The Enrollee is also mailed written notification of the decision, including the Enrollee's right to request a State Fair Hearing if the original decision is upheld, and the process for doing so.

STATE FAIR HEARINGS

An Enrollee may initiate a State Fair Hearing in the following instances, in accordance with Section 24 of the Draft Contract:

- WellCare of Kentucky fails to resolve an appeal within 30 days,
- The Enrollee exhausts WellCare of Kentucky's internal appeal process
- if he or she is dissatisfied with an Adverse Benefit Determination within 120 days of WellCare of Kentucky's final appeal decision, as provided for in 42 C.F.R. 438.408.
- An Adverse Benefit Determination that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service.

If the enrollee's appeal decision regarding and adverse benefit determination is upheld, the final determination notice includes the Enrollee's rights to request a State Fair Hearing within 120 days of the final appeal decision. If the Enrollee requests a State Fair Hearing, WellCare of Kentucky will furnish all documentation and will participate in the Hearing in accordance with 907 KAR 17:010 and any other applicable state or federal guidelines.

c. Involvement of Enrollees and their caregivers in the process.

We recognize that **Enrollees have a voice** and a right to understand how to engage when they feel that their needs are not met. We go to great lengths to educate Enrollees, families, caregivers, and authorized representatives about the grievance and appeals process through an array of awareness efforts, including initial education and ongoing outreach.

New Enrollee Materials: **Within five business days of enrollment**, we send a New Enrollee Welcome Packet, which includes the Enrollee Handbook to inform Enrollees and their families of their grievance and appeal rights, and how to access them. Within the Handbook and on our website, we specifically spell out grievance and appeals processes including:

- Enrollee right to a grievance or appeal and the difference between them
- How to file a grievance by phone, writing, or via our website
- How to request an appeal of services denied, reduced, suspended, or terminated
- How to request expedited appeals
- How to appoint a representative to file a grievance or appeal on their behalf

Our support extends beyond just supplying education through printed and online materials. Call center staff, care managers (CMs), providers, and community partners all receive training on our grievance and appeal process so they can educate and assist Enrollees and their representatives as needed.

Enrollee Call Center: Enrollee Services Representatives are often an Enrollee's first contact with us. These associates receive training and have call scripts to guide them as they inform Enrollees about the grievance and appeals process and assist them with filing, as requested.

Care Managers: For Enrollees enrolled in care management, our "no wrong door" process requires CMs to educate Enrollees and their families on the grievance and appeals process. Additionally, CMs may submit grievances or appeals on the Enrollee's behalf, if desired.

Providers: Providers are often the Enrollee's first line of information for Adverse Benefit Determinations so we comprehensively train them on Enrollee grievance and appeals rights, including the provider's right to request an appeal verbally or in writing on behalf of the Enrollee with written consent.

Special Assistance: We make necessary accommodations to assist Enrollees who may have impaired hearing, impaired vision, or speak a language other than English with filing an appeal or grievance (e.g., completing forms or taking procedural steps). This includes, but is not limited to, providing interpreter services at no cost to the Enrollee and toll-free numbers that have adequate TTY/TTD and interpreter capability.

d. Tracking grievances and appeals received by type and trending results for use in improving operations.

Grievance and appeal data play a critical role in our WellCare KY QI program. We want to know if an Enrollee is unhappy with his or her care, or with the treatment, he or she receives. Using our grievance and appeal system, **we continuously track and trend data to identify trends and make program improvements.** This ultimately reduces the number of grievances and appeals. Given the rich source of information found in these trends, we report the findings to various committees, both quarterly and year-over-year. This includes the UMAC Committee, CSQI Committee, and QI Committee. These committees review and discuss trends, barriers, and opportunities for improvement and assign workgroups to conduct root cause analysis and drive process improvements such as education or internal remedial training. We also use our grievance and appeal data to assess the performance of our subcontractors and identify areas for additional monitoring. Community Advisory Groups (CAGs) also review grievance and appeal trends, Enrollee satisfaction data, and other information to help identify and address potential operational issues.

e. Reviewing overturned decisions to identify needed changes.

WellCare of Kentucky recognizes that to continuously improve, we must resolve the Enrollee, parent, or caregiver concern, and focus on the root cause of the individual issue, monitoring for emerging trends. We do this by trending and analyzing our grievance and appeal data to identify potential systemic issues. We act proactively to find and prevent issues before they affect Enrollees. Associates dedicated to reducing Enrollee grievances and appeals comprise our Root Cause Analysis (RCA) team, led by Operations Manager, Rhia Aponte. The team uses our grievance and appeal system to enhance root cause tracking, streamlining identification, and initiating preventive measures as part of our standard grievance and appeal workflow. Our RCA team does not wait for a grievance or appeal to occur. Instead, they open an RCA case upon identification of an issue and begin creating a remediation plan. Any subsequent grievances and appeals are associated with the same RCA case to further inform their understanding of the issue and drive process improvement. The UMAC, CSQI, and QI Committees receive a summary report of RCA team activities.

Using Results to Drive Improvements: Through our disciplined approach, we have made significant improvements in our Enrollees' experiences. For example, the RCA team identified an issue of providers balance billing our Enrollees. In response, we implemented an Enrollee

Services team to provide personal assistance to Enrollees with balance billing problems; and conducted provider education through our claims team. Additionally, our grievance and appeal system may identify key words as dissatisfaction and create a grievance for review. If the review proves that there is no complaint, we will close accordingly; otherwise, we will submit it as a grievance.

15. Marketing

C.15. MARKETING

a. Provide a summary of the Vendor's Marketing and distribution plan, describing the following at a minimum:

i. The system of control over the content and form of all Marketing materials.

ii. The methods and procedures to log and resolve Marketing Grievances.

iii. The verification and tracking process to ensure Marketing materials and activities have been approved by the Department and adhere as required by Section 25.1 "Marketing Activities" and Section 4.4 "Approval of Department" for the Vendor and its Subcontractors.

b. Describe the Vendor's understanding of the populations in the Commonwealth and define how it will adapt its Marketing materials to reach the various populations and audiences.

C.15. MARKETING

WellCare of Kentucky complies and will continue to comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 15 Marketing of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix,** provided electronically.

WellCare of Kentucky deeply values the privilege to serve the Enrollees in Kentucky Medicaid and the opportunity to provide enhanced access to providers and services while improving health outcomes. From our launch in 2011, we recognized that each Enrollee has unique needs and the best way for us to serve them is by understanding each Enrollee, the communities in which they reside and the community of providers and stakeholders nearby. This objective of understanding our Enrollees led us to establish our six regional offices and hire staff across the Commonwealth. This strategy and commitment optimizes our ability to appreciate what works and what does not in each community, to increase potential for face-to-face interactions with Enrollees and providers, and to demonstrate that we really are Kentuckians serving Kentuckians.

a. Provide a summary of the Vendor's Marketing and distribution plan, describing the following at a minimum:

WellCare of Kentucky complies and will continue to comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 15 Marketing of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix.**

WELLCARE OF KENTUCKY - AN MCO OF CHOICE

Following our philosophical approach to meeting Enrollees where they are, WellCare of Kentucky has the highest MCO voluntary choice rate of all other MCOs in the Commonwealth with 80% of Enrollees voluntarily selecting us. In addition to a large network of satisfied providers, we believe Enrollees choose us because of how we support them with their health and beyond. It is both rewarding and humbling that we have outperformed our competitors during the last three open enrollment periods.

Our Marketing approach consists of promoting the WellCare of Kentucky brand during the annual open enrollment period. We deliver our "choice" message during open enrollment to inform eligible Enrollees that we are an MCO option for their personal health care needs, and we provide information to help them understand their choice.

Beyond Healthcare, A Better You: We are committed to Enrollees' wellbeing, which includes alleviating unmet needs impeding them from participating fully in their lives. We have developed a system of support through our Community Connections Help Line and local community partnerships to serve our Enrollees with their food, housing, or even employment needs. WellBeing, in Figure C.15-1, our warm and fuzzy brand icon, is a symbol of our commitment to the total health of our Enrollees helping them down the path to a better, healthier life.

Figure C.15-1 WellBeing

Our Community Relations Specialists (CRS) embody our community-based, service-oriented approach. They span the Commonwealth from Paducah to Lexington to Hazard proudly representing WellCare of Kentucky in the community and focusing on what is really important and adds the most value: assisting Enrollees with their needs and supporting our community partners. Our leaders, top to bottom, embrace this broader view of Marketing, **and so do our Enrollees who, on the most recent CAHPS, scored us higher than all other MCOs for Enrollee satisfaction.**

We conduct Marketing activities in all eight (8) Commonwealth regions and distribute DMS approved culturally accessible materials aligned with 42 C.F.R. 438.10 which we translate to Spanish. Our Marketing program's policies and procedures mirror 42 C.F.R. 438.104 and contract requirements, and built-in controls ensure adherence to all rules and regulations. We have a user-friendly grievance process for Enrollees dissatisfied with any aspect of our Marketing program and attain resolution within 30 days.

MARKETING PLAN

Our Marketing plan combines DMS-approved mass media Marketing directed at Enrollees during open enrollment throughout the Commonwealth with community-based activities close to Enrollees and community partners. Our two-prong approach reaches Enrollees with our focused message of "choice" during open enrollment. Beyond the open enrollment period, our community-based team engages Enrollees and community partners all year round.

Open Enrollment Marketing Campaign

We know how important it is for Enrollees to know their MCO choices during the annual open enrollment period so they can select the MCO which best meets their needs. Accordingly, during this period, we focus our Marketing messages and resources on the value and benefits of choosing WellCare of Kentucky. Our large-scale mass media advertising campaign during open enrollment is customized to reach Enrollees in each of the eight (8) regions and includes the following activities (please see **Table C.15-1**):

- Out of home advertising - Billboards on main roads in both urban and rural areas; public transportation bus shelters along routes to providers, shopping sites, and government offices (Social Security, DMS, and WIC).

- Targeted use of radio, especially in rural areas, to close the gap on Medicaid recipients living in areas that may lack widespread internet connections.
- Increased use of digital ads on Facebook, Instagram, and other social sites using a simple message with a "click" option to get more specific information on WellCare of Kentucky, value added benefits, and open enrollment resources
- Advertising in Spanish to reach the growing number of Hispanic residents

Table C.15-1 Media Plan

WellCare - Kentucky - Media Plan									
Period	April	May	June	July	August	September	October	November	December
	Planning					Pre-Marketing	Open Enrollment		
WellCare - Marketing Activities									
Marketing Planning Activities	Media Planning		Develop Marketing Materials						
	Establish Relationships		Submit Marketing Materials (for appr				Distribution of Marketing Materials		
	Define Target Audience		Pre-enrollment Education				Community Relations & Events		
	Educational Marketing to Providers						Member Communications		
Statewide - Digital Marketing									
Mobile Banner ads									
Spotify - Digital audio & banners									
Facebook - Paid ads									
OTT - Connected TV									
Paid Search									
Region 1 - Paducah									
Posters							15 Posters	15 Posters	
Transit and/or Bus Ads							10 Kings/Shelters	10 Kings/Shelters	
Radio (multiple stations)							35 35	35 35	
Region 2 - Evansville									
Posters							20 Posters	20 Posters	
Radio (multiple stations)							35 35	35 35	
Region 3- Louisville									
Billboards							5 Billboards	5 Billboards	
Posters							12 Posters	12 Posters	
Transit and/or Bus Ads							15 Kings/Shelters	15 Kings/Shelters	
Radio (multiple stations)							35 35	35 35 35	
Region 4 - Bowling Green									
Billboards							5 Billboards	5 Billboards	
Posters							10 Posters	10 Posters	
Transit and/or Bus Ads							12 Kings/Shelters	12 Kings/Shelters	
Radio (multiple stations)							35 35	35 35	
Region 5 - Lexington									
Billboards							5 Billboards	5 Billboards	
Posters							20 Posters	20 Posters	
Transit and/or Bus Ads							15 Kings/Shelters	15 Kings/Shelters	
Radio (multiple stations)							35 35	35 35 35	
Region 6 - N. KY									
Billboards							3 Billboards	3 Billboards	
Posters							15 Posters	15 Posters	
Transit and/or Bus Ads							12 Kings/Shelters	12 Kings/Shelters	
Radio (multiple stations)							35 35	35 35 35	
Region 7 - NE KY									
Posters							15 Posters	15 Posters	
Radio (multiple stations)							35 35	35 35	
Region 8 - SE KY - Tri Cities									
Posters							15 Posters	15 Posters	
Radio (multiple stations)							35 35	35 35	

Our Marketing team engages Enrollees at community events and educates Enrollees about WellCare of Kentucky benefits and services and helps them make an informed choice of MCOs. They provide information about open enrollment dates, the lock-in period, and other information to assist Enrollees with navigating the open enrollment period whether they

choose us as their MCO or not. For questions about eligibility and enrollment, we refer to the Assisters and will help Enrollees locate Assisters in their communities if one is not present at the event.

"Always On" Marketing Team

After open enrollment, we continue to engage with our communities focusing on health education and healthy behaviors, especially focused on local area needs and disparities. We attend and sponsor events such as back-to-school events and health fairs where we can continue to demonstrate to our Enrollees and communities our commitment to better health. With a service-oriented approach, and knowledge of community resources, our Community Relations Reps assist Enrollees and non-Enrollees alike who may have social barriers and direct them to our Community Connections Help Line for referrals to social services organizations to provide support with housing, food, or safety needs. At the community level, we support our community partners' events helping them communicate their health and wellness messages to a wider audience. For example, events we sponsored illustrated in **Table C.15-2**, focused on some of the Commonwealth's priority areas from Section 34.2 Conditions and Populations in the Draft Contract, thereby aligning our support with community partners and DMS.

Table C.15-2 Events Supporting DMS Health Priority Areas

Focus Area	Event	Description	Region
Heart health	Bullitt County Health Department	Healthy Hearts Wear Red Luncheon	3
Obesity	YMCA Kids Day	Healthy eating habits	2
Cancer	Go Red for Women	Breast cancer awareness	3
Mental health	Marshall County High School	Grief counseling	1
Maternal and infant health	Expectant Parents Fair	Baby shower	4
Tobacco cessation	University of KY	Conference	5

Overall, the Marketing team participated in over 200 community events and meetings since last year across all eight (8) regions. Please see **Table C.15-3** for a partial list of our community participation throughout the Commonwealth. Just as important is our community collaborations. For example, we participate in monthly meetings with the Assisters and Family Resource and Youth Services Centers Coordinators (FRYSC) in Frankfort to discuss how to better educate Enrollees about resources and supports. At one meeting we presented information about our WellCare Works program thus providing key information for the Assisters to communicate to Enrollees searching for this type of information.

Table C.15-3 Statewide Marketing Events

Regions	Events
1	W KY Health and Wellness Summit; Paducah Health and Wellness Summit; Murray State University Independent Youth Empowerment Conference
2	YMCA Kids Day; 2018 Dust Bowl; Light of Chance Breathe Program
3	Grayson County Health Fair; Go Red for Heart Health; Park DuValle Give A Smile Health Fair; Healthy Hearts Wear Red; Healthy Start 502 Fathers baby shower;
4	Expectant Parents Fair; Stand for Children Day; World Refugee Day; WKU Medical Center Health and Wellness Expo; Special Needs Expo; OH Baby expectant Parent fair
5	Eastern Kentucky Health Fair; Child Abuse Prevention Family Day; LexEnd Poverty; Lexington Homeless Stand Down; 21st Annual Mountain Fest Health Fair
6	Silver Grove Back to School; OPE Health Resource Fair; FRCYS Regional Meeting
7	Community Baby Shower; Expungement Fair NKY; Child abuse prevention conference in Morehead
8	EKU Health Fair; KY Moms Baby Shower; MCHC Health Fair; Black Gold Festival; American Lung Association Lung Force Expo; Christmas for Charity ARH Center

TRAINING

WellCare of Kentucky has not been sanctioned for a Marketing violation at any time since the beginning of Medicaid managed care in 2011. We believe this record is due, in part, to our training program which prepares our Marketing Reps to conduct business fully aware of the rules and never at risk of breaking them.

Marketing Reps must successfully complete a 40-hour enterprise-level training course upon hire and annual refreshers thereafter as a condition of employment:

WellCare Policies and Procedures - These topics bring them into alignment with the WellCare Way so they effectively represent our values in the community. Topics include our Mission, Values and Vision; Code of Conduct and Business Ethics, HIPAA, and other topics.

Compliance Training - These topics instruct them on being compliant in the field. Topics include Fraud Waste and Abuse, Anti-kickback statute, federal regulations governing Medicaid, and other topics.

Cultural Competency - These topics prepare our CRS to honor our Enrollees' diversity and learn to communicate effectively with Enrollees speaking different languages and from diverse cultures.

Brandon Lau, Medicaid Marketing Director provides Marketing training for the CSRs. The training includes developing knowledge of all the prohibitions in Section 25.2 Marketing Rules

of the Draft Contract. In addition, a situational learning component provides opportunities for the CSRs to apply their knowledge to likely scenarios in the field. For example, CSRs must respond correctly to a scenario in which an Enrollee asks about Medicaid eligibility. The CSRs must know to direct the Enrollee to DCBS.

WellCare of Kentucky ensures that Enrollee gift cards or value-added benefits meet the requirements of Social Security Act §1128A, the Contract and any other applicable federal and state laws. We acknowledge that approval of these benefits by DMS shall not be construed as superseding federal or state law.

i. The system of control over the content and form of all Marketing materials.

WellCare of Kentucky's Marketing materials comply with 42 C.F.R. 438.10 and Section 22.6 Enrollee Information Materials in the Draft Contract. WellCare of Kentucky's Chief Compliance Officer, Rebecca Randall, has direct oversight of the Marketing materials approvals process as well as ensuring all Marketing-related activities comply with DMS contract requirements and state and federal regulations.

We use only Marketing materials which DMS has approved in writing, and we have an internal multi-level review process to ensure our materials, as well as those of our delegated subcontractors, not only comply with Marketing rules and regulations but are culturally aligned with our Kentucky Medicaid Enrollees. Our Medicaid Marketing Material Review and Approval Process (Policy C6-SS-003) governs our system of control over the content, form, and distribution of all Marketing materials and establishes these controls over our subcontractors' activities. Through this process, designated staff review the materials on three (3) separate occasions before submitting for DMS approval:

The Medicaid Marketing Director, or a designate, submits a written materials request through Papyrus, a project management tracking system to request, track, and manage the material development process.

Papyrus creates a job order, assigns a unique tracking number (e.g., WCKY12345), and routes the job order to the product development team to develop the Marketing copy.
The team develops written copy at the required sixth grade reading level as determined by Flesch-Kincaid; ensures the document adheres to the 12-point font size requirements; selects culturally appropriate images aligned with the diversity of Kentucky Medicaid Enrollees; and selects a format corresponding to the purpose of the material: tri-fold brochure, postcards, flyer etc.

The team routes the draft written materials to the job requester for initial approval.
If the job requester approves, the product team uploads the job into the Regulatory Affairs SharePoint site which generates an alert that a new job is in queue to be reviewed.
A Regulatory Affairs Specialist, or designee, reviews the materials for Kentucky Medicaid specific compliance elements including but not limited to: sixth grade reading level; minimum of 12 point font size; grammatical or typographical errors; culturally appropriate images; appropriate format aligned with job purpose and message; compliance with contract

requirements, policies, procedures, and other guidelines; and functioning phone numbers and web links.

If the Specialist determines the materials are compliant, the Specialist adds the job to the Materials Review weekly agenda for review by the Materials Review Committee. The committee is led by Rebecca Randall, Chief Compliance Officer, and includes leaders from Marketing, Quality, Population Health Management, Provider Relations, Network, Pharmacy, and Operations.

If the Committee approves the material, the Specialist uploads the job request to the DMS SharePoint site and follows the DMS procedures by indicating if the request for approval is a resubmission, entering the number and name of the materials to be reviewed, and attesting that the submission for approval includes the following:

- Confirmation of readability,
- Intended audience,
- Reason for expedited request (if expedited), proposed distribution date,
- Purpose,
- Translation certificate, and
- Is error free.

If the request is for an expedited review, the Specialist provides one of the DMS-defined criteria for expedited review.
If the Specialist determines prior to the Materials Review Committee meeting that the materials do not comply or the Materials Reviews Committee does not approve the material, the job is returned to the Product team specifying the deficiencies or reasons for non-approval. The Specialist works with the Product team to remediate any issues preventing submission for approval and resubmits once corrections or modifications are made.
Once material is approved by DMS and notification is received by the Regulatory Affairs Specialist, the approval record is archived in our SharePoint library. All approved materials reference the unique tracking number as well as the date approved by DMS. This process is followed for all of WellCare's delegated subcontractors. By contract, subcontractors are required to submit all applicable material to the Regulatory Affairs Department prior to use to obtain DMS approval.

ii. The methods and procedures to log and resolve Marketing Grievances

We respond to Marketing Grievances through established policies and procedures that recognize Enrollees' fundamental rights to express dissatisfaction and have their concerns addressed and resolved expeditiously, respectfully, and in a cultural competent manner. We also respond to and resolve grievances originating from DMS, other agencies, providers, or from any other source, with the same urgency and diligence as we do for Enrollee grievances. Although we have not logged any Marketing Grievances since 2017, we have a NCQA certified Grievance process which complies with all DMS requirements and is designed to identify, receive and respond, track, review, report, and resolve all expressions of dissatisfaction.

(WellCare of Kentucky provides a detailed description of our process in our response to Question C.14 "Enrollee Grievances and Appeals.")

If the Enrollee or other entities express a grievance in the field to Marketing staff (e.g., a community event, provider visit, etc.) or through the typical intake process through the Enrollee Services line, we attempt “on the spot” or First Call resolution. If resolved, the grievance is logged into our grievances and appeals workflow management system.

If the grievance is not resolved on the same day, we activate the formal grievance process through the grievances and appeals Coordinator who logs the grievance and initiates the process of acknowledging, tracking, and resolving the grievance within 30 days.

After logging the grievance, the Coordinator routes the case to the appropriate functional areas responsible for Marketing materials (VP of Marketing) or a customer service complaint (VP of Enrollee Services) for resolution.

Our Customer Service Quality Improvement Committee and the Quality Improvement Committee review any Marketing grievances, analyze trends, and conduct root cause analysis to drive operational improvements regarding our materials, activities, or the conduct of our Community Relations Specialists.

If during the grievance resolution process we discover a true marketing violation, our Customer Service Quality Improvement Committee and Quality Improvement Committee will refer the matter to our Regulatory and Compliance Department for corrective action. Depending on the level of severity, corrective actions may include retraining of associates, disciplinary actions (including termination) and the imposition of penalties and/or sanctions if the violation was attributed to one of our subcontractors.

iii. The verification and tracking process to ensure Marketing materials and activities have been approved by DMS and adhere as required by Section 25.1 “Marketing Activities” and Section 4.4 “Approval of Department” for the Vendor and its Subcontractors.

WellCare of Kentucky's policies and procedures governing Marketing materials submission and approvals process ensure that we and our subcontractors adhere to Section 25.1 Marketing Activities and Section 4.4 Approval of Department in the Draft Contract. We acknowledge that general health education materials do not require prior approval by DMS, and we ensure, through our policies and procedures, that such materials comply with this Contract and state and federal regulations and laws. We further acknowledge that we are subject to penalties for materials found to be non-compliant as set forth in Appendix B Remedies for Violation, Breach, or Non-Performance of Contract.

As previously stated, neither WellCare of Kentucky, nor any of our subcontractors, has never been sanctioned for a Marketing violation from contract inception in 2011. With our proven processes and single point of accountability for our materials and activities, we are confident that we will maintain this perfect record during the new contract period.

VERIFICATION AND TRACKING PROCESS

As described in Section 15.a.i, our experienced Regulatory Affairs team manages a rigorous, systematic process ensuring all materials created by WellCare or any of our subcontractors, comply with all DMS contract requirements, state and federal regulations as well as our internal quality control standards before we submit to DMS for approval.

We apply this rigor to the verification and tracking process for submission of materials and proposed activities for approval through the state-defined process utilizing DMS's SharePoint site and managed through our Regulatory Affairs SharePoint site as described below:

After submitting the material for review and approval from DMS, the Regulatory Affairs Specialist enters the date of submission and the DMS assigned tracking number on the internal Regulatory Affairs SharePoint site.

We limit job requestors and other non-Regulatory Affairs staff to "read-only" access to the Regulatory Affairs site ensuring the original copy is not edited post submission to DMS. We do however provide visibility into the status of the jobs such as whether they are under review or approved/not approved.

We do not provide subcontractors with access to the Regulatory Affairs site.

When the review is complete, DMS notifies us in writing through a DMS generated email with the following approval decisions which trigger our subsequent actions:

1. **Approved** - We update the status in our Regulatory Affairs SharePoint site and notify the job requester. We route the job to the fulfillment team for posting (advertising) or printing (written materials). An example is provided in **Figure C.15-2**. For verification, all written materials include a job number and approval date. The material is stored on the Approved Marketing and Member Material SharePoint Site and distributed to the applicable functional area for use.

Figure C.15-2 Sample Written Material

2. **Not Approved** - We update the status within the Regulatory Affairs SharePoint site and notify the job requester. The job **will not be fulfilled** and materials **will not be disseminated to Enrollees**. The job is marked "closed" in Papyrus, our project management tracking system.
3. **Needs Clarification** - We contact the job requester and provide DMS's questions/notes. We change status to "Pending WellCare Review" in the Regulatory Affairs SharePoint site accordingly.
4. **Withdrawal** - We request DMS to withdraw the request for approval. We indicate "Withdrawn" status in the Regulatory Affairs SharePoint site.

   By limiting access to materials under DMS review to designated Regulatory Affairs staff, we effectively prevent unapproved materials from being accessed, fulfilled, or distributed prior to DMS disposition. These controls also apply to subcontractors who, at all times, are at

arm's length from our materials. We provide materials to subcontractors only when they have been approved.

b. Describe the Vendor's understanding of the populations in the Commonwealth and define how it will adapt its Marketing materials to reach the various populations and audiences.

Since 2011, we have been serving Medicaid Enrollees throughout the Commonwealth and know that they are not one, undifferentiated cohort. They are children, mothers, and adults who may speak Spanish or other languages. Some live in the highlands of Eastern Kentucky or downtown Louisville. Thus, to reach our Enrollees wherever they live or languages they speak requires adapting not only our materials but our approach.

IN THEIR OWN LANGUAGE

We know that language could be one of the biggest barriers to participating in one's health care and that poorly translated materials prevent effective communication. We translate all Marketing materials to Spanish using only certified translators. In addition, the messages in our health promotions items such as toothbrushes floss, and first aid kits are also in Spanish. We translate to other languages upon request including Braille and produce DVDs for Enrollees with low literacy. We can also develop translated materials to keep in stock in a language not yet meeting the 5% threshold if there is a need. With our community-based presence throughout the Commonwealth, our Marketing team, field-based clinical teams, the Provider Relations team, or providers themselves could help us identify populations we need to engage in their own language with ready-made materials.

DIGITAL COMMUNICATIONS

More and more of our Enrollees rely on digital communications to obtain or respond to information. For example, there was a 135% increase in the MyWellCare mobile app downloads from 2018-2019. Adapting our approach from materials to digital keeps pace with technology that facilitates communications. Through our digital channels, we communicate information about benefits, such as our Healthy Rewards incentive as well as information about open enrollment, recertification due dates, or even a prompt to schedule their annual exam.

PERSON TO PERSON

For populations living in more rural, remote areas of the Commonwealth, adapting to a person-to-person approach is more effective than adapting materials. Our marketing team, for example, engages Enrollees in the eastern part of the Commonwealth at events such as the Black Gold Festival, health fairs, and other community gatherings. Our approach includes working through our network of community partners, such as Kentucky Homeplace, to communicate with Enrollees. We have adapted to this approach understanding that some Enrollees rely on community or faith-based organizations they trust for information and guidance. Educating our partners about our benefits and services and Medicaid program information is one of the most effective channels to reach some Enrollees.

We also adapt a high-touch approach when we believe it will be more effective than distributing materials. For example, at the Annual Hispanic Latino Health Education Fair in

Lexington, our Marketing team brought a Spanish-speaking interpreter to the event. The interpreter engaged Spanish speakers in conversations about WellCare of Kentucky and community resources, such as housing and education with greater detail than could be communicated with materials. Adapting our approach is also vital to improving health outcomes. For example, in Bowling Green, we have Enrollees who are Somali refugees in our Care Coordination program. With limited English proficiency and isolated from the community at large, the most effective method to engage them is in person with interpreters from their own community. Interpreters accompany our Care Coordinators for home visits and together they educate Enrollees about refills, making and keeping appointments, and even accompany Enrollees to provider appointments with the Care Coordinator.

16. Enrollee Eligibility, Enrollment and Disenrollment

WellCare Launches Digital Life Coach Program for At-Risk Foster Youth in Kentucky

WellCare
Beyond Healthcare. A Better You.

C.16. ENROLLMENT ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

a. **Describe the approach to meeting the DMS's expectation and requirements outlined in RFP Draft Medicaid Managed Care Contract and Appendices "Draft Medicaid Managed Care Contract and Appendices."**

b. **Detail any limitations and/or issues with meeting the DMS's expectations or requirements and the Vendor's proposed approach to address such limitations and/or issues.**

C.16. ENROLLMENT ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

a. Describe the approach to meeting the DMS's expectation and requirements outlined in RFP Draft Medicaid Managed Care Contract and Appendices "Draft Medicaid Managed Care Contract and Appendices."

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 26.0 Enrollee Eligibility, Enrollment, and Disenrollment of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare acknowledges that DMS has authority over the provisions and policies outlined in Section 26 governing Enrollment Eligibility, Enrollment, and Disenrollment. We specifically acknowledge DMS:

- Has the exclusive right to determine eligibility and enrollment without appeal by the MCO [26.1]
- Ensures an equitable distribution of Enrollees across the participating MCOs through its assignment algorithm [26.2]
- Reserves the right to re-evaluate and modify the Auto-Assignment algorithm anytime for any reason [26.5]
- Will provide written notice to WellCare of Kentucky of any modification of the Auto-Assignment algorithm before the implementation of such modification [26.5]
- May develop MCO enrollment limitations based on quality, cost, competition, and adverse selection [26.5]
- In addition, we recognize that DMS has primary responsibility for receiving, validating, and processing annual redeterminations as well as accepting and processing changes reported by the Enrollee. However, we are also committed to making any reasonable accommodations or providing necessary assistance to persons protected by the Americans with Disabilities Act in order to assist DMS with redeterminations and changes [26.12]

PROCESSING ENROLLMENT FILES SINCE 2011

We have been processing HIPAA 834 transaction files in Kentucky since the first days of managed care in 2011 in increasing numbers, processing approximately 450 million Enrollee transactions since 2016. Although we focus on technical execution, we do not lose sight that the enrollment files contain our Enrollees and that their ability to access benefits and receive the right level of care is subject to our performance.

We accept all Enrollees whether they selected us or were assigned to us through DMS's auto-assignment logic, and we personalize the Enrollee experience based on enrollment file information. For example, if an Enrollee is pregnant and indicated as such on the enrollment file, the processing of the file will route them to our CareCentral system for Care Coordination assignment where a Care Coordinator will work with them on getting the best care for their pregnancy. If the Enrollee is a child, we know to communicate to the caregiver directly and not directly with the child.

GENERAL ENROLLMENT PROVISIONS

In accordance with Section 26.3 General Enrollment Provisions**,** we do not discriminate against potential Enrollees on the basis of an individual's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin, and we do not use any policy or practice that has the effect of discriminating on the basis of an Enrollee's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin.

ENROLLMENT PROCEDURES

Enrollment and Eligibility System

The features of our Enrollment and Eligibility System (EES) process demonstrate our current capabilities while reinforcing that we are already prepared to serve Medicaid Enrollees under a future contract.

- *Systems Interface –* Our systems have been successfully interfacing with DMS since 2011, and our processes are calibrated to DMS's file transfer protocols.
- *EES Team–*Experienced Kentucky-trained operators/analysts facilitate the enrollment transactions and remediate file discrepancies usually within 24-Hours.
- *Category Recognition -* Our EES identifies all Kentucky aid categories including demographic information, and special flags such as: **Enrollees with guardianship codes** for prompt health needs assessment and outreach to the Department of Assisted/Integrated Living (DAIL) for Care Coordination; **Priority populations needing immediate services**, e.g., pregnant Enrollees for rapid downstream integration with our Care Management portal, CareCentral, and our Enrollee service platform, CAREConnects, to facilitate immediate evaluation by our Care Coordination team.
- *Agile -* We adjust our business processes to adapt to DMS changes, such as the recent redesign of the 834 for the Kentucky HEALTH implementation. We participated in over 18 months of joint design, planning, and 834 file testing. As a result, over the course of a single weekend we were able to seamlessly transition to loading an 834 format which contained more than 63 new different data elements and was, on average, 66% larger than the previous 834 file.
- *Capacity -* Since 2011 we have grown from 113,000 to more than 430,000 Enrollees, absorbing the growth and executing larger volumes of transactions without disruptions in service. Our excess system capacity will absorb additional enrollment under the new contract without the need for any incremental investment.

Confirmation Letter and Identification Card

Onboarding our new Enrollees timely and helping them become active in their health is a top priority. We design our business processes for consistent, reliable performance, sending Enrollees their ID card and confirmation letter within five Business Days and ensuring they receive the materials within three days of mailing. In 2019, **we met this timeliness requirement close to 99% of the time so that our Enrollees from Paducah to Ashland could quickly activate their benefits and engage in their care.** To ensure Enrollees always have an identification card when they present for services, we provide self-service options for them to obtain their cards through our secure Enrollee portal and MyWellCare mobile application.

Our confirmation letters include all the information required in **the contract.** In addition to the required information, the mailing also includes:

- A copy of the provider directory for their region
- A Healthy Rewards brochure explaining the incentives program for preventive healthcare
- An Over the Counter program booklet explaining the program benefits
- A Quick Start Guide delivering key enrollment information to Enrollees' fingertips for successful onboarding to WellCare of Kentucky

ENROLLMENT ELIGIBILITY FILE AND ENROLLMENT PERIOD

We begin covering services based on the effective date provided on the eligibility file. For most Enrollees, DMS provides an effective date that is the first day of the calendar month in which the eligibility transaction is sent. Exceptions to this standard processing are newborns and presumptively eligible (PE) Enrollees. When DMS sends newborns or PE Enrollees on the eligibility file, they indicate that coverage should begin on the date of birth and date of eligibility determination, respectively. In all cases, WellCare of Kentucky begins covering services based on the effective date provided by DMS on the eligibility file.

We process enrollment files upon receipt acknowledging the HIPAA 834 file as the source of truth for all new, terminated, and changed Enrollees and notify DMS of discrepancies. Each month, we submit a current roster from our enrollment production environment to DMS for comparison and identification of Enrollees who need to be added or terminated. Outside the formal mismatch process, we perform routine ad hoc analyses to ensure the information received on the 834 file meets DMS regulations and is aligned with Kentucky HEALTHNET.

If Enrollees report address changes, we advise them to contact DCBS. We monitor the 834 file for 60 days, and if the address change does not appear by the 60th day, we send DMS a report of unverified address changes.

PERSONALIZING THE ENROLLEE EXPERIENCE

WellCare of Kentucky maintains continuous open enrollment for newly eligible Enrollees and accepts all Enrollees regardless of our enrollment levels as we have during this contract period.

We built our excellent reputation in Kentucky based on our dedication to understanding our Enrollees and delivering personalized solutions for them. We not only enroll all the eligible

populations listed in this Section**,** but we correctly match them with their corresponding benefits plan, value-added benefits, and their particular circumstances. For example,

- *SSI (non-dual)*: Given their prevalent health conditions, we refer to Care Coordination, identify courses of treatment, and match Enrollees with a corresponding PCP with appropriate specialty/experience.
- *Dual Eligibles*: We work with Medicare providers to coordinate care, reduce overutilization, minimize service duplications, and manage cost of care.
- *Retroactively Eligible*: When Enrollees receive medical services prior to their application for Medicaid coverage, they are typically allowed to request retroactive coverage up to 3 months prior to their application date. This pattern of retroactive coverage has become a standard operating procedure given our affiliates' experience across 11 other Medicaid states. We cover all Medically Necessary services during the retroactive coverage period without a Prior Authorization. Additionally, if an Enrollee has been retroactively assigned, we routinely waive our timely filing requirements.
- *Newborn infants*: We create a temporary ID for every newborn for providers to reference if service authorizations are needed. Once the hospital has reported the delivery to DMS and DMS has sent the permanent Medicaid ID, we load the newborn's effective enrollment date set to the date of birth. This ensures all costs are associated with the newborn's permanent Medicaid ID.
- *Communications Access*: We are committed to supporting the language or access needs of our Enrollees to ensure they understand the enrollment process including processes such as recertification. We provide a language line with on-demand, certified interpreters supporting over 200 languages including American Sign Language. We translate all materials to Spanish and can translate to other languages as well, including Braille, or produce materials in large print. For Enrollees with low literacy, we produce videos.

PERSONS INELIGIBLE FOR ENROLLMENT

Since we use the 834 file as the sole source of truth for enrollment and disenrollment, we typically do not experience interactions with excluded populations. However, in some circumstances, Enrollees may transition to an excluded population. In these circumstances we have programs in place to ensure we cover the costs of covered services provided to the Enrollee during the first 30 days of transition, including physicians, physician assistants, APRNs, or any other medical services that are not included in the nursing home facility per diem rate.

Enrollee Request For Disenrollment

Enrollees have the right to switch MCOs within contract regulations, and we educate and assist Enrollees with the process, such as informing that a request can be made orally or in writing and the various regulatory provisions governing a disenrollment request:

- If the request is made during the 90-Day change period, we inform Enrollees about the change period provisions allowing them to change without cause and for any reason and instruct them on how to disenroll via the DMS disenrollment process.
- If the request is made outside the 90-Day lock-in period, we educate Enrollees on the for cause reasons as provided in 42 CFR 438.56 and instruct the Enrollee to contact the DMS

Contract Compliance Officer for a State Fair Hearing if the request to disenroll is not granted.

We encourage the Enrollee to make the disenrollment request to DMS, since DMS is responsible for enrollment and disenrollment; however, in the event the disenrollment request is submitted directly to our staff, we submit that request to DMS for a determination.

WellCare of Kentucky Request for Disenrollment

In accordance with the provisions of this Section, WellCare of Kentucky does not request disenrollment of an Enrollee based on an adverse change in the Enrollee's health, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment with us seriously impairs our ability to furnish services to either this particular Enrollee or other Enrollees.

We educate Enrollees regarding their responsibilities and understand it is sometimes necessary for an MCO to request Enrollee disenrollment if the Enrollee:

- Is found guilty of Fraud
- Is abusive or threatening
- Is admitted to a nursing facility for more than 31 Days
- Is incarcerated in a correctional facility
- No longer qualifies for Medical Assistance per DMS guidelines
- Cannot be located

If we disenroll for any of these reasons, we follow the DMS process of submitting our disenrollment requests in writing including the reasons for our request and, if applicable, the reasonable steps taken to educate Enrollees about their behavior.

CONTINUITY OF CARE UPON DISENROLLMENT

All Enrollees can expect for WellCare of Kentucky to cover the costs of Medically Necessary Covered Services without requiring prior approval. If an out-of-network provider is furnishing the services, we will offer a single case agreement. When appropriate, Care Coordinators will transition the Enrollee to a network provider and assist with appointment coordination with the new provider and furnish updated care plan information.

We understand that disenrollment decisions and their timing are determined by DMS. Our primary responsibilities during a disenrollment request center on serving and educating the member where appropriate, providing DMS accurate information to support their decision, and above all, ensuring the Enrollee's continuity of care if DMS determines the disenrollment request will be granted.

b. Detail any limitations and/or issues with meeting the DMS's expectations or requirements and the Vendor's proposed approach to address such limitations and/or issues.

As a long-term incumbent plan within the Kentucky market since 2011, we have met all the requirements of this Section. **We will continue to do so under the new contract with no limitations or issues.** If we do encounter issues, we are an innovative MCO who develops

creative solutions that not only benefit WellCare of Kentucky but the entire Medicaid managed care system as we detail in the next Section.

INNOVATIVE SOLUTIONS

Incarcerated Enrollees Since 2015, DMS has been providing information on the 834 file indicating when an Enrollee is incarcerated. The incarceration periods are reported to DMS by Enrollees or correctional facilities and, when received on the 834 file, we cease paying claims for the Enrollee. During our evaluation of this data, we learned that often we are not alerted of the incarceration until months, or sometimes years, after the Enrollee was first incarcerated, and occasionally we do not receive correct discharge dates.

To learn sooner when Enrollees are incarcerated and determine more accurately the dates of admission and discharge, we developed a proprietary Artificial Intelligence solution that uses claims data and case notes to identify Enrollees likely receiving services while incarcerated. We then verify that information through the Kentucky Department of Corrections online database to confirm incarceration periods. We are currently developing a process to provide this information and documentation to DMS. This proprietary process will allow DMS to confirm that Enrollees are incarcerated weeks or months ahead of the current process, resulting in decreased costs and increased enrollment accuracy.

Locating Enrollees

All state Medicaid agencies face a constant challenge ensuring that Enrollees update their address and other contact information timely. DMS operated a multi-year initiative to suspend Enrollees unable to be contacted in an attempt to improve contact information accuracy. Because maintaining contact with our Enrollees is essential to ensuring they receive the proper care and services, we have developed a powerful search function to locate hard to reach Enrollees, establish their addresses, and determine if they are deceased. We mine our data warehouse for phone numbers and physical addresses. The data aggregator examines:

- Claims data
- Information from Care Coordinator's notes
- Pharmacy Benefits Manager (CVS) and contracted pharmacy information
- Commonwealth enrollment files
- HUD’s Homeless Management Information Systems
- External information vendors such as LexisNexis
- Public records

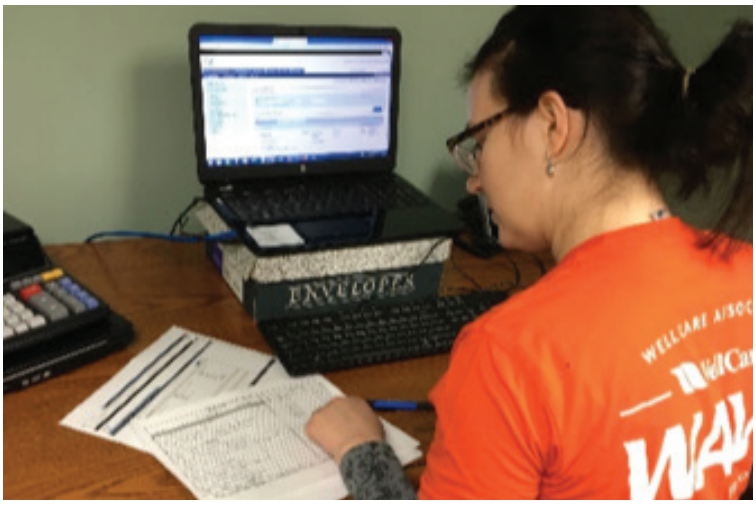
From our data mining, if we determine the Enrollee is deceased, we notify DMS as timely as we can, consistent with Section 26.17. For other Enrollees, we generate a list of phone numbers and last known addresses and attempt to reach Enrollees telephonically or in-person through our field-based teams. If we make telephonic contact, we verify physical addresses and inform the Enrollee of their responsibility to notify DMS of their change. We do not attempt to notify DMS immediately, but monitor the 834 for evidence that the member appropriately reported their change. If the 834 is not updated to reflect the updated address or contact information within 60 days, we then report that updated information to DMS as required by Section 26.7 of the contract.

WellCare's Recertification Care Center - Avoiding Disenrollment

We know that access to benefits and services, continuity of care, courses of treatment and more are at risk if Enrollees miss their annual recertification requirement. Given our recognition of the problem, we created a Care Center in Hazard which employs local customer service agents to engage Enrollees prior to their recertification date. The Care Center enables us to proactively outreach to Enrollees in multiple scenarios, including recertification.

Using a combination of outbound calls, written letters, and text messaging, we have dramatically increased successful recertifications for our Enrollees. During the first 11 months of operation, we were able to outreach to households containing more than 32,000 Enrollees who were within 15 days of losing Medicaid eligibility and had not yet recertified. Even though we were contacting Enrollees who had not responded to previous communications from DMS and now had fewer than two weeks to recertify, we were able to achieve a **recertification rate of 82%** for this population, thereby maintaining continuity of services and reducing enrollment/disenrollment churn.

17. Provider Services



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C.17. PROVIDER SERVICES

a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:

i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.

ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.

iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.

iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.

b. Describe the Vendor's proposed Provider Services call center, including an overview of the following at a minimum:

i. Approach to assuring the call center is fully staffed during required timeframes.

ii. Location of proposed operations.

iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.

c. Provide an overview of the Vendor's proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers.

Provide sample screenshots of provider websites currently maintained by the Vendor.

d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.

e. Provide the Vendor's proposed approach to provider orientation and education.

f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:

i. Methods for assisting providers who are not enrolled in Medicaid with the enrollment process

ii. Proposed process for conduct of credentialing until such time that a Credentialing Verification Organization (CVO) is contracted by the Department.

iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).

iv. Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims

Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s)

g. Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:

i. The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.

ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.

iii. Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

C.17. PROVIDER SERVICES

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 27 Provider Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:

Having built and maintained a comprehensive and diverse statewide network of more than 34,500 contracted providers over our eight years as an MCO for Kentucky's Medicaid Managed Care program, WellCare of Kentucky has developed a trusting relationship with our network providers by ensuring they have the support they need to provide the highest quality of care to the Enrollees they serve. In doing so we have **earned #1 NCQA Customer Satisfaction from 2016 to 2019 among all Medicaid MCOs**. Over that time we have developed and refined our Provider Engagement Model, one that combines "high touch" with "high tech" through a combination of the most extensive physical presence of any MCO in the Kentucky Medicaid Managed Care Program along with 24/7 provider support available through multiple channels. It includes:

- Six regional offices throughout the Commonwealth staffed with experienced and dedicated provider relations representatives who live, work, and understand the communities they serve
- Community-deployed Quality, Operations and Care Coordination staff dedicated to supporting network providers and available to assist in meeting program quality goals and resolving payment issues at the individual provider or system level
- Multiple avenues for communicating with the network and hearing from providers, including webinars, our Provider Advisory Panel, Provider Summits, regular onsite visits to provider offices and provider surveys

- A call center staffed by highly trained agents enabling providers to quickly get the support they need, when they need it
- A streamlined provider portal with enhanced claims, authorization, Enrollee profile and live chat functionality that reduces administrative burden for providers

The success of our Provider Engagement Model is demonstrated by the results of our annual Provider Satisfaction survey, which showed that **91.6% of our providers would recommend WellCare of Kentucky to other providers.** We achieved these results by directly engaging our providers face-to-face, hosting summits and webinars to educate providers on new initiatives, listening to their feedback and implementing changes such as improving our online provider portal and refining authorization rules to reduce administrative burden.

"WellCare has become the easiest managed care organization to do business with. We have monthly meetings with several members of the WellCare team. Every meeting is attended by the Provider Relations Manager, Provider Relations Representative, as well as any additional WellCare support staff we request to resolve issues. In between meetings, they are always available by phone or email to address any problems that arise....There are very few MCOs that provide the face-to-face outreach such as this to assist with questions and concerns."

– DALE SUTTLES, PRESIDENT, SUNRISE CHILDREN'S SERVICES

i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.

Our Provider Engagement Model has evolved since our initial program implementation, when our original provider relations staff began visiting providers across the Commonwealth to educate them on the concept of managed care. During the launch of Medicaid Managed Care, it quickly became clear that providers in Kentucky were looking for a more personal experience with their managed care companies. Understanding the need to establish a closer connection to our provider partners, we established six regional offices across Kentucky, see **Figure C.17-1**, enhancing our ability to be in touch with the communities we serve.

Today WellCare of Kentucky's dedicated Provider Engagement Team consists of 51 associates in a variety of roles with a wealth of experience engaging with providers across the Commonwealth. Provider Relations Manager Anthony Piagentini leads a team of 15 Provider Relations (PR) Representatives, four Hospitals Services Specialists, three Provider Relations Managers and a Hospital Services Manager all serving our provider network out of our regional offices. **In 2019 alone, our PR Representatives made over 6,600 personal visits to provider offices that comprise our network of health care practitioners and facilities across Kentucky.**

Figure C.17-1 WellCare of Kentucky Presence

The centerpiece of our Provider Engagement Model is the **PR Representative**. Our PR Representatives are based throughout the Commonwealth, working out of our six regional offices. These individuals serve as the primary point-of-contact for network providers focusing on primary care, behavioral health, and specialty care. **Our PR Representatives live in the areas they serve, are invested in their communities, and are familiar with the issues, challenges, patterns of care and culture of those areas.** Some of our PR Representatives have worked for our program since its inception, and many have worked in and alongside the provider practices and facilities they support. For example, we have recruited PR Representatives from Appalachian Regional Healthcare (ARH) and Baptist Health. Every provider has a dedicated PR Representative responsible for supporting his or her practice or center.

Upon joining our network, a newly-contracted provider is contacted by a PR Representative who provides an orientation, explains their role as a primary point of contact and advocate for the provider, and discusses with them how they can best support the provider on an ongoing basis. The PR Representative is fully accountable to their provider relationships and serves as the primary point of contact for each provider. They are the key owner of the relationship and the provider's advocate to ensure they receive the support they need when they need it.

PR Representatives work in partnership with our **Quality Practice Advisers (QPAs)** to help engage practices to improve quality measures and provide more cost-efficient care. QPAs are trained nurses who review HEDIS measures, clinical practice guides and leave toolkits that support ongoing quality improvement activities. WellCare of Kentucky Senior Director of Quality Laura Betten leads a team of 16 QPAs and three managers who support our providers from our regional offices. Like our PR Representatives, QPAs live and work in the regions they serve. They are assigned to specific practices and are aligned with the provider relations team. They frequently make joint meetings with providers to provide the best possible services to providers in their offices in the most efficient manner. **In 2019 alone, WellCare of Kentucky's QPAs made over 6,000 visits to provider offices to advance the Commonwealth's quality measures.**

QPAs are trained on DMS' priority measures and collaborate with providers to ensure they understand their quality progress reports. On a monthly basis, the Provider Relations, Network Management, Care Management, and QPA teams hold a "P360" huddle meeting reviewing our top providers' performance in quality and cost measures by region. These meetings focus on a 360 degree view of the practices, including all aspects of quality and cost, and include interdisciplinary teams such as pharmacy and clinical teams. Through P360 huddle meetings, the team reviews the practice panel clinical performance, including a heat map of care gaps. They then use that information to focus on certain practices or develop condition/service specific campaigns. The team collaborates to develop a targeted plan for each provider to enhance practice quality and outcomes.

Aligning Goals for Higher Performance and Higher Provider Satisfaction

PR Representatives and QPAs are the primary provider-facing roles within WellCare of Kentucky, working directly with providers to facilitate a positive relationship with WellCare and to increase our overall quality performance through provider-specific initiatives. While previously QPAs and PR Representatives might visit a provider's office separately, WellCare recently realigned our Provider Engagement Team structure so QPAs and PR reps could conduct more joint meetings with providers. This increased communication between the PR team and QPA team and resulted in more efficient and effective visits for providers.

The collaboration between the PR team and QPA team extends to all facets of our operations. For example, the PR and QPA Directors have a standing bi-weekly meeting to discuss ongoing initiatives. This also includes shared responsibility related to goals and objectives. The PR team has the same quality goal as the QPA team and the QPA team has the same provider satisfaction goals of the PR team. This level of collaboration, from goals, through leadership, into daily activity in the field demonstrates our commitment to the best provider experience in the industry.

Understanding that different types of providers face unique challenges, WellCare of Kentucky has four specialized PR Representatives called **Hospital Service Specialists (HSS)** dedicated solely to supporting the more than 130 hospitals in our network. HSS team members are typically recruited from institutions so they are more familiar with their operating model and their unique support needs.

Based on feedback from facilities and recognizing the need not only for hospital-specific support at the local level but also coordination of institutional issues at the regional and statewide levels, we reorganized our provider relations structure in 2018. Prior to this each HSS team member was assigned to a regional manager who also managed PR Representatives. Given the significant differences in the focus areas of institutions versus professional practices, we reorganized the team so that all HSSs reported to a dedicated hospital services manager. This approach allowed us to more rapidly spot emerging trends within our hospital network and address them before they cause abrasion.

The HSS team typically conducts monthly Joint Operating Committee meetings with each institution in which an interdisciplinary team from both the institution and WellCare of Kentucky work collaboratively to review financial performance, quality metrics, pharmacy utilization, and to plan for future initiatives.

"I have seen many instances of us being able to identify concerns as quickly as they occur. One example is an issue we were having with the base code for IV Therapy. At a JOC meeting with Tabatha Nelson, HSS, at Ephraim McDowell Medical Center, their team shared with us examples of claim denials for a missing base code. They brought in their IV Therapy expert and we discussed at length what their expectations were. That same week I proceeded to see my other HSS's send us single claim issues from other facilities with the same concern. This issue could have very easily been overlooked due to the sporadic examples being sent to each of our four HSSs. Due to the fact that our Hospital Services is all on one team, we were able to identify that we had a trend amongst several facilities. This allowed us to work with our internal partners and correct the edit and reprocess the impacted claims. "

– CATHY DAVIS, HOSPITAL SERVICES MANAGER, WELLCARE OF KENTUCKY

To ensure effective and efficient support of all issues, PR Representatives and HSSs engage various professionals at WellCare of Kentucky who are tasked to perform specific functions on behalf of network providers. In addition to QPAs, these include **Operations Account Representatives (OARs), Patient Care Advocates (PCAs), Provider Operations Coordinators (POCs), Practice Transformation Specialists, and the Claims Resolution Team:**

- *Operations Account Representatives (OARs)* are experienced claim professionals who conduct billing education and are empowered to efficiently resolve issues, including the ability to perform real-time, on-site claims adjustments at provider offices. OARs monitor claim utilization and denial rates and provide one-on-one training when billing errors are identified. This is especially helpful to rural providers and critical access hospitals, where limited staff resources are focused on patient care. This ensures that these critical providers do not suffer from delayed payments. OAR team members attend calls with providers and meet face-to-face during events like our Provider Summits to make adjustments and correct issues in real-time if possible.
- *Patient Care Advocates (PCAs)* provide local support of our quality improvement program. PCAs are WellCare of Kentucky employees who are physically located in select network provider offices and are focused on connecting Enrollees to care including accessing detailed Enrollee and provider reports and scheduling appointments for targeted Enrollees with identified gaps in care including immunizations, ADHD follow-up, asthma medication adherence and EPSDT well child visits. Through our HEDIS and care gap discussions with providers, we found many were engaged and eager to address gaps in care but lacked resources needed to conduct Enrollee outreach and follow up. PCAs address this need. Our PCA program is both a service enhancement for providers and a best practice.
- *Provider Operations Coordinators (POCs)* work to assure accurate and timely loading of all provider contracts and demographic data. They routinely reconcile provider rosters with our systems to make updates needed to provider records. They interface directly with providers along with PR Representatives.
- *Practice Transformation Specialists* act in a consulting role for practices interested in improving their overall practice model. They work onsite at provider offices assisting them to evolve their business model to successfully achieve cost and quality goals associated with value-based purchasing (VBP) agreements.

- *Claims Resolution Team (CRT)* members research complex claim issues including applicable state and federal policy to ensure the market is accurately applying claims policies. The team is engaged any time we encounter a claims dispute trend where there is conflicting information or ambiguity on how the policy should be applied and we need to do more comprehensive research on the appropriate implementation of payment policy.

While there are many different roles on the support team, and these roles make the team more productive, the PR Representative remains the primary point of contact to streamline and enhance the provider experience. For instance, when a provider brings a claims issue to his or her PR Representative, the PR Representative begins by researching the issue to determine the cause of the problem. It could be a contract issue, a configuration problem, an authorization issue, or a provider error. Depending on the root cause, a different team of experts within WellCare will fix the problem. Instead of being bounced from one WellCare employee to the next, the provider can rely on their PR Representative to be their central point of contact no matter which issue caused the claims problem.

It is this dedication to prompt, direct, and accountable provider service--from a coordinated team of highly skilled, locally-based provider relations representatives--that has resulted in 91.6% of Kentucky providers saying they would recommend WellCare of Kentucky to other physician practices. Going forward, we are committed to maintaining that standard and continuing to look for new ways to better support our providers in delivering the highest quality care to Kentucky Medicaid Enrollees.

ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.

We offer a variety of modes through which providers can interface with WellCare representatives for instruction and updates as well as to offer input on WellCare initiatives. These include our Provider Advisory Panels, Provider Summits, Joint Operating Committee meetings, Webinars, and Technical Advisory Committee Meetings. Through these channels we are able to understand and respond to the changing needs of our providers.

Provider Advisory Panel: Under the direction of Provider Network Director Bonnell Irvin, WellCare of Kentucky has created a Provider Advisory Panel comprised of providers from all eight regions, organized and facilitated by Provider Relations. The Provider Advisory Panel serves as a consulting resource to WellCare of Kentucky in policy and operational matters, and further strengthens the bridge between WellCare and the provider community. We identify potential provider panel members from recommendations by the respective

Providers Asked	WellCare Responded
Faster Provider Enrollment	✓
Reduction in authorization requirements	✓
Enhanced provider portal, more self service functions	✓
Add skilled hospital billing professionals	✓
Access to claims experts in the field	✓

region's Provider Relations team. The panel members consist of PCPs and specialists who are independent providers not connected to hospitals.

Depending on the agenda of the panel, WellCare of Kentucky representatives may include our Medical Directors, Provider Relations Manager, and their team members. The agendas are created by collaboration of the Network Management leadership team in concert with Provider Relations. We hold Provider Advisory Panel meetings quarterly in each of our six regional offices. Although we prefer to have all attendees available in the office, at times we connect our providers virtually via video teleconference to avoid the need for excessive travel and to ensure we have representation from across Kentucky. All panel recommendations and meeting outcomes are reviewed for consideration by WellCare's Kentucky leadership team.

Provider Summits: Each year WellCare of Kentucky hosts multiple regional provider summits across the Commonwealth. Summit agendas include general presentations from leadership, presentations from key departments that impact all providers (portal, case management, claims, for example), a Q&A session with our leadership, and breakout sessions on individual topics such as Waiver implementation, regulatory changes, and plan highlights such as our work with Community Connections claims adjustments, behavioral health and quality improvement. In 2019, 471 providers attended our regional summits. WellCare of Kentucky has hosted these provider summits every year since the launch of the Medicaid Managed Care program.

Joint Operating Committees: For our large provider groups and hospitals, we hold regularly occurring JOCs with formal agendas to review comprehensive performance metrics and mutually identify opportunities to improve overall success of the partnership and performance under value-based payment (VBP) arrangements.

Based on discussions at JOC meetings, WellCare created a hospital surge report that shows facilities a quick picture of common denial reasons, total paid and total denied claims. Along with the report, we provide best practices to improve operational processes to reduce denied claims.

Webinars: Throughout the year, WellCare hosts bi-weekly webinars on a variety of topics that inform and update our provider partners on both WellCare initiatives and Department or Commonwealth initiatives that may impact providers. For instance, we conducted a number of webinars prior to the launch of KY Health. We collect feedback from attendees that enables us to identify additional educational or training needs and develop future trainings targeted to meet those needs. Some topics we've developed based on feedback from our providers have been our pharmacy preferred product list and authorization procedures.

Technical Advisory Committee Meetings: Representatives from WellCare of Kentucky's leadership team attend all Technical Advisory Committee (TAC) Meetings. Attendance at these meetings allows us to listen to important feedback from providers that we have used to take positive action. For instance, in a recent Hospital TAC meeting, DMS and the Hospital TAC discussed changing the timeframe for altered authorizations after an outpatient procedure when there were unforeseen adjustments made during the procedure that required an authorization. Immediately after the meeting, WellCare was able to coordinate with our

Utilization Management team to alter our post-procedure authorization timely-filing guidelines to comply with DMS' direction. We were able to implement the change more rapidly because we attended the TAC meeting and had researched the solution prior to DMS issuing their final decision.

iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.

WellCare closely monitors provider satisfaction in order to continually improve the provider experience and ultimately assist providers in better serving our Enrollees. We use a "no wrong door" approach to feedback from providers, using a variety of different methods to measure provider satisfaction and gather the critical information necessary to make these improvements. These include annual provider satisfaction surveys, as well as data collected from post-call surveys, provider summits, and feedback on our provider portal.

Annual Provider Satisfaction Survey: Our annual Provider Satisfaction Survey is conducted by SPH Analytics (SPHA), a National Committee for Quality Assurance (NCQA) certified survey vendor. This survey is designed to support NCQA standards for health plan accreditation, as well as ensure our provider satisfaction program remains compliant with key reporting requirements. The survey helps identify opportunities for improvement by asking providers for feedback on a variety of topics, including:

- Other health plans (comparative rating)
- Finance issues
- Utilization and quality management
- Network/coordination of care
- Pharmacy
- Health plan call center service staff
- Provider service representatives

The survey also includes a free form section where providers can provide unrestricted feedback about any topic relevant to them. Results are then correlated to identify the items most important to overall provider satisfaction.

Post-call satisfaction survey: At the end of each call from a provider to our call center, providers are offered the opportunity to complete a survey on their interaction to assess the effectiveness and convenience of the interaction and offer feedback. The results of these surveys are reviewed on a monthly basis by the Kentucky Provider Relations team who develop action plans for improvement. Provider representatives also follow up directly with a provider who has expressed dissatisfaction in order to remediate any issue. This process for collection of feedback, analyzing feedback and individually following up on each issue with the individual provider allows us to measure satisfaction and make adjustments on an ongoing basis.

Provider Summit Feedback: We distribute surveys to attendees of our annual provider summits which provides valuable insight into our providers' satisfaction with this forum, as well as input on what training topics providers would like to learn about, what functionality and tools they would like to see, and what WellCare could do to more effectively support them. For example,

the results of our Provider Summit survey from our Lexington summit showed that 90% of our attendees "Agreed" or "Strongly Agreed" that the summit met their expectations.

Provider Portal Feedback: We collect real-time feedback on our Find-A-Provider tool to enhance the user experience with this tool or the website as a whole. Content, navigational and search improvements have been made as a result of this feedback. Based on survey feedback, we expanded the number of radius miles for providers in rural areas and enhanced specialist searches by adding additional key words to the database. As an enhancement, at transaction confirmation time the user will be asked to complete a survey on the effectiveness and convenience of the transaction. Results will be analyzed and reported to the appropriate areas within the organization, including Provider Relations.

Provider Meetings, Workgroups, and Committees: We capitalize on our Joint Operating Committee, Provider Advisory Panel, and Provider Summits, as well as our participation in the Kentucky Primary Care Association and Kentucky Hospital Association meetings to be aware of and address provider concerns. For example in a recent Provider Advisory Panel meeting a provider questioned how their staff could see the coordination of benefit information we have on file for their assigned enrollees; our monthly provider portal training includes training on COB availability, so we invited the provider and their staff to the next training session. Additionally, based off recent feedback we have made adjustments to training and communication related to a variety of issues:

- Peer comparison reports – WellCare has been doing this but we have focused in on certain provider types and are now expanding this process across a broader audience
- Reviewing report timeliness and seeing how we can improve it so it is more 'real-time'
- Conducting internal meetings related to UM procedures on small physicians who perform infrequent services requiring authorization but have zero history of overturns. Considering creative expansion of our Gold-card program.

iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.

Our entire approach to provider services, from the way our PR Representatives engage providers at the local level and take accountability for resolving any issues from initiation through resolution, to the way our management structure is set up to spot trends and proactively address them, to the multiple open channels of two-way communication between WellCare and our providers, is set up to minimize complaints and escalations to DMS. Our involvement in TAC meetings, our careful consideration of legislative changes or new Department requirements, our engagement with providers to understand the pain points they may experience as a result of changes or the training and education they may need to adapt--all of these serve to reduce provider abrasion and decrease the likelihood of widespread or ongoing issues that reach DMS level.

Our team also closely monitors Grievances and Appeals trends, claims denial trends, and every metric of provider satisfaction on an ongoing basis. When we discover issues affecting multiple providers, we conduct regular status meetings to resolve systemic operational problems until those issues are resolved. The first escalation step if there is an identified trend that can't be

solved at the PR Representative level is to document the issue in our internal Network and Provider Operations Call (NPOC) log. This log documents each issue along with the responsible person and a timeline for completion. This is reviewed on a standing monthly call with our Provider Relations and Operations leadership. If the issue has a longer resolution timeline or requires coordination with enterprise resources, it is escalated to Chief Operating Officer Ben Orris and Provider Network Director Bonnell Irvin.

Although this is the formal escalation process, our entire leadership team, including Plan President Bill Jones, attends our Provider Summits, where they interact with providers. At each of these forums, our leadership team shares their direct email address and phone number. Any provider is welcome to email or call our leadership team directly to escalate a problem. This is reflective of our “no wrong door” philosophy on collecting and addressing provider issues.

We also carefully consider how changes we make in our own operating model may affect our providers and proactively plan to ensure that those changes do not result in provider escalations to DMS. WellCare of Kentucky has a weekly meeting reviewing any potential changes which are planned for our operating model. This leadership team meeting includes Provider Relations leadership to evaluate any possible impacts to providers. Once we establish that any change could impact providers, our Market Analytics team generates a report that estimates the impact to providers broken down by vendor. Depending on the type of change and total impact, we use a combination of tools to communicate any change impacting providers once the change is approved by DMS. This includes:

- Provider portal notification
- Mass mailing
- Provider Relations or HSS representative on-site training
- Leave-behind print material during office visits
- Webinars

We develop a custom communication plan using any or all of these techniques depending on the extent of the proposed change. For example, if the change has a small impact to a handful of providers, we may simply educate the PR team, create a one-page leave behind document and incorporate that messaging into our regularly scheduled visits to the impacted offices while leaving the collateral with the office. For more comprehensive changes that impact many providers, we would use almost all of the above-mentioned communication tactics. We have also adjusted our communication and implementation timeline depending on the complexity of the change. For more complex changes, we offer more time until implementation to prepare providers properly for the impact to their operations.

b. Describe the Vendor’s proposed Provider Services call center, including an overview of the following at a minimum:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 27.2, Provider Services Call Center of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Offering the best experience for providers who interact with us is a top priority, with a focus on satisfaction, quality and first-call resolution. Our provider call center is staffed by highly trained agents with broad-based experience handling provider inquiries. They assist providers with all manner of inquiries including eligibility, prior authorizations, referrals, claims (medical, behavioral, pharmacy), fraud and abuse hotline referrals, current network status and the administration of out-of-network services. Our call center staff is backed by systems and processes that enable us to continually meet or exceed DMS' service level requirements. The result is a seamless experience that enables providers to quickly get the support they need, when they need it.

WellCare of Kentucky has maintained a Provider Call Center satisfaction rate of over 88% since 2016.

i. Approach to assuring the call center is fully staffed during required timeframes.

WellCare of Kentucky operates a fully-staffed call center Monday through Friday 8:00 am – 6:00 pm Eastern Standard Time, including federal holidays. During normal business hours, callers can bypass the IVR system and speak directly to a live representative at any time. Providers also may contact us through our Live Chat web service via the provider portal during normal business hours of operation. This web service gives portal users the ability to contact us in real-time and ask a question or discuss an issue they are having and receive immediate support without interrupting their workflow.

We employ sophisticated oversight processes to staff appropriately so that we can achieve our service metrics and be available to our providers when they need us. We use the NICE workforce management system to facilitate adequate staffing. NICE 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 predict call volume and project required staffing. This tool enables us to forecast call volumes, schedule representatives, control call traffic between locations, perform staffing analysis, and report on key performance indicators (KPI). To deliver accurate call volume forecasting and staffing, intervals of 30 minutes are used to understand arrival patterns. By monitoring and analyzing each half hour through our Customer Service Command center, we are able to apply appropriate staffing levels to meet the callers' needs in a timely manner. NICE allows us to effectively and efficiently develop weekly, monthly, annual, and multi-year planning scenarios that accurately forecast the impact of changes in key performance drivers on our call centers' service quality and staffing requirements.

ii. Location of proposed operations.

Our WellCare of Kentucky's service delivery model for provider inbound and outbound calls includes our Work-At-Home- Agent (WAHA) service model staffed by associates located in Kentucky. These Kentucky based associates residents are fully trained and supervised virtually using all of our call center tools (i.e., call monitoring, call recording, queue management, etc.). Combined with CAREConnects, our award winning, proprietary agent desktop solution, our WAHA strategy enables us to deliver a localized approach to provider support through Kentucky-based associates. WAHA allows for rapid deployment during non-forecasted demands, seasonal peaks, hard to staff shifts and crisis management. In addition, staff can be

easily localized in any region within the state. This approach, supported by an outstanding training model, gives us access to a broad talent pool from which to recruit and hire, with no geographic restrictions.

Supporting the Kentucky team is our South Carolina based call center whose team members are fully trained on Kentucky Medicaid benefits and services. The South Carolina team is trained on all aspects of the Kentucky Medicaid program and are equipped to handle all provider inquiries including claims, authorizations, benefits and eligibility questions.

iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.

Quickly responding to providers in need of assistance is crucial in helping them maintain their work flow and productivity. Chief Operating Officer Ben Orris, is responsible for the oversight and monitoring of the call center to ensure DMS' standards are being met. He has real time access to WellCare's Command Center, to monitor the service levels at any time. Additionally he is provided dashboard reports that detail the Kentucky call center's service levels five times throughout each day.

In order to meet the high call center standards demanded by DMS and our network providers, our Kentucky operations are supported by WellCare Command Center operations. The WellCare Command Center is made up of a centralized team of associates dedicated to full-time monitoring of capacity and performance across all of our local call center locations nationwide. This team monitors average speed of answer, abandoned call rate, blocked call rate, average hold time, timely response to inquiries, accurate response to inquiries and phone etiquette. The Command Center is the control center for all provider services functions and performance, providing real-time monitoring of service levels and coordinates action in order to achieve our service level targets.

The Command Center features numerous display screens which display data and trends including, but not limited to, calls in each queue, length of time callers have been waiting to speak to a representative, and number of representatives available to assist callers. Command Center management monitors service levels and adjusts operations as necessary to ensure service level requirements are continuously met. Because weather can pose threats to our operations, the Command Center continuously displays and monitors the weather to identify any potential impacts and rebalance workloads as needed so there is no threat to service level performance.

All possible actions are taken to prevent service level issues, but the team has documented contingencies that can be enacted immediately when they do occur. These contingencies allow us to re-route call traffic to other trained agents where pockets of agent availability exist. We also adjust skilling strategies so that prioritization can be applied to queues in need, and as necessary, subsidize staffing by pulling trained agents from work types that aren't tied to real-time demand. All of this is accomplished through direct communication and highly effective partnership with our sites. The command center team is actively engaged with local Kentucky Management team when these contingencies are put in place throughout the day.

As we do today, WellCare will continue to meet the following performance standards as measured by monthly averages for the provider services and pharmacy call centers:

- Call abandonment rate of less than five percent (5%)
- Eighty percent (80%) of calls are answered by a live voice within thirty (30) seconds, and the remaining twenty percent (20%) are answered by a representative with an additional thirty (30) seconds. “Answer” is defined as response to each caller who requests to speak to a live representative
- Accurate response to call center phone inquiries by call center representatives is ninety percent (90%) or higher
- One hundred (100) percent of call center open inquiries are resolved within seventy-two (72) hours

Additionally, all voice messages left during non-business hours are returned within one business day. The process we employ to assure all return calls to providers are timely include checking voicemail box on a daily basis at the start of each business day. Callbacks are completed daily with three attempts made to the provider. A daily summary is sent to Provider Relations leadership with updates on voicemail received and completed. The standard Call Monitoring Quality Assurance process that is in place for inbound calls is performed on outbound calls to ensure quality and timeliness of resolution.

c. ***Provide an overview of the Vendor’s proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers.***
Provide sample screenshots of provider websites currently maintained by the Vendor

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 27.3, Provider Services Website of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically.

Offering providers and their staff multiple ways to interact with us improves service delivery for our Enrollees and reduces administrative burden on providers. Available 24/7, our secure provider portal serves as a one stop shop for providers and their staff to process transactions and get real-time information at the time that works best for them, improving the efficiency of our providers and allowing them to focus on treating their patients, our Enrollees. Our Section 508 and HIPAA-compliant secured portal has transactional capability, informational resources and self-service tools specifically for our network providers and is compliant with all Department requirements.

The portal gives our providers access to a variety of tools and information as shown in **Table C.17-1.**

Table C.17-1 Provider Web Portal Functionality

Provider Web Portal Functionality	
Enrollee Information	• Eligibility verification with applicable co-payment amounts – allows providers to confirm an Enrollee's PCP assignment, health plan and co-payment information • Pharmacy utilization • Inpatient admission log • Membership panel assignment report • Interfaces with our service management platform, CareCentral, to reflect Enrollee care gaps • Unable to contact – if we've been unable to contact the Enrollee for 30 days, we let the provider know and ask if they have updated information • HEDIS information and tools
Claims	• No-cost electronic claims (both single claims and batch) submission via direct data entry. Includes real time HIPAA EDI compliance check supporting Strategic National Implementation Process (SNIP) data validation with error responses • Check claim status • Edit and rebill a claim (corrected claim) • Submit a dispute or appeal • Save a draft of a claim
Authorization Support	• Prior authorization submission • Check authorization requirements • Check status of prior authorization
Training	Complete assigned training modules such as Provider Orientation, Cultural Competency: Provider Program, Secure Provider Portal Overview, Interactive HEDIS Online Portal Training
Visit Checklist	A tool that combines our appointment agenda with additional information for the providers to take to an Enrollee meeting. The person who checks eligibility can easily print this or create a PDF for the practice management software and make it available to the provider when they meet with the Enrollee. When the visit is done provider offices can use this same service to tell us about care gaps and health conditions electronically, allowing us to more quickly get this vital information to manage an Enrollee's health. The checklist contains information including: • Open care gaps • Inpatient visits • Prescription use • Historical health conditions

Provider Web Portal Functionality	
	• Participation in service and disease management
Preferences	• Providers can also choose to go paperless for specified correspondences
Control their Accounts	• Providers control how has access to their accounts and at what level – they can create individual sub-accounts for staff members, assign roles that keep separate billing and medical accounts
Submit Demographic Changes	• Providers are able to submit changes of address, telephone numbers, hours of operation, open/closed panels and providers who join or leave the practice
Additional Information	• Provider Message Centers: Allow for delivery of self-service ad hoc reports to requesting providers as well as important notices • Resource Center: A gateway to the forms most commonly used by providers, quick reference guides and other helpful information such as "how to" job aids • Care Gap Submission Tool: Allows providers to electronically submit medical records to our Quality Improvement staff to help providers identify and better manage care gaps for Enrollees. It also allows providers to correct and view previously submitted medical records • Links to CHFS, DMS, and the CVO(s) • Information on how to file an appeal and obtain prior authorizations

Our provider portal is also connected to our integrated Care Management system, which allows us to share the outcomes of health screens, EPSDT information, social determinants of health obstacles, Enrollee assessments, care plans, and multi-disciplinary team contacts with providers. Providers can also view open and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, EMR interchange or submission of supplement medical record information. They can also view appointment agendas, which allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment including all known diagnoses and associated care needs derived from evidence-based guidelines.

Because we value the opinions and ideas of our providers and their staff to improve our relationships, we recently completely redesigned our secure provider portal based on feedback from providers and their staff. Though we use industry standard processes for developing requirements, when building and testing the portal (as with all outward-facing systems), we enlisted the aid of focus groups consisting of all types of provider groups from across the country. Their initial feedback, coupled with their participation in the design and testing processes, was vital to our producing a portal that addressed the unique and particular issues they have to deal with on a daily basis, and made it easier for them to do business with us.

Innovation

The redesigned portal now features live chat functionality enabling users to connect with a provider support representative in real-time to inquire about the status of claims. Using the chat for claims inquiries enables providers to reach the front of the queue ahead of those waiting on a phone line so they can receive immediate assistance including real-time claims adjustment without interrupting their workflow. Providers also have the ability to print and review chat transcripts. In the coming months, we will be expanding chat capability to enable providers to inquire about authorizations, Enrollee benefits and eligibility, as well as to get live assistance with any registration, login or technical issues related to the web portal. As we look toward the future, we will continue to seek ways to add functionality to the portal that reduce administrative burden and improve our providers' experience with us.

SAMPLE SCREENSHOTS

From the provider portal home screen users can quickly navigate to see authorizations and referrals, look up claim status, and access trainings, as shown in **Figure C.17-2.**

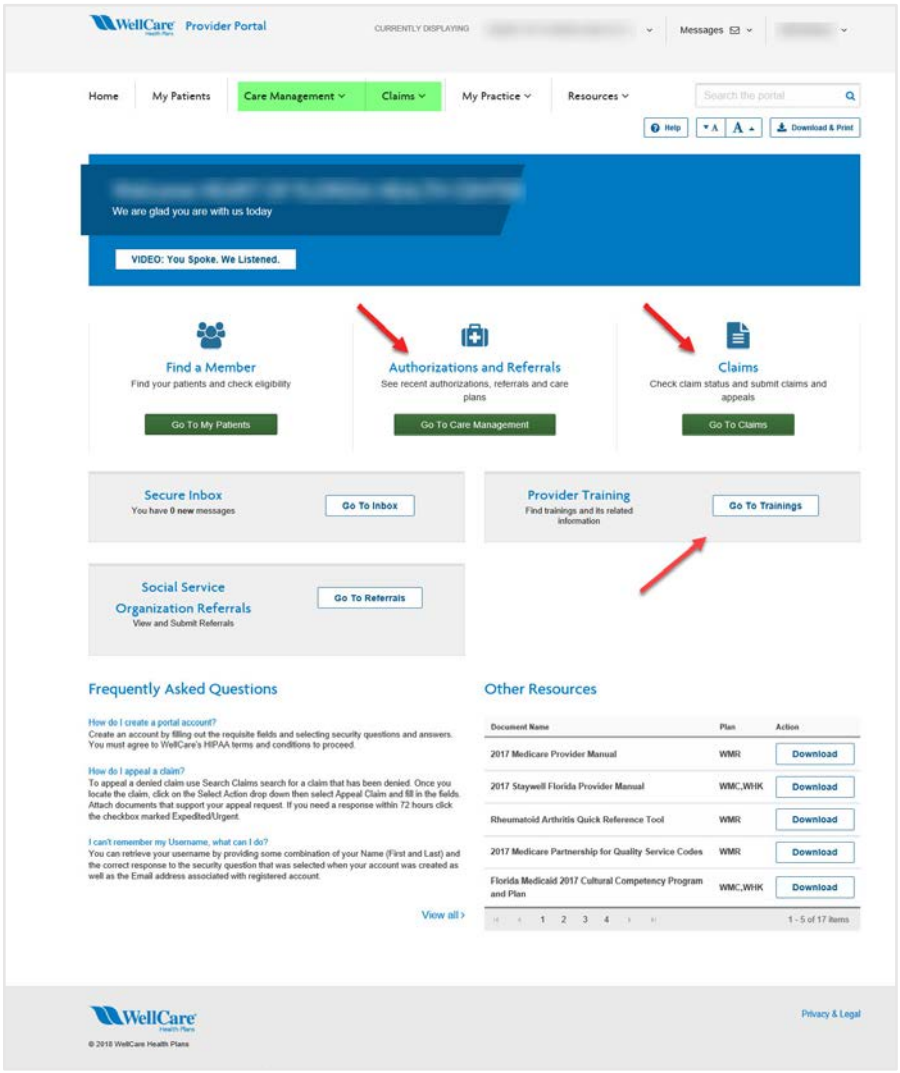

Figure C.17-2 Provider Web Portal Home Screen

The provider portal hosts a searchable database of provider training modules accessible at any time, as shown in **Figure C.17-3.**

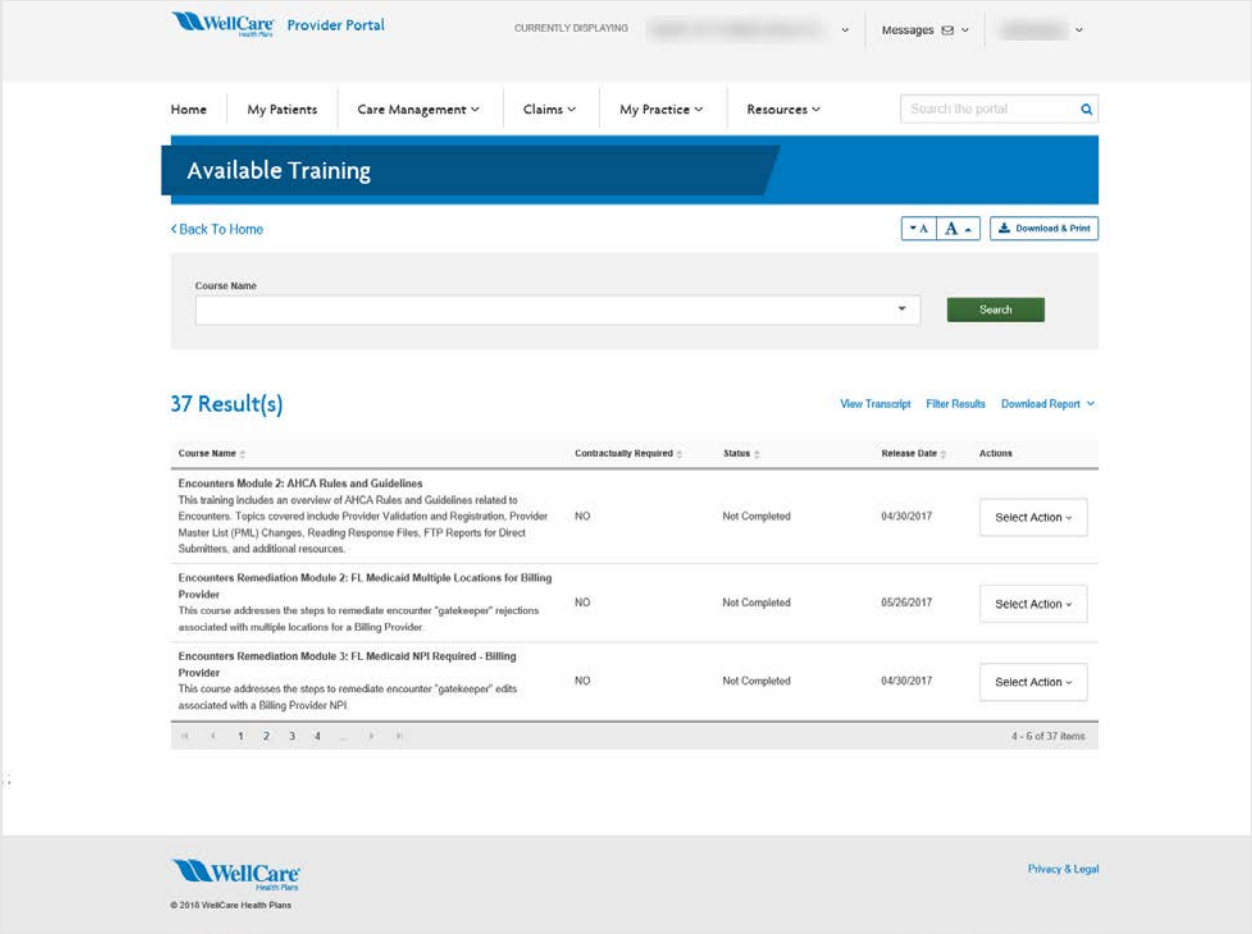

Figure C.17-3 Provider Training

Providers can search for and check the status of claims using the portal, as shown in **Figure C.17-4.**

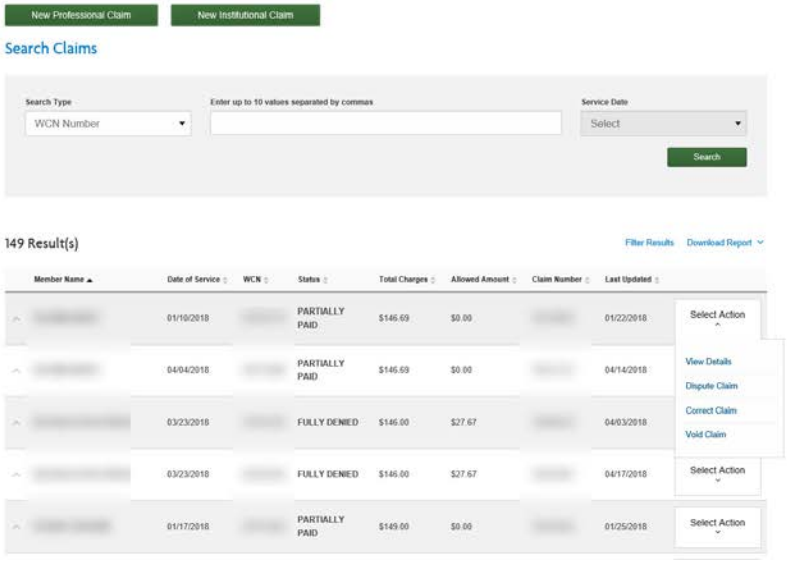

Figure C.17-4 Claims Search

d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 27.4 Provider Manual and Communications of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in our **Attachment X Contract Compliance Matrix**, provided electronically.

As we do today, we will continue to maintain and distribute to all contracted providers the WellCare of Kentucky Provider Manual, a comprehensive resource of program information that providers may reference at any time. We issue newly-contracted providers a Provider Manual within five business days from inclusion of the provider in our network and provide online access to the Provider Manual and any changes or updates. The Provider Manual and all provider materials are available both online and in hard copy format upon request of the provider. The Table of Contents for our Provider Manual, with separate dedicated sections for BH and Pharmacy, includes:

- Provider rights and responsibilities
- Provider and Enrollee Administrative Guidelines
- Covered Services
- Enrollee rights and responsibilities and cost-sharing requirements
- Information for PCPs about Advance Medical Directives and their responsibilities for informing Enrollees
- WellCare Policies and Procedures

- Information for accessing the WellCare program materials through the Call Center, Website, and Provider Portal
- Provider credentialing and recredentialing
- Provider and Enrollee Grievances and Appeals process
- Claims submission process and requirements
- Provider Program Integrity requirements and reporting suspected Fraud and Abuse
- Utilization Management, Care Coordination, and Disease Management
- Prior Authorization procedures
- Medicaid federal and state laws and regulations
- Overview of the QAPI program
- Overview of value-based payment (VBP) models
- Standards for preventive health services
- Delegated Entities
- Behavioral Health
- Pharmacy
- WellCare of Kentucky Resources

As we currently do for our existing contract, we will submit the Provider Manual to DMS for approval, including any provided by a Subcontractor for direct services, and any updates to the Provider Manual, prior to publication and distribution to providers. Please see **Attachment C.17.d Provider Manual**, provided electronically, for our current WellCare of Kentucky Provider Manual. We will also prepare and issue provider communications as necessary to inform providers about our policies, initiatives or other information. WellCare of Kentucky understands that DMS will approve provider communications prior to distribution only if they change or amend the way the WellCare of Kentucky conducts business with the provider or when there are material changes to the Medicaid managed care program (e.g., changes to federal and state laws, provider notification of a rate change).

e. Provide the Vendor's proposed approach to provider orientation and education.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in **Section 27.5, Provider Orientation and Education** of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Effective training is a critical element of supporting our network providers and improving quality of care for Enrollees. We employ a blended training delivery model that includes classroom, Provider's office, web courses, reference tools such as the Provider Manual, and real-time interactive web meetings. Our provider training modules are in place to support compliance, improve provider performance and quality, ensure understanding of Department requirements and enhance provider satisfaction. These modules are delivered upon initial training and are all available through the provider portal.

In accordance with DMS' contract requirements, we conduct initial orientation for all providers within 30 days after WellCare places a newly contracted provider on an active status. Our PR

Representatives conducted 356 orientation training sessions with our providers in 2018 through several mediums, including in-person, online, and over the phone.

Our New Provider Orientation covers the following topics:

- WellCare Overview
- Kentucky Medicaid Program Overview
- Provider Resources
- Provider Portal
- Provider & Enrollee Rights and Responsibilities
- WellCare's Compliance Program
- Covered Services, EPSDT Services
- Utilization Management, Case/Disease Management, Transition of Care
- PCP Notification of Admissions
- Quality Improvement Program
- Claims and Encounter Data Submission
- Appeals
- Grievances

Providers are given other training tools, including manuals; quick reference guides and resource guides with step-by-step instructions for routine activities such as claims submission and authorization requests; provider bulletins and newsletters; and clinical coverage and practice guidelines. We ensure that all providers receive initial and ongoing education to operate in full compliance with the Contract and all applicable Federal and Commonwealth requirements, and that all providers receive targeted education for specific issues identified by WellCare or DMS.

Through our comprehensive Provider Engagement Model, described earlier, we also offer a number of channels through which providers can receive ongoing education and training. These include monthly visits with their PR Representatives and QPAs, Provider Summits, the provider portal and our popular ongoing webinars. Throughout the year, our Provider Relations team hosts bi-weekly webinars on a variety of topics that inform and update our provider partners on both WellCare initiatives and Department or Commonwealth initiatives that may impact providers. Topics change frequently and vary based on market conditions. For example, when certain program changes go live, we talk about the impact these changes will have on providers. Through our provider summits and other provider engagement activities we also collect feedback that enables us to identify additional topics for future webinars. Recent provider webinar topics have included:

- WellCare Provider Portal
- Kentucky HEALTH Waiver
- DMS Mandated Copays
- P4Q Program/Appointment Agendas
- Community Connections Program
- Quality/HEDIS/Care Gaps
- WellCare Works Program

In 2018, we had an average attendance of more than 200 providers for each webinar. Our initial webinar on the Kentucky HEALTH Waiver drew more than 400 attendees, prompting us to hold a number of follow-up webinars on the topic to meet the demand of our network providers for this important information.

f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 27.7 Provider Credentialing and Recredentialing and Appendix J Credentialing Process of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically.

Since first developing the provider network to serve Medicaid Managed Care enrollees in Kentucky, we have worked not only to ensure that our providers met the criteria necessary to provide the quality of care demanded by the Commonwealth, but to make the process of submitting that criteria and joining the network as seamless and efficient as possible.

In the effort to continue to do so, we support DMS' goal to reduce administrative burden on providers through the establishment of a centralized credentialing process. Since 2015, we have worked closely and successfully with many of our State partners on transitioning to a centralized provider credentialing model. For example, we collaborated with the State of Georgia in the development and implementation of an NCQA-certified centralized credentialing process using a credentialing verification organization (CVO). We have also worked with CVOs in our Texas, New York, Arkansas, and Arizona health plans. In Illinois, WellCare has supported the effort of the Department of Healthcare and Family Services to enable providers to submit credentialing applications via the web-based IMPACT system.

Our extensive experience working in multiple markets, each with distinct processes enables WellCare of Kentucky to be an effective partner with DMS in the effort to streamline the credentialing processes for providers under Medicaid managed care. We look forward to consulting, collaborating, and sharing best practices with DMS to accomplish this goal.

i. Methods for assisting providers who are not enrolled in Medicaid with the enrollment process.

Our locally-based PR Reps and POCs are educated about Kentucky Medicaid enrollment as part of their training and work directly with providers to answer any questions related to the enrollment application. They ensure providers have the appropriate links to complete and submit the enrollment forms, and assist new providers to ensure all required information is included in the submission to the state in order for the provider to receive prompt assignment of a KY Medicaid provider ID number. They also help providers select the appropriate key items such as provider type, or taxonomy codes as defined by the state as well as explain other items based on how the state uses these data elements as well as how the state uses the information for enrollment and transmission to MCOs. This assists providers in avoiding any delays in the loading process and allows claims to process correctly immediately upon enrollment.

ii. Proposed process for conduct of credentialing until such time that a Credentialing Verification Organization (CVO) is contracted by the Department.

Until the transition to a CVO, WellCare of Kentucky will continue to conduct credentialing of providers as it does today, in compliance with (NCQA), KRS 205.560(12), 907 KAR 1:672 and other applicable state regulations and federal laws. Our provider credentialing process is critical to ensuring our Enrollees receive quality health care from providers who have been evaluated and verified as having met the standards required to become part of our network. Our process fully supports DMS' goal to contract with health plans that have comprehensive, quality-driven provider networks. Furthermore, our credentialing process ultimately serves to ensure that enrollees have access to appropriate, medically necessary services in a timely manner and in the most appropriate setting, achieving the best possible quality outcomes while containing costs.

WellCare currently complies with DMS' Draft Medicaid Managed Care Contract requirements by credentialing or recredentialing providers within 90 days of receipt of all relative information from the provider, or 45 days if the provider is providing substance use disorder services.

In 2018, WellCare of Kentucky credentialed 1,802 providers with an average turnaround time of 13.43 days.

CREDENTIALING PROCESS

WellCare of Kentucky maintains documented policies and procedures for credentialing, recredentialing and between-cycle monitoring and maintenance of providers. At least annually, or as needed, we review our policies and procedures in order to make any changes necessary to maintain compliance with applicable state and federal accreditation requirements as well as our internal compliance program and code of conduct and business ethics. Our policies and procedures related to credentialing and recredentialing are formally reviewed and approved by our Quality Improvement Committee (QIC). WellCare's Credentialing Committee is a subcommittee of the Quality Improvement Committee overseen by WellCare of Kentucky Medical Director Howard Shaps. It is comprised of a combination of seasoned health care professionals with broad experience in the industry and specific local experience including WellCare's Chief Medical Officer, community physician participants, provider relations and corporate resources that run the company's overall credentialing process.

As per NCQA standards, clean credentialing files are reviewed and approved at least twice per week by the Medical Director. During the monthly Credentialing Committee meeting, the committee is presented a listing of all providers approved by the Medical Director during the prior month. The Credentialing Committee then focuses on reviewing and discussing individual credentialing applications that contain potential issues. This process allows credentialing application turnaround time to remain low. In addition, the Quality Improvement Committee reviews the meeting minutes of the Credentialing Committee on a quarterly basis.

We perform credentialing and recredentialing for every independent practitioner and organizational provider in our network. Initial credentialing is conducted prior to the effective date of the provider's provider contract, and recredentialing is conducted every three years.

Providers are required to be credentialed prior to being listed as a participating network provider of care or services to our Enrollees.

Application and Initial Steps. The credentialing process begins with completion and submission of a credentialing application from a provider. For independent practitioners in Kentucky we use the KAPER-1 or CAQH Universal Credentialing Application Form. When a credentialing application is received from a provider, the application and all corresponding documentation is submitted into the WellCare workflow/tracking system. Once the application is determined to be complete, a credentialing specialist reviews it for completeness and performs the necessary verifications.

The credentialing specialists perform primary and secondary source verifications in accordance with NCQA guidelines. Primary source verification is documented verification by an entity that conferred or issued a credential (e.g., medical school, a residency program, or a licensing board) that an individual's statement of possession of the credential is true. Secondary source verification is documented verification of a credential through obtaining a verification report from an entity listed as an acceptable secondary source, on the basis of a statement from that entity that they have performed the primary source verification.

Credentialing Requirements. WellCare's credentialing requirements adhere to those criteria listed in Appendix J in the Medicaid Managed Care Contract and are also listed in our attached Credentialing and Recredentialing Policies and Procedures document.

Approval Process. Upon receipt of a completed, verified credentialing application from an independent practitioner or organizational provider (which includes, as applicable, a site inspection evaluation), our Medical Director reviews the application and supporting documentation. Providers who meet our established "clean file" criteria are approved by our Medical Director, and these files are presented in list format at each meeting of the Credentialing Committee.

If a file does not meet established criteria for "clean" files (e.g., there is a licensure issue or the site inspection did not meet all requirements), the file is presented to the Credentialing Committee for review and recommendation. When the determination is favorable to the provider, the approval is forwarded to our Quality Improvement Committee (QIC). In the event the Credentialing Committee recommends a denial decision, we notify the provider of the reasons and, as applicable, offer the right to appeal. The minutes of the Credentialing Committee are provided to the QIC. The QIC forwards to our Board of Directors the minutes of the Credentialing Committee as well as a report containing the decisions of our Medical Director and the Credentialing Committee.

When a provider's application is approved (by the Medical Director or the Credentialing Committee, as applicable), the credentialing database is updated with the active status of the provider, the credentialing approval date, and the recredentialing due date. Based on the credentialing decision date and the active status of the provider in the credentialing database, a credentialing specialist prepares and sends a letter to the provider advising the provider of the approval. The letter includes the specialty/scope of services the provider has been approved for and advises the provider of the requirement for recredentialing every three years.

Recredentialing Process. WellCare performs recredentialing for providers, including practitioners and organizational providers, at least every three years. Recredentialing information is collected under a current, signed and dated attestation of correctness and completeness. Providers entering their recredentialing timeframe are notified in writing by the Credentialing Department. This written notice includes a recredentialing application and instructions on how to complete and submit it. Once the application is received by the Credentialing Department, the information is verified via primary source verification and clean files are presented and reviewed by the Medical Director for approval. Any provider who has issues identified during their recredentialing process will be presented to the Credentialing Committee for review prior to being approved to continue serving in WellCare's network.

In-between Cycle Monitoring: Providers are monitored on an ongoing routine basis. At the time of initial credentialing and on a monthly basis thereafter, the Credentialing Department reviews any sanctioning action taken against providers by state and federal regulatory bodies. This monitoring includes review of Medicaid/Medicaid Sanction Exclusion and Reinstatement reports, the List of Excluded Individuals and Entities, Medicare Opt-Out listings, System for Award Management Exclusions and professional licensing actions. If a network provider is identified as having lost his or her license to practice medicine for any reason, the provider is automatically terminated from the network. If a provider has been subject to disciplinary action but their license is not terminated, the details of the disciplinary action is presented to the Credentialing Committee for a recommendation and decision on the provider's continued network participation.

iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).

We strongly support the efforts of DMS to streamline processes for providers enrolling in the Kentucky Medicaid Managed Care program. With the transition to centralized credentialing, it will be critical to educate providers about the credentialing verification organization (CVO) process to assure they are able to effectively navigate it and reap the benefits of the reduced administrative burden. Providers will be impacted on a rolling basis as they are up for recredentialing and they transition to the new process.

To provide consistent information to providers and their office teams about the credentialing and recredentialing process, WellCare of Kentucky will seek to partner with the other MCOs, DMS, and DMS' CVO(s) to develop shared content. Together, we have the opportunity to promote DMS' collaborative efforts, minimize provider burden, deliver consistent instructions, and improve provider satisfaction.

Since 2015, nationally WellCare has affiliates have worked closely and successfully with many of our state partners on transitioning to a centralized provider credentialing model. For example, our Georgia affiliate collaborated with the State of Georgia in the development and implementation of an NCQA-certified centralized credentialing process using a CVO. Our affiliates have also worked with CVOs in Texas, New York, Arkansas, and Arizona health plans. In Illinois, WellCare supported the effort of the Department of Healthcare and Family Services to

enable Providers to submit credentialing applications via the web-based IMPACT system. Our extensive experience working in multiple markets, each with distinct processes enables us to be an effective partner with the DMS in the effort to streamline the credentialing processes for providers under Medicaid managed care. We look forward to consulting, collaborating, and sharing best practices to accomplish this goal.

EDUCATING PROVIDERS

We are developing a multi-pronged provider education strategy to implement prior to the go-live date that will leverage online information and materials, webinars, and the work of our provider relations staff. This approach will ensure that all potential providers and current providers have easy access to the necessary information to complete the credentialing and recredentialing process with the CVO(s).

Provider Manual

Our Provider Manual will provide contact information for the CVO(s) and a description of the credentialing and recredentialing process, including roles and responsibilities of the provider, CVO(s), and MCOs. We will work with the CVO(s) to incorporate other information to assist providers in navigating the credentialing and recredentialing processes, such as checklists and other aides. We will submit any updates to the Provider Manual related to information about the CVO process to DMS for review and approval prior to publication or distribution.

Online Information

Our providers and their office staff are busy. Administrative activities, such as credentialing and recredentialing, may occur outside of regular business hours. We therefore will ensure that they will have 24-hour access to information and aides on our and subcontractors' public and private provider websites.

On the public-facing page on our website, we will post links to the CVO(s) website(s) for easy access to application materials. To promote consistency, we will include information similar to that in the Provider Manual describing the credentialing and recredentialing processes and all parties' roles and responsibilities. We will add responses to our Frequently Asked Questions (FAQ) page which will speak to the CVO(s) process. We will update these as new questions or issues are identified to best meet the needs of our providers.

To further assist providers as they begin to navigate the process of completing applications, we will work with the CVO(s) to develop job aides that provide detailed explanations and examples of the types of information that must be provided to the CVO(s). These job aides will be available on our public website and provider portal to enable easy access for new and existing providers.

We will incorporate informational items and reminders about the credentialing and recredentialing processes into our provider newsletters with the CVO(s) contact information and links to the CVO(s) website(s).

Provider Engagement Team

Our PR Representatives, OARs, POCs, and other Provider Engagement Team members are the frontline points of contact for potential and current network providers and will receive training on the role of the CVO(s) and the processes for credentialing and recredentialing. To support this training, these staff members will have access to online materials and talking points that will help them to address provider questions and know how to route complaints raised by providers related to the CVO process.

Webinars

WellCare's Network Management staff members will conduct live webinars to educate potential providers on the process for credentialing and contracting to become Medicaid providers enrolled in WellCare of Kentucky's network. Through these live webinars, providers will be able to engage with the Network Management staff and get their questions answered in real-time. In addition, we will post materials from the webinars online so they can be accessed by providers while they work through the application process.

iv. Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims.
Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s)

Under the CVO process, WellCare will monitor a daily file from the CVO to identify newly credentialed providers who have not engaged with WellCare of Kentucky for contracting. WellCare will make the decision to contract with a provider within 30 days of receiving the verified credentialing information from the CVO file.

Once a contract has been executed, Network Management will send the contract to Provider Operations, who will initiate the retrieval of the CVO credentialing documents from the Fiscal Agent's website using the file and the Application Tracking Number (ATN). POCs will load the provider into the claims payment system. Within 10 days of an executed contract with a provider, our systems will be updated to include the accepted provider as a participating provider in our network. If any additional time beyond the 10 days is needed, WellCare will notify the provider. This time will not exceed an additional 15 days.

Claims Payment Policy

In accordance with Commonwealth requirements, WellCare of Kentucky's policy is to pay claims submitted by providers with a valid Medicaid Provider identification number as of the date of credentialing. We will continue to honor this policy to assure continuity of care for our Enrollees without worry of payment for our providers. Therefore, regardless of the load date, claims with dates of service on or after the credentialing date submitted by a Medicaid provider will be paid. WellCare not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and the completion of our credentialing process.

VENDOR'S PROPOSED CREDENTIALING POLICIES AND PROCEDURES

Please see **Attachment C.17.f.iv Kentucky Credentialing and CVO Transition Policies and Procedures**, provided electronically, for our proposed credentialing policies and procedures, and procedures for coordination with the CVO(s).

g. Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 27.10 Provider Grievances and Appeals of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically.

WellCare maintains a comprehensive provider Grievances and Appeals program designed for rapid and thorough resolution. Our goal is to improve access to care, quality and cost effectiveness, but the complexity of health care delivery sometimes necessitates that issues receive a second review. Our mission is to resolve all provider grievances and appeals accurately and timely to maintain strong partnerships as we work together towards improved outcomes for our providers and Enrollees. Our defined process protects provider rights, and is supported by industry-leading tools and technology such as iCAREPath, our customized workflow management system, ensuring every provider Grievance and Appeal is appropriately documented and resolved from beginning to end. In order to continuously improve, we must not only resolve the concern being raised, but focus on the root cause of the issue as well as monitor for emerging trends. We analyze and trend this rich data set to identify systemic issues leading to proactive measures to prevent future sources of dissatisfaction. We "Solve the Issues" see **Figure C.17-5** before providers are impacted.

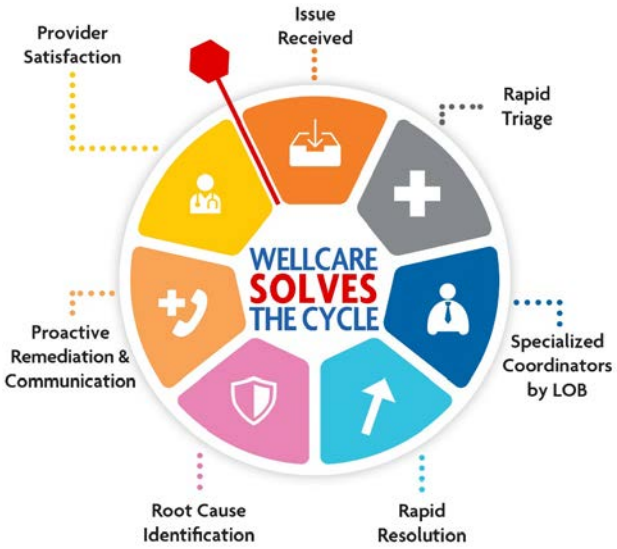

Figure C. 17-5 WellCare Solves the Cycle

i. The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.

To most effectively leverage our best-in-class resolution process, we provide options for our providers to reach us in the way they want to. Our Provider Engagement Team offers providers rapid, thorough resolution of issues through:

- Their local PR Representatives responsible for the overall provider relationship.
- OARs equipped with the technology and authority to adjust claims and resolve issues while in the provider's office.

- QPAs and Care Coordinators who work directly with providers with a sole focus of improving health outcomes.
- Specialized units in our contact center for first call resolution of provider issues and real-time adjustments for simple low dollar claims issues and an offline team designed to handle the complex issues to ensure our providers only call once.
- Digital preferences are captured for providers to ensure they can register with our portal. From there, they can contact us and receive communications their way via email or portal notifications.

We strive for the real-time resolution of provider complaints. Our PR Representatives appropriately clarify matters, provide additional information, or rectify misinformation while the provider is on the phone. Tools for rapid resolution include our Provider Claims Support team that handles high-level claims inquiries and a Provider Escalation team for escalated calls. Our advanced speech analytics system automatically alerts a supervisor in real time to join a call to further facilitate first call resolution when the system detects a change in speech patterns or specific verbiage.

If the provider wishes to proceed with a formal complaint, they are instructed on their rights. Once received, complaints are categorized as either grievances or appeals depending on whether an adverse determination is involved. The Provider Claims Support team uses the iCAREPath platform which performs data enrichment to validate measures such as timely filing, duplicate submissions and more to ensure the case receives proper treatment from the beginning.

iCAREPath drives our ability to process grievance and appeal requests within expected timeframes. The platform delivers real-time workforce management monitoring, allowing coordinators to resolve cases according to established standards. Once the case enters the iCAREPath system, we process grievances and appeals using a standardized approach that includes automation, machine learning, and artificial intelligence. It reads the context and sentiment with standardized and automated communications throughout the process, through:

- Automatic case creation through the consumption of digital submission (fax, email, web)
- Auto assignment of cases to staff based on associate availability and skillset
- Real time tracking of cases and the current stage of development
- Automatic reminders for aging cases including supervisor dashboard alerts and automatic escalation for expiring cases
- Auto population of reporting elements to produce regulatory reports and audits
- Document and image storage residing inside the application
- Workflow requirements and business rules residing within the platform to reduce the reliance on manual processing instructions
- Automatic generation of acknowledgment letters, requests for information, and case status letters within timeliness standards
- Automated letter development and fulfillment of resolution letters
- Enhanced root cause tracking to streamline identification and process improvement

Appeals are thoroughly investigated and a new review is performed by WellCare staff not involved in the original adverse decision. Once a resolution is developed, the provider is promptly provided written notice of the outcome and further administrative remedies if applicable.

WellCare resolves provider grievances or appeals and provides written notification of the resolution that is received by the provider within 30 days. If the grievance or appeal is not resolved within 30 days, WellCare will request a 14-day extension from the provider.

ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.

We continuously review provider grievance and appeal outcomes to identify trends and operational or clinical opportunities to improve the provider experience using a defined process that includes data mining, monitoring, analytics and dedicated staff. Each month our Root Cause Analysis (RCA) team gathers data from the previous month's grievances and appeals to:

- Perform analytics, looking for trends and prioritize emerging issues for root cause analysis
- Conduct root cause analysis and develop remediation plans
- Present recommendations to assigned committees
- Drive performance improvement initiatives
- Monitor grievances and appeals to ensured expected outcomes are achieved

Our overriding objective in the self-audit process is to drive performance improvement processes and improve outcomes by:

- Decreasing the number of denial decisions that are reversed by identifying the root cause and creating operational and education solutions to improve interrater reliability
- Improving the effectiveness and quality of our operational processes by identifying claim processing and billing errors and initiating education
- Identifying potential systemic issues and remediating them before they become grievances or appeals
- Increasing provider satisfaction with the services provided by working across multiple departments to resolve Member and provider concerns

The findings from these self-audits are reported quarterly to the Utilization Management Medical Advisory Committee, Customer Service Quality Improvement Committee, and Quality Improvement Committee. Data regarding trends, barriers and opportunities for improvement are discussed and analyzed with workgroups assigned to conduct root cause analysis and drive process improvements.

Our system has enhanced root cause tracking to streamline identification and initiate preventive measures as part of our standard grievance and appeal workflow. iCAREPath captures, tracks, and reports the status and resolution of all provider grievances and appeals, including associated documentation, from receipt to resolution, regardless of source or network status. **We use this data to identify opportunities to improve our performance in functional areas** such as medical management, administrative services, provider network

development, and education material clarity. This allows us to address not only issues affecting individual provider satisfaction, but to also identify and address potential trends in the delivery system as a whole. When trends are identified, prompt steps are taken to mitigate those issues that lead to provider grievances and appeals.

We continuously review patterns and trends and make adjustments as appropriate to avoid provider abrasion and improve satisfaction. Based on our experience unpaid claims are frequently the reason for provider appeals. To address this, we instituted our "one touch" resolution process with a specialized group of highly trained agents in place for call escalation who are empowered to make real time adjustment to a claim if an error is detected.

In Kentucky, we will use our "one touch" resolution process and RCA team to ensure providers are paid timely and accurately.

New initiatives we have undertaken as a result of root cause analysis and provider feedback include:

- Outbound call unit established to proactively educate provider offices on balance billing issues and work with them to identify root cause and underlying issues
- OARS established with ability to adjust claims in real time and on-site at the Provider's office
- Dedicated phone escalation team to quickly resolve provider issues
- Implementation of a repeat caller alert flag that alerts the Provider Support Service Center associate to escalate an inquiry if it is not fully resolved during the call

Specific examples of improvements as a result of self-audits include:

- *Authorization Submission:* Our appeals team noticed a significant spike in Provider appeals related to lack of prior authorizations in Kentucky, prompting measures to be implemented to educate certain high volume providers on the correct method to submit prior authorization requests. Provider training was conducted with providers who had high volumes of appeals. We took the opportunity to clarify and update processes in our Provider Manual and Quick Reference Guides in all Medicaid states. The combination of training and revised provider materials reduced the appeal rates by 23% in Kentucky and 15% for our New York plan from 2015 to 2016.
- *Encounter Data:* Our Illinois Encounter Operations Team used our Provider Scorecard to identify an issue with a local IPA in Kane County who was not meeting completeness and accuracy service levels. The encounters operations manager reached out to the local PR Rep to coordinate outreach to the IPA. Together they were able to guide the IPA through the data correction and resubmission process for $1.3 million in claims, bringing them into compliance before the State's deadline and resolving 97% of the IPA's errors.
- *Chiropractor Appeal:* In another recent local example, we were receiving a high level of appeals from chiropractors related to our payments related to the use of a claim modifier. This included many overturned appeals and overturned independent external reviews. Our claims resolution team reviewed this in depth and it revealed that our clinical coverage guidelines were indeed not in line with national guidelines. We updated our clinical guidelines, resulting in an elimination of these appeals and more satisfied providers.

iii. Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

To ensure ongoing transparency with DMS, WellCare of Kentucky will continue to submit a monthly Provider Appeals and Grievance Activity report to DMS. The report includes the number and types of grievances and appeals received; disposition of all grievances and appeals, status, and final outcomes; Number of grievances and appeals resolved by type of resolution; the type of service and dollar amount for all overturned denials; and the average turnaround times for resolution by type of grievance or appeal based on quarterly totals.

DECREASING FUTURE GRIEVANCES AND APPEALS

In addition to our iCAREPath platform, WellCare invested in a dedicated Root Cause Analysis (RCA) team fully dedicated to reducing Grievances and Appeals. We have a multi-pronged approach designed to reduce complaints across the board. WellCare employs dedicated specialists that have a direct line into our complaint organizations but are embedded in the supporting department. This means that a person searching for a root cause on a claim-related complaint resides in and is fully versed in claims; they do however, have the connection and accountability to the complaint organization.

We have also created a RCA Analytics and Governance team. This team serves two purposes:

- *Validation of the RCA Specialists' research and remediation:* WellCare finds this to be an important, two-step process. It covers research into how a breakdown occurred, or how to eliminate confusion in areas where there was no error made by WellCare. This process would not be effective if we did not govern the remediation. WellCare takes the approach of separating the RCA case from the original complaint for one reason: the RCA case will remain open until the cause is fully remediated. Even after the original complaint is closed, WellCare continues to hold itself accountable until an adequate remediation is identified and implemented. The proposed remediation is presented for approval and the governance team approves the remediation or rejects it back for a more impactful remediation to be proposed.
- *Analytics and Reporting:* WellCare does not wait for a complaint to occur before starting an RCA case. Once we are aware there is an issue, we open an RCA case. This gives us an axiom for our issue management. We begin crafting a remediation immediately and work towards proactive solutions, such as reprocessing a batch of claims before a Provider has to submit a dispute or to call us. We may also communicate to impacted Enrollees before they are even aware of an issue. As complaints come in, they are associated to the RCA case to understand and measure the true impact as a way to improve.

WellCare appreciates that no MCO can fully avoid complaints and grievances, but we work to discover and remediate them before the impact takes place.

C.17 Provider Services

- Attachment C.17.d Provider Manual (Provided Electronically)
- Attachment C.17.f.iv Kentucky Credentialing and CVO Transition Policies and Procedures (Provided Electronically)

18. Provider Network

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C.18. PROVIDER NETWORK

a. Provide the Vendor's proposed Provider Network development strategy to ensure a comprehensive statewide network across all provider types. The Vendor's strategy must describe the following:

i. Innovative approaches to recruit providers and to develop and maintain the Vendor's provider network to ensure network adequacy standards and highest quality care, including.

1. Strategies to recruit providers in traditionally underserved as well as non-urban areas, by health need, and to overcome expected accessibility challenges.
2. Strategies and methods to address workforce shortages and network gaps, included proposed initiatives to collaborate with the Department and other contracted MCOs to develop innovative solutions to meet the healthcare needs of Enrollees.
3. Strategies for contracting with providers in bordering states to help address network adequacy challenges, including lessons learned and successes or challenges with this approach

ii. Approach to providing out-of-network care when timely access to a Network Provider is not possible, including the Vendor's approach to supporting Enrollees in accessing such care.

iii. Approach to ensure Network Providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities.

iv. Approach to ensure a comprehensive network to address the needs of all Enrollees, including the provision of services in a culturally sensitive and linguistically appropriate manner.

v. Strategies the Vendor will implement to ensure the network adequacy and access standards are met if actual Enrollment exceeds projected Enrollment.

b. If Subcontractors will provide Covered Services, describe how network development efforts will be coordinated with the Vendor's provider network development strategy and how the Vendor will monitor the Subcontractor's activities and ensure transparency of these activities to the Department.

c. Describe the Vendor's approach to use telehealth services to improve access. Include the following at a minimum.

i. Criteria for recognized sites.

ii. Education efforts to inform providers and Enrollees.

iii. Whether reimbursement will be available to the presenting site as well as the consulting site or only the consulting site. Include any requirements or limitations on reimbursement.

iv. Lessons learned and successes or challenges with implementation of telehealth services for other programs the Vendor has served and that the Vendor will consider for provision of telehealth services in Kentucky.

d. Describe the Vendor's provider contracting strategies, including processes for determining if a provider meets all contracting requirements (at the time of enrollment and on an ongoing basis), as well as processes for corrective action and termination.

Include copies of the Vendor's proposed contract templates for individual practitioners and for facilities as attachments

e. Demonstrate progress toward developing network capabilities for statewide access by providing evidence of existing contracts or signed Letters of Intent with providers by provider type (for the Vendor and Subcontractor). Include the following information at a minimum:

i. A Microsoft Excel workbook by provider type listing every provider that has signed a contract or Letter of Intent, including the provider's name, specialty(ies), address and county(ies), Medicaid Region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s).

ii. A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county.

iii. A statewide Geographic Access report of all providers with LOIs color coded by provider type by Service Region.

f. Describe proposed Enrollee to provider ratios by provider type, as well as the Vendor's methodology for considering a provider's FTE when calculating network adequacy standards.

g. Describe the Vendor's proposed methods for ongoing monitoring and assessment to ensure compliance with network adequacy and access to care standards, including tools used, the frequency of reviews, and how the Vendor will use findings to address deficiencies in the Provider Network. The response should also address how the Vendor monitors appointment availability and wait times.

Provide samples of tools and/or reports

h. Describe how the Vendor would respond to the network termination or loss of a large provider group or health system. Include information about the following at a minimum:

i. Notification to the Department and Enrollees.

ii. Transition activities and methods to ensure continuity of care.

iii. Analyses the Vendor will conduct to assess impact to network adequacy and access, and how the Vendor will address identified deficiencies.

C.18. PROVIDER NETWORK

a. Provide the Vendor's proposed Provider Network development strategy to ensure a comprehensive statewide network across all provider types. The Vendor's strategy must describe the following:

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 28.0, Provider Network of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare of Kentucky embraces the Commonwealth's fundamental vision that ease of access to integrated, high quality health care services is crucial to Enrollee health, wellness, and satisfaction. Since 2011, our focus has been on developing and maintaining a comprehensive network that provides all of our Kentucky Medicaid Managed Care Enrollees access to the care they need, when they need it. **Today we deliver high quality healthcare for more than 430,000 Medicaid Enrollees through the largest and most comprehensive network of all the Kentucky MCOs, one that includes:**

- Approximately 5,500 Primary Care Providers
- More than 1,700 Pediatricians
- More than 26,000 Specialists
- More than 130 Hospitals
- 14 Community Mental Health Centers
- More than 260 Federally Qualified Health Centers/Rural Health Clinics
- More than 1,400 Pharmacies

Our Provider Network team is led by Director Bonnell Irvin, and she is supported by Candice Bowen for provider contracting and Anthony Piagentini for provider services. Our network has been built to consider current and anticipated Medicaid enrollment, expected utilization of services given the characteristics and health care needs of our Medicaid Enrollees, and the number and types of providers required to provide the necessary services to those Enrollees, taking into account the numbers of network providers who are not accepting new Medicaid patients. It considers the geographic location, language and culture of our network providers and our Enrollees, considering distance, travel time, the means of transportation ordinarily used by our Enrollees, and whether the location provides physical access for our Enrollees with disabilities. Our philosophy since inception has been to meet the providers where they are and our six regional offices and dispersed provider relations team reflects this approach. We conduct provider summits across the Commonwealth and seek opportunities for our provider relations staff to meet with providers face to face.

Our network includes every hospital today that was in our original network in 2011. In fact, we are the only Medicaid MCO in the Commonwealth to keep a contract with Appalachian Regional health system **to ensure access to care for Enrollees in Region 8 since launch**. We

have never and will never turn providers away, having maintained a contractual relationship with every contracted provider in our original network and only grown from there.

We retain providers by doing more than simply signing a contract with them.

We value our provider partnerships, offering providers **opportunities to increase revenue** by improving the quality of care they provide. **We engage providers through our regionally-based Provider Relations staff** who personally visit providers to ensure they get the operational support they need to serve their Medicaid Enrollees. We also **wrap community supports around Enrollees** encouraging them to actively participate in their care and reducing the missed appointments that are costly for Medicaid providers. WellCare of Kentucky continues to maintain the largest Medicaid network in the Commonwealth because **we stand alongside our provider partners.**

Maintaining a comprehensive network of providers that deliver high quality care requires rigorous oversight to ensure that providers are meeting Enrollee needs and program requirements. It involves engaging with and supporting providers in meeting those requirements. It also means continually looking for new and innovative ways to broaden our network and extend access to underserved areas. Our processes for provider network management combine these elements and ultimately serve one purpose: to ensure that Enrollees have access to the highest quality care in a timely manner and in the most appropriate setting, achieving the best possible quality outcomes.

i. Innovative approaches to recruit providers and to develop and maintain the Vendor's provider network to ensure network adequacy standards and highest quality care, including.

We continually evaluate our network to ensure that we maintain network adequacy standards and seek innovative approaches to recruit additional providers to our network in order to expand access to the highest quality care for our Medicaid Enrollees. Our Network Management team reviews GeoAccess and network adequacy reports on a monthly and quarterly basis by provider and facility specialty type. Reports on current Enrollee distribution, provider/Enrollee ratio by specialty, and proximity standards are maintained and cross-referenced during these processes. The team also utilizes real-time Quest Analytics reports to understand the network of all Medicare providers by county and specialty within Kentucky to cross-reference these Medicare provider details with the Kentucky Medicaid roster. If we determine that a provider (with a needed GeoAccess specialty) has recently received their Kentucky Medicaid ID, the Network Management team will actively recruit the provider to join the WellCare of Kentucky provider network.

If a needed provider specialty is identified but not available in the current Kentucky Medicaid roster, the team will utilize the Medicare providers listed in the Quest Analytics data to recruit them to first obtain a Kentucky Medicaid ID and subsequently a WellCare of Kentucky participation agreement. In addition to our Network Management team, every day our regionally-based Provider Relations (PR) Representatives and other field-based associates use their local knowledge to identify providers who are new to the area and initiate contracting discussions in the effort to maintain and broaden our network.

We also strive to look for innovative solutions that take us beyond mere compliance with network access and availability standards, especially in traditionally underserved areas. One innovative method to recruit additional providers to our network and increase access to care was our recent contracting efforts with **Fast Pace Urgent Care Clinics.** In order to increase access to primary care providers in areas of need, WellCare recently entered into a value-based purchasing (VBP) arrangement with 18 Fast Pace locations across the Commonwealth. Fast Pace would not typically contract with an MCO to provide primary care services at their urgent care centers under standard Medicaid reimbursement rates. However by entering into an agreement where Fast Pace can realize increased revenue for meeting quality and cost-efficiency goals, they were motivated to join our Medicaid network. While we met access to care requirements in these areas prior to contracting with Fast Pace, 3,400 of our Medicaid Enrollees are now assigned to Fast Pace and can more conveniently access primary care services closer to home.

1. *Strategies to recruit providers in traditionally underserved as well as non-urban areas, by health need, and to overcome expected accessibility challenges.*

Through our eight years of providing access to care for our Medicaid Enrollees, WellCare has gained extensive insight into the health needs of traditionally underserved and non-urban areas of Kentucky. We have developed or are exploring several strategies to mitigate access barriers due to provider shortages, including:

- *Identifying Medicare Providers to Recruit:* When we find a gap in access for a Medicaid recipient, we look at the Quest Analytics tool to see if there is a Medicare provider of the provider type needed that is not listed on the KY State file. If located, we approach the practice by phone or in person in an effort to convince them to see Medicaid patients. If necessary, we may offer an additional financial incentive such as a higher rate or VBP contract to take on the additional population of Enrollees.
- *Physician Extenders:* WellCare extends access to services through contracts with mid-level provider types including licensed social workers, physician assistants and nurse practitioners who often are more available in rural communities, subject to geographic restrictions and license. We also partner with educational institutions and have been successful in supporting recruitment efforts for nurse practitioners, physician assistants and nurse midwives.

Extending Access to OUD Services

Recognizing the need to expand care for Opioid Use Disorder (OUD) treatment in underserved areas, WellCare of Kentucky donated $100,000 to Volunteers of America to build a new addiction treatment program for new and expectant mothers in rural areas with no resources. We also provided hyper-local grants totaling $35,000 to OUD Recovery Programs across Kentucky such as Addiction Recovery Care (ARC).

- *"Gold Carding" of Specialist Providers:* Enrollees have limited access to certain specialist providers throughout Kentucky, especially in rural areas. Dermatologists are a particularly sought-after specialist for our Enrollees. In many cases, seeing a dermatologist entails two visits: first for an initial consult, after which the dermatologist must obtain and authorization to perform a procedure, and the second visit for the procedure itself. Understanding that this created an administrative burden on these providers and delayed care for our Enrollees in rural areas, WellCare of Kentucky reviewed authorization requests from these dermatologists and found that the rate of denial of authorization was less than one percent. As a result, we have begun a process to "gold card" our dermatologists which will allow them to treat our Enrollees during the first visit without obtaining an authorization for treatment from WellCare. We will continually review this process to ensure it is successful and achieves the expected outcomes.

Under the new contract, we look forward to continuing to develop new ideas for around the Commonwealth and with input from DMS in achieving our shared goal of making all services more widely available and accessible to our Enrollees residing in these areas.

2. *Strategies and methods to address workforce shortages and network gaps, included proposed initiatives to collaborate with DMS and other contracted MCOs to develop innovative solutions to meet the healthcare needs of Enrollees.*

Perhaps no factor is more impactful on health outcomes than lack of access to care due to shortages in the healthcare workforce. According to the Association of American Medical Colleges, Kentucky ranks 40th in the United States in its physician workforce per 100,000 people. WellCare has a history of supporting workforce development efforts. For example, in conjunction with the **University of Kentucky Center for Excellence in Rural Health**, WellCare of Kentucky provided $180,000 in funding for scholarship programs aimed at increasing the number of doctors and nurses working in primary medicine and psychiatry in Eastern Kentucky.

While there is no single answer to solving workforce shortages, WellCare is increasingly looking to develop and support initiatives that address this issue. One innovative approach to addressing gaps in the provider network and overcoming physician shortages is **Community Paramedicine**. Community paramedicine extends access to care by expanding the role of Emergency Medical Service (EMS) personnel to fill gaps in primary care availability and mitigate transportation barriers by providing home-based care. Community paramedicine providers can provide a number of services including assessment services such as taking vital signs, medication compliance and blood pressure readings; prevention services such as

immunizations and in-home fall prevention; and primary treatment such as wound care and medication administration, as well as referral to medical and social services.

With the recent passing of House Bill 106, WellCare is excited to support the expansion of community paramedicine programs that further extend access to care in underserved areas of Kentucky. In fact, WellCare is among the first managed care organizations to create a care management model around community paramedicine that serves patients in need and establishes an effective financial model for municipalities and states to make it sustainable, pragmatic and workable. The model deploys an integrated care team with the community paramedic into areas with workforce shortages to provide physical and behavioral health, lab draws, and to assess the home for environmental health risks.

Paramedicine: Hometown Medics Program

Through our Hometown Medics program, currently being implemented in our North Carolina market, WellCare will provide educational grants and job placement for combat medics and Navy corpsmen transitioning from military service to the community paramedicine field. Under a physician, ARNP or medical director's supervision and orders, graduates of this program will provide our Enrollees with health evaluation and management services in their home, including diagnostic testing, screening for chronic diseases and unmet social needs, intravenous therapy, wound care and many other services. This innovative rural health solution aims to reduce costly and uncomfortable ED visits and readmissions for certain diseases and conditions.

As part of the effort, in our other markets WellCare is recruiting and covering training and certification costs for medically trained military veterans or transitioning military personnel to step into community paramedicine positions, providing an elegant solution for staff needs, while addressing veteran employment challenges. There's also a financial benefit to the community, both from a cost-savings perspective from a recruiting standpoint, and because it can help stimulate the local economy as far as workforce development. With the expansion of paramedicine in Kentucky and in collaboration with DMS and other MCOs, WellCare will look to bring this model to the Commonwealth.

Innovation in Access to Care: LifeCare

WellCare saw a level of care gap for behavioral health services for adolescents who weren't necessarily needing hospitalization, but were challenging to manage at home. Our behavioral health lead and Network Management team recruited Tennessee-based LifeCare to bring virtual hospitalization to the Commonwealth. WellCare entered into a pilot with LifeCare to provide the FITT Program of virtual residential treatment for youth living with caregivers in a community setting. This is an intensive in-home program partnering with families to resolve crises, avoid out-of-home placement and provide skills for future crisis prevention.

In many of our other markets, WellCare has also worked with providers to establish "clinic days" to address workforce shortages and address network gaps, and we will actively look to recruit specialists from larger health systems in more densely populated areas of Kentucky to

establish satellite clinics for providing care one or two days a week in areas of need. This strategy can be combined with an alternative payment arrangement, as we do in our Hawaii market, where we incentivize providers to offer clinic days on islands with limited access by offering a higher reimbursement rate. We plan to approach the University of Kentucky and The Medical Center in Bowling Green to consider this approach in some of our rural Western Kentucky counties in partnership with **ARcare**, a multi-location FQHC.

Additionally, we've embraced telehealth as a method for addressing workforce shortages and increasing access to primary and specialty care in many of our markets, including Kentucky. We support the Commonwealth's objective to increase the use of telehealth in conjunction with the passing of Senate Bill 112 that expands telehealth coverage and payment parity for telehealth services, and are fully prepared to work with DMS toward these goals. We are also open and willing to collaborate with DMS and other MCOs through our DMS Operations Meetings and our involvement in the Kentucky Association of Health Plans. We look forward to the opportunity to discuss collaborative solutions that address workforce shortages in the Commonwealth.

3. *Strategies for contracting with providers in bordering states to help address network adequacy challenges, including lessons learned and successes or challenges with this approach.*

Contracting with providers outside the borders of the Commonwealth is crucial in addressing network adequacy challenges and serving the specific needs of Enrollees in areas where those needs cannot be met by Kentucky providers. Based on those needs our network contracting department identified two academic medical centers, **Vanderbilt University Medical Center** and the **University of Cincinnati**, who offer specialized tertiary and quaternary services that are needed by our Enrollees in western Kentucky (served by Vanderbilt University Medical Center) and northern Kentucky (served by University of Cincinnati Medical Center). These cross-border providers are closer to home for many of our Enrollees than in-state facilities so it is imperative that we offer them as a choice to our Enrollees. We also contract with **Children's' Hospital of Cincinnati Medical Center (CCHMC)**, one of the leading children's' hospitals in the nation. They offer specialty pediatric and primary care services for many of our children located in northern Kentucky, as well as across the Commonwealth.

Additionally, we contract with out-of-state acute care hospitals such as **Cabel Huntington** in Huntington, West Virginia and **Deaconess Hospital** in Evansville, Indiana to supplement our in-state network and to offer easier access to emergency services, women's health, pediatrics and specialty services such as neurosciences and cardiovascular. It is important to us that our Enrollees have convenient access to services they need.

Expanding Our Network to Ensure Access to Vital Care

WellCare's Transitional Care Coordinator at University of Kentucky Hospital visited two adolescent Enrollees that both had been admitted with Eating Disorders and Malnutrition. Both needed intensive inpatient residential treatment, however it was quickly determined that there were no residential facilities in Kentucky that could treat an adolescent eating disorder. The Transitional Care Coordinator worked with the Network Management team to identify an appropriate placement. While some facilities were available in the private sector, they would not consider a Medicaid child. The team reached out to Center for Discovery, an organization with facilities in Chicago, Atlanta and Orlando that specializes in this type of treatment. Center for Discovery wanted to help but did not have a Kentucky Medicaid MAPP number and had been told it was a long process.

At that point the Transitional Care Coordinator reached out to the Network Management and Regulatory departments to see what could be done to secure the proper credentialing for this facility. The facility was gracious enough to work with WellCare of Kentucky and we began working them through that process. With the help from our partners at DMS we were able to complete that process within a few days. The Network Management team signed a Single Case Agreement with the provider paving the way for the Enrollees to enter treatment.

Our Network Management team plays a vital role in cases like the one above where challenges exist not just in finding appropriate care for a service not available within the Commonwealth but in quickly securing the proper credentials necessary to provide that care. In these cases, the Network Management team assists the out-of-state provider by directing them to the Kentucky Medicaid Provider Enrollment Portal. They also assist the provider with completing the required forms if needed, and review the completed application for completeness prior to submission. Additionally, Network Management staff will make calls on behalf of the provider to the Medicaid Provider Enrollment Customer Services line, sharing the basics of the issue and at all times protecting against the disclosure of PHI, and verbally requesting expedited handling of the application as needed.

ii. Approach to providing out-of-network care when timely access to a Network Provider is not possible, including the Vendor's approach to supporting Enrollees in accessing such care.

While our goal is to maintain a comprehensive provider network that makes services available to our Enrollees that exceed required access and availability standards, we recognize there are instances when a needed service is not available in-network. On these occasions, our Utilization Management and Service Management Teams establish appropriate and timely referrals and arrangements to ensure seamless transitions and transfers to a qualified out-of-network provider. In these cases, our Network Management team executes a single-case, non-participating agreement with the provider for the specific case, and works to recruit them into our network to eliminate a future need for such arrangements.

If our network is unable to provide medically necessary covered services to a particular Enrollee within our network we move swiftly to provide services to Enrollees via out-of-network

providers. If out-of-network care is required, we attempt to locate a provider in the same geographic area as the Enrollee. If one is unavailable, we will transport the Enrollee to another part of the Commonwealth or out-of-state to access services as necessary. If the medical service requires an overnight stay, lodging and meals are covered. We make every effort to ensure that the most appropriate arrangements are made for the Enrollee in each circumstance, and have well-developed and well-tested processes to ensure these out of network services are coordinated and delivered in a timely fashion. Our clinical colleagues assist with appointment scheduling and pass cases along to our Utilization Management team to ensure appointment approval. Our Network Contracting team is available to create agreements, if necessary, to ensure for service reimbursement.

Supporting Enrollees in Accessing Out-of-Network Care. We educate Enrollees on how to access an out-of-network provider when medically necessary. WellCare's customer service representatives, Enrollee advocates and service managers receive training and education to coordinate benefits and assist Enrollees with primary insurance and other third-party liability. WellCare representatives also facilitate the transfer of records and arrange for transportation for the Enrollee to the out-of-network provider as needed. For example, we have worked with Children's Hospital of Philadelphia to secure treatment for a pediatric patient with many rare and complex conditions.

iii. Approach to ensure Network Providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities.

WellCare remains committed to ensuring our network providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities. To address issues related to accessibility for Enrollees with physical disabilities, we capture information about the physical accessibility of provider's office during our initial credentialing and contracting activities, including compliance with ADA standards. We publish physical accessibility information in our provider directories, so Enrollees and their caregivers can see it when selecting a provider.

Going the Extra Mile to Enable Enrollees with Disabilities to Access Care

Not only do we ensure providers have the proper access for Enrollees with disabilities, we work to make sure Enrollees are able to overcome barriers due to disabilities that prevent them from getting to their appointments. In Region 7, a WellCare Care Coordinator identified an Enrollee who uses a wheelchair for mobility who could not get to her PCP appointments because her house did not have a ramp. Through our Community Connections program, we partnered with a Christian biker group who built a wheelchair ramp onto the Enrollee's home. She can now see her doctor and also attend church and social events.

Partnership efforts like this not only benefit the Enrollee in enabling them to get to their appointments but also benefit providers in reducing no-shows, one of the key reasons why many providers drop out of a Medicaid program. By supporting our networks with community programs that coordinate access, we also sustain and build our provider network.

WellCare also serves over 100,000 Enrollees with serious mental illness (SMI) nationwide, and understands the importance of contracting with providers who have experience providing

services to individuals with mental disabilities. We work to recruit physicians based on experience, references, referrals from other providers, and qualifications that include education and training on individuals with developmental disabilities. We are also working in other markets on partnerships aimed at training and sharing of best practices and successful approaches to best serving these individuals. Approach to ensure a comprehensive network to address the needs of all Enrollees, including the provision of services in a culturally sensitive and linguistically appropriate manner.

WellCare administers Medicaid programs in some of the most culturally and ethnically diverse areas of the country, including Hawai`i and New York. Our Medicaid Enrollees in Kentucky include many of the Commonwealth's refugees as well. Our network management capabilities allow us to build and maintain provider networks for the more than 17% of our Medicaid Enrollees for whom English is not their primary language as well as our culturally and ethnically diverse membership.

Our recruitment strategy is focused on contracting with providers who are committed to caring for the Kentucky Medicaid program's population and who share the cultural and linguistic demographics of our membership. Upon contracting with WellCare of Kentucky, providers indicate the languages spoken in their office. This information is uploaded into our provider data systems and used to help Enrollees, other providers and WellCare staff in identifying providers who speak their language. Languages Spoken is an advanced search feature of our Find-a-Provider Tool on our Enrollee website and mobile application.

Even with a diverse network of providers, there are times when Enrollees must see providers who do not speak their language. In these cases, we provide in-person and telephonic language translation resources at no cost to the Enrollee or provider. When necessary, we train our staff to activate our language line, which has more than 2,000 interpreters on call 24/7 to translate more than 200 languages. Training includes teaching Enrollee service representatives to participate seamlessly in three-way calls with ASL interpreters via Video Relay Service so that hard of hearing or deaf Enrollees are never at a disadvantage in accessing information or services.

iv. *Approach to ensure a comprehensive network to address the needs of all Enrollees, including the provision of services in a culturally sensitive and linguistically appropriate manner.*

We ensure access to services in a culturally sensitive and linguistically appropriate manner by ensuring that our network providers and their staff receive ongoing education, training and support in culturally and linguistically appropriate service delivery. During their initial visit with newly-contracted network providers, our PR representatives provide cultural competency training and materials which covers the following objectives:

- Defines cultural competence as it relates to healthcare
- Defines Culturally Linguistically Appropriate Services (CLAS) objectives and WellCare's program components
- Identifies how company materials support cultural competency

- Identify the tools and resources WellCare uses to deliver on CLAS objectives
- Identifies the provider's role in delivering culturally competent care and services

Our cultural competency training program is accessible through the Provider Manual, provider portal, and provider newsletters. We also provide a link on our website to the Health Resources and Services Administration (HRSA) Cultural Competence website which provides a self-study module for which providers can obtain continuing education credit. The site also offers high-quality tools for improving spoken and written communications with patients, reducing health disparities and improving cultural competency.

v. *Strategies the Vendor will implement to ensure the network adequacy and access standards are met if actual Enrollment exceeds projected Enrollment.*

As an incumbent CMO, we have a well-developed and field-tested infrastructure for managing statewide enrollment growth. Our success in maintaining access standards is due to our multi-pronged, proactive network management strategy which emphasizes ongoing readiness activities and implementation of rapid response protocols during periods of unexpected enrollment growth.

- *Maintain Excess Provider Network Capacity:* Over our eight years serving Kentucky Enrollees, we have successfully implemented network development policies and procedures which are proactive rather than reactive to growth. We accomplish this by aiming to exceed access standards by building in excess capacity, so if we do experience an influx of new Enrollees, we can provide a smooth transition for Enrollees while maintaining geographic access and appointment availability standards. If we identify a deficiency in meeting access standards, our Network Management team promptly develops a detailed action plan, which includes attempting to contract with any available providers whose inclusion in our network would expand access to care. The team identifies potential providers via Enrollee requests, provider referrals, researching competitive data, or through their knowledge of the community.
- *Monitor Enrollment and Provider Network Capacity:* As part of our proactive network management processes, we continually monitor enrollment and provider network trends. Specifically, our data analytics analyze monthly enrollment and disenrollment data by region, county, and ZIP code. We also examine auto-enrollment data and “Enrollee choice” reports to study broad market trends across the Commonwealth. We also monitor the adequacy of our provider network to anticipate future needs by reviewing GeoAccess reports, appointment availability audit reports, and other network-related data, such as firsthand feedback from PR Representatives and provider complaints. We also compare our contracted provider network to the universe of available Medicaid providers using the state’s most current Medicaid provider listing. We synthesize this data to guide our recruiting and retention efforts. As we aggregate and review all of this information, trends in membership, access, and network availability become apparent. We immediately create action plans to account for predicted trends, preparing us to accommodate a potential influx in Enrollees.

- *Initiate and Maintain Open Communications with DMS:* As changes in state or federal policy can have a significant impact on enrollment, WellCare's dedicated actuary maintains regular communications with DMS to continually stay abreast of likely or pending administrative or legislative changes that may affect enrollment.
- *Rapid Response Protocols:* When we predict or experience a rapid increase in growth or a sudden influx of new Enrollees, WellCare implements a series of rapid response protocols and processes that engage staff and providers to effectively maintain access standards. These actions include:
    - *Provider Relations:* Locally based PR Representatives at our six regional offices throughout the Commonwealth contact providers with closed panels and work with them to open their panel to accommodate the growth. PR Representatives also work with providers to extend their hours as a way to expand appointment availability. In order to communicate and educate providers on the increase in enrollment, we run "banner messages" on our provider portal, provide other information on this site to inform network providers regarding enrollment growth trends, and facilitate a connection with the provider and their PR Representative. On a case-by-case basis, we negotiate a single case agreement so that an Enrollee's health care needs will be met within geographic access and appointment availability standards if access to a particular type of provider is not available through our contracted network.
    - *Enrollee Services:* WellCare has the staff resources and experienced leadership to quickly assess expected Enrollee service needs and implement protocols to prepare customer service staff when we experience rapid growth or a surge in enrollment. Activities include increasing call center staff ratios, cross-training staff in other units to support the increased demand, and training cross-functional teams in Health Services to meet increased requests for prior authorization approvals.
    - *Claims and Utilization Management:* Our Network Management department alerts our Claims and Utilization Management departments about the expected increase in Enrollees so staff is prepared to respond quickly to a likely surge in claims and requests for prior authorization approvals, ensuring timely and prompt payment. In the event of a sudden influx of a large group of Enrollees, we will institute strategies designed to ensure continuity of care.
    - *Health Services:* Our Network Management department also engages nurses, care coordinators and Health Services department staff to communicate pending enrollment expansions and to learn of any concerns and how to mitigate any potential risks to a smooth transition for new Enrollees.

We have used this approach to successfully respond to an increase in Enrollee enrollment without any adverse effects on our performance in meeting access standards or operational service level standards. In 2012, we absorbed a total of 64,000 Enrollees after the sudden withdrawal of another MCO from the Kentucky market. In 2014, we absorbed approximately 100,000 Members due to Medicaid expansion, many in the first few months of the year, exceeding the predictions made by DMS. In both cases, we relied on our excess network capacity, close monitoring of our existing network, rapid response protocols and open lines of communication with DMS to successfully ensure access to care for the additional Enrollees.

b. If Subcontractors will provide Covered Services, describe how network development efforts will be coordinated with the Vendor's provider network development strategy and how the Vendor will monitor the Subcontractor's activities and ensure transparency of these activities to DMS.

WellCare of Kentucky understands that we are solely responsible for providing a network of Covered Services as described in Draft Medicaid Managed Care Contract Section 30, Covered Services. We have developed and continue to maintain a robust network of providers and facilities to deliver needed covered services to our Enrollees. For the following Covered Services, WellCare of Kentucky employs a subcontractor:

- *Dental:* The subcontractor for our 1,333 dentists is Avesis Dental
- *Vision:* The subcontractor for our 1,463 vision providers is Avesis Vision

WellCare of Kentucky has had a successful partnership with Avesis Dental for over six years and Avesis Vision since we began serving Medicaid Enrollees in the Commonwealth.

COORDINATION OF WELLCARE OF KENTUCKY AND SUBCONTRACTOR NETWORK DEVELOPMENT STRATEGIES

The WellCare of Kentucky Network Management team reviews the annual Network Development Plan of each subcontractor in coordination with the annual review and ongoing update of our overall recruitment plan. We coordinate recruitment protocols and practices with that of our subcontractors by holding them accountable through written contracts and audits, to the same standards of compliance for: network adequacy for geographic access and appointment timeliness and availability; NCQA or other credentialing criteria, as appropriate, and protocols for maintaining current licenses and other relevant credentialing criteria; and performance standards to which WellCare of Kentucky are held in DMS contract requirements and in federal statute. Our subcontractors also attend Technical Advisory Committee (TAC) meetings with WellCare of Kentucky leadership and other Commonwealth healthcare stakeholders. Subcontractors must submit their related network development policies and procedures to WellCare of Kentucky for review.

OVERSIGHT AND MONITORING OF NETWORK DEVELOPMENT ACTIVITIES OF SUBCONTRACTORS

WellCare Vendor Manager Jaime Wayne has oversight of Avesis' network development activities. Mr. Wayne and our Compliance Oversight Team monitor network development activities of Avesis using the same reporting tools (such as GeoAccess software) for evaluating compliance with benchmarks for network adequacy, and also rely on feedback (such as Enrollee and provider grievances/complaints) to evaluate subcontractors' network development activities and outcomes. The most recently reviewed quarterly Network Adequacy reports for quarters 3 and 4 of 2019 for both our dental and vision networks have been provided as **Attachment C.18.b-1 Dental Quarterly Network Adequacy Report**, **Attachment C.18.b-2 Dental After Hours Quarterly Network Adequacy Report**, **Attachment C.18.b-3 Vision Quarterly Network Adequacy Report** and **Attachment C.18.b-4 Vision AfterHours Quarterly Network Adequacy Report**, provided electronically. These reports are conducted utilizing a "secret shopper" survey methodology in which anonymous callers attempt to contact in-

network dental and vision providers to schedule appointments within contractually required timeframes. Conducted quarterly, they are shared with our Delegation Oversight team, Network Management department and Kentucky leaders during monthly Joint Operating Committee meetings.

WellCare also monitors the network adequacy of our dental and vision provider networks through real-time tableau reports that can be reviewed by the Contract Oversight Team at any time. We have included a sample of this reporting dashboard which offers a high level view of network adequacy across the Commonwealth. This reporting dashboard also allows us the opportunity to drill down to review adequacy at a county level as well. Please refer to **Attachment C.18.b-5 Sample Reporting Dashboard**. Our Avesis contract vendor manager, Jamie Wayne, conducts monthly Joint Operations Committee (JOC) meetings with our Kentucky leadership team consisting of Compliance Oversight, Network Management and Operations to review real-time metrics including but not limited to network adequacy. A sample agenda from November 2019 is included as **Attachment C.18.b-6 Sample JOC Agenda**.

Through these efforts, WellCare ensures that all contractual obligations are met or exceeded.

We also require subcontractors to provide advance notification to WellCare of Kentucky of a decision to close network enrollment for new provider contracts, to reopen network enrollment, or to close a provider panel.

As changes in state or federal policy can have a significant impact on enrollment, WellCare of Kentucky maintains regular communications with DMS to continually stay abreast of likely or pending administrative or legislative changes that may affect enrollment.

c. Describe the Vendor's approach to use telehealth services to improve access. Include the following at a minimum.

Telehealth services offer the benefit of expanding access to care for all Kentucky Medicaid Enrollees, including those who live in rural and underserved areas, have complex conditions or schedules that can make travel difficult, or simply prefer the convenience or privacy afforded by telehealth access. Today WellCare of Kentucky has an established telehealth presence in the Commonwealth. **In 2018, we paid claims to providers for over 6,800 telehealth services for over 20 different types of services**. We have also been active in the telehealth discussion in the Commonwealth, having participated in Kentucky Telehealth Board meetings for several years as well as the Telehealth Task Force resulting from SB 112, and having provided comments to DMS regarding its telehealth regulation (907 KAR 3:170).

We support the Commonwealth's objective to increase the use of telehealth in conjunction with the passing of Senate Bill 112 that expands telehealth coverage and payment parity for telehealth services, and are fully prepared to work with DMS toward these goals. **We are particularly excited to leverage telehealth capabilities as a component of substance use disorder (SUD) treatment.** A required component of SUD treatment for those receiving medication assisted treatment (MAT) is that individuals receive psychological counseling in addition to the medication. Many Enrollees who need SUD treatment are employed (part-time or full-time) or are parents who lack funds to pay for childcare. Some lack transportation or face

transportation challenges, even with the non-emergency medical transportation benefit. This makes attending regular, in-person counseling sessions extraordinarily challenging.

We recognize DMS' expansion of its SUD treatment scope on July 1, 2019. Included in this initiative is the creation of Behavioral Health Services Organization (BHSO) Tier II providers who provide outpatient SUD treatment including MAT. One component of this initiative is to enable narcotic treatment programs (NTPs) in Kentucky, which historically have used methadone as the MAT medication, to participate in Kentucky's Medicaid program and be paid for MAT. As part of the initiative, DMS added methadone to the covered MAT medications.

We intend to utilize the telehealth option for Enrollees receiving SUD treatment (particularly from BHSO Tier II providers) in order to enable them to receive counseling where most convenient for the Enrollee including their home, job, or elsewhere. WellCare of Kentucky already covers psychotherapy via telehealth; however, utilization has not been substantial. In partnership with DMS' expanded SUD treatment initiative, we plan to promote (to providers and Enrollees) the option to use telehealth for the counseling/psychotherapy component of SUD treatment.

We also understand the rural nature of the Kentucky landscape and the transportation barriers Enrollees have for getting to a specialist appointment. As a priority based on need, we will work with Rheumatologists, Endocrinologists, and Dermatologists to open up access through telemedicine for these Enrollees.

The possible uses of telehealth are almost limitless and we've only addressed a few initiatives that we plan to target and prioritize. However, WellCare has a broad base of experience to draw upon in developing and launching telehealth initiatives. With Kentucky's telehealth expansion, we are very excited about employing what we've done in other markets in the Kentucky market as well as continually exploring new options.

i. Criteria for recognized sites.

The establishment of guidelines and standards for telehealth is an important element of ensuring effective and secure delivery of quality healthcare. Our criteria for recognized telehealth sites in the Commonwealth is as follows:

- The provider must be currently enrolled and in good standing with Kentucky's Medicaid program
- The provider must be licensed in Kentucky to receive reimbursement for telehealth services under Medicaid
- The provider must not be currently listed on the Kentucky DMS Provider Terminated and Excluded Provider List
- The provider must not be currently listed on the U.S. Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities
- The provider must demonstrate that their technology is secure and HIPAA compliant
- The provider must demonstrate appropriate quality-of-care protocols and patient confidentiality guidelines.

As the use in telehealth expands in the Commonwealth, we will work to ensure that our standards are in alignment with evolving Commonwealth and federal regulations regarding telehealth sites.

ii. Education efforts to inform providers and Enrollees.

Through our national model for telehealth, WellCare has made investments to educate Enrollees on telehealth opportunities and train providers on telehealth access and reimbursement policies. WellCare of Kentucky will leverage that experience and work with DMS and our network partners to examine opportunities to promote the expansion of telehealth under the new regulations through direct education of our provider and Enrollee communities.

EDUCATION EFFORTS TO INFORM PROVIDERS

In our markets today, WellCare PR Representatives proactively identify and meet face to face with providers, primary care physicians, healthcare organizations, and local facilities (e.g., schools) in to encourage, discuss, and support enabling their facilities and practices for telehealth services. We educate providers on the logistics, payment options, eligibility, technology, implementation, and best practices involved. We also provide education and one-on-one conversations to inform providers about our reimbursement policy, coverage policies and the potential benefits of telehealth for both Enrollees and providers.

Our outreach efforts also inform providers of our documentation and billing requirements, both of which require minimal modification to providers' current operational practices. We explain potential cost savings for providers engaged in telehealth resulting from missed appointments and the potential opportunity for increased reimbursement by offering additional and/or non-traditional appointment times. We believe this continuing effort to educate providers will increase access to telehealth services for our Enrollees.

Going forward, we will introduce these efforts to our Kentucky providers. We will also educate providers on the new telehealth regulations and provide versions of our in-person educational presentations in a variety of forums including breakout sessions at our annual Provider Summits; on both our public website and provider portal; and through our popular bi-weekly Webinar series.

Demonstrating the Value Telehealth to Providers and Enrollees

A fourteen-year old boy living with Asperger's Syndrome becomes depressed and withdrawn when his father unexpectedly dies. Instead of his mother having to take off work and drive an hour (due to traffic) each way to a therapist appointment, he is able to have his sessions at home via a secured portal with our tele-behavioral health provider. The use of telehealth in this case has allowed the boy to really open up with this therapist and has eliminated any barriers that may have resulted in missing appointments. The boy participates in weekly counseling sessions via telehealth directly from his home. The benefits of telehealth go beyond improved access and convenience. His mother said that he is very comfortable with the service and he is doing much better; the boy described the service as wonderful. We have used this case study as a model to educate our Enrollee, provider and case management communities on the value of telehealth.

EDUCATION EFFORTS TO INFORM ENROLLEES

Because telehealth is an innovative approach for receiving care, many Enrollees and their families are not familiar with this treatment option. In order to educate Enrollees about telehealth in the Commonwealth, WellCare provide telehealth information and resources through the following channels:

- Enrollee Handbook
- Enrollee Services Representatives
- Care Coordinators
- Periodic Mailings such as Newsletters
- Enrollee Web Portal
- MyWellCare Mobile App

Additionally, WellCare is updating our provider directory to provide Enrollees with information on providers who offer telehealth services.

iii. Whether reimbursement will be available to the presenting site as well as the consulting site or only the consulting site. Include any requirements or limitations on reimbursement.

Under certain conditions, WellCare will make reimbursement available to the presenting site as well as the consulting site. As an example, WellCare has, to a limited extent, reimbursed the presenting site for a telehealth consultation using HCPCS code Q3014 (“Telehealth facility fee"). Going forward, WellCare intends to expand utilization of this model by engaging with local health departments (LHDs) to act as presenting sites for telehealth consultations.

LHDs already provide care to our Enrollees, but we envision using them in this scenario as conduits to specialty care in particular (dermatology and ophthalmology, for example) as well as to substance use disorder treatment. As LHDs are located statewide (in all 120 counties) this will be especially beneficial for our Enrollees in rural areas. The LHD would need to demonstrate they possess secure, HIPAA-compliant technology in order to host consultations.

Related to this WellCare intends to embrace the “store and forward” telehealth option. This option can be used for radiology consultations (CT-scans, MRIs, MRAs, X-rays) in which a clinical expert reviews the given image and provides an assessment to the provider who is treating the Enrollee. The consult can occur while the Enrollee is still present in the treating provider’s office or later at a more convenient time for both the treating provider and the clinical/radiology expert. In this scenario, WellCare will reimburse the treating provider for any procedures or services rendered during the office visit as well as reimburse the clinical consultant for the assessment. The provider who transmits the radiology image to the clinical consultant will need to demonstrate they possess secure, HIPAA-compliant technology for the transmission.

iv. *Lessons learned and successes or challenges with implementation of telehealth services for other programs the Vendor has served and that the Vendor will consider for provision of telehealth services in Kentucky.*

WellCare has developed a multi-faceted strategy to expand the use of telehealth that builds on national research, as well as our experience in the Commonwealth and in our other markets. We have experience with both hub-and-spoke models and direct-to-consumer models of telehealth, and have worked alongside our state partners as they transitioned to new models. For example, in our Florida market, we adapted quickly to the new direct-to-consumer model, engaging providers across the state to rapidly build an enhanced telehealth network for Enrollee access to PCPs, specialty providers, and behavioral health providers. As we've implemented telehealth services in Florida and other markets, we've gained valuable insight into the challenges involved in doing so, including startup costs, lack of awareness about telehealth on the part of Enrollees and lack of provider education around telehealth benefits and billing procedures.

Bringing Telehealth into the Home

At our Florida health plan, we partner with IMPOWER, an Orlando-based, non-profit organization providing behavioral health and child well-being services. Enrollees attend telehealth appointments to receive e-prescribed controlled medications and engage in behavioral health treatment with clinicians from their homes, using a smartphone, tablet, or laptop device. We were able to arrange services via telehealth for a homebound autistic child in need of psychiatric care. Her parents were thrilled at the approach, as it would have normally required her to be transported by ambulance to her office visits that were traumatic to the child and exasperated her behaviors. This case was important in demonstrating the importance of removing the previous definitions of hub and spoke and allowing telehealth to be delivered in and Enrollee's home.

One challenge many providers face in offering telehealth services are the startup costs necessary to equip their practices to become telehealth sites. **WellCare is addressing this challenge** through direct funding as well as incentive-based contracting. In August 2017, we partnered with Metro West Nursing and Rehab Center, a 120-bed skilled nursing facility (SNF) in Orlando, to facilitate access to physician services via telehealth during evenings, nights, weekends and holidays when nationally about 70% of all SNF-to-hospital transfers occur. The program enables a qualified physician to perform a virtual examination at the resident's bedside using audio, video and monitoring technology. The goal of this program is to prevent avoidable acute admissions and readmissions of SNF residents by providing the opportunity to effectively evaluate a resident's medical condition and accurately differentiate those residents that truly need acute care services from those that can and should remain and be treated in the SNF. WellCare supported the program by making a one-time technology payment to the facility to offset the cost of operationalizing the program and by

To address technological barriers to telehealth in Kentucky, WellCare is supporting the work our partner, SOAR (Shaping Our Appalachian Region) is doing to increase access to broadband internet in rural areas of the Commonwealth.

offering a value-based payment directly to the facility where the virtual visit through telehealth resulted in an avoided and unnecessary hospital admission.

WellCare has also had success in partnering with other organizations to develop and fund startup costs for initiatives that extend access to healthcare through telehealth. In a collaboration with the Georgia Partnership of Telehealth and Appling HealthCare Systems, WellCare of Georgia helped open two new school-based health centers at Appling County Elementary and Appling County High School. Launched in 2015, WellCare provided the funding to equip each school with telehealth systems that allow school nurses to connect students and faculty to healthcare providers at Appling HealthCare System via a video conference. This program was able to help children receive much-needed access to care in rural areas of the state. As a true community partnership, this collaboration was able to positively impact healthcare in the Appling school district.

Another challenge to implementing telehealth programs is reluctance on the part of providers to integrate telehealth into their clinical practice. While payment parity laws reduce concerns over reimbursement and increase adoption, providers still must be informed about the benefits of providing telehealth both for their practices and for the Medicaid Enrollees they serve. **WellCare is addressing this challenge** by educating providers on how offering telehealth services has the potential to reduce missed appointments and enable providers to increase revenue by offering non-traditional appointment times, as well as the benefits of providing an alternative to in-person visits for patients on occasions when coming into the practice would be inconvenient. By also educating providers about documentation and billing requirements, we can further reduce provider reluctance to offering these services and increase adoption of telehealth.

Lack of awareness of telehealth on the part of Enrollees is another challenge in implementing telehealth services and increasing access to care. **WellCare is addressing this challenge** through our communication efforts to make our Enrollees not only aware of telehealth generally, but to connect them to telehealth providers directly. As described above, this includes providing telehealth information and resources through our Enrollee Handbook, MyWellCare Mobile App, Enrollee Web Portal, as well as through our care coordinators and Enrollee Services Representatives. More directly, we can connect Enrollees with telehealth services by providing them with information on providers who offer telehealth services on our provider directory.

As the Commonwealth moves forward with its expansion of telehealth under SB 112, WellCare looks forward to the opportunity to leverage our experience and knowledge to replicate our success with these methods in Kentucky. By engaging in partnerships with organizations to create and fund new telehealth initiatives, using incentive-based contracting as a vehicle for engaging providers to practice telehealth, and educating both providers and Enrollees in the benefits of telehealth, WellCare can help the Commonwealth realize the potential of this innovative healthcare delivery model: to enable all Enrollees across Kentucky, no matter where they live, to access the care they need when they need it.

d. Describe the Vendor's provider contracting strategies, including processes for determining if a provider meets all contracting requirements (at the time of enrollment and on an ongoing basis), as well as processes for corrective action and termination. Include copies of the Vendor's proposed contract templates for individual practitioners and for facilities as attachments.

WellCare of Kentucky follows all NCQA standards for contracting and credentialing. Kentucky legislation dictates the offering of participation agreements to any willing provider (AWP) in the Commonwealth of Kentucky who is eligible for credentialing per NCQA standards. We will continue to comply with this mandate and with the contract requirements in Section 28.2, Network Providers to Be Contracted.

Once a request for a network participation is received from a provider, our Network Management team collects all documentation required to produce the contract documents. However, before the contract is initiated, Network Management policy requires that we verify the provider: a) is not on the Medicare Excluded Provider List, and b) is registered as a business with the Kentucky Secretary of State. Required credentialing documentation is sent along with the new provider contract, and must be returned with the signed agreement. This process includes authorization to check the provider's CAQH, medical liability and property liability coverage, licensure by Kentucky and the OIG, as well as scheduled Site Inspection and Evaluation for unaccredited facilities. The site inspection confirms that requirements for physical accessibility, proximity to bus lines, secure medical record and medicine storage, fire extinguishers and sprinkler systems, and emergency preparedness and evacuation plans are met.

WellCare monitors our network providers on an ongoing basis to ensure that they continue to meet contractual requirements. This includes ongoing review of CMS provider standards and excluded provider updates, as well as detailed reviews of multiple compliance sources at the time of recredentialing, and review of monthly reports from OIG, SAMS (System for Award Management), Medicare and Medicaid exclusion lists, and Medication Dispensary, among others, which are cross-referenced against our participating provider directory. If a provider is identified as being on any of these reports, WellCare initiates actions to term the provider and to notify affected Enrollees.

CORRECTIVE ACTION AND TERMINATION

We also review Enrollee grievances and appeals trends, results from site evaluations, quality of care investigations, and results of medical record reviews to monitor our network providers. When performance or compliance issues are identified, we will make every effort to bring the provider into compliance with required standards and avoid a termination that would disrupt our network. For instance, in 2017 a provider of short-term residential substance abuse services did not meet the 80% passing score on their Behavioral Health Medical Record Review (BH MRR) in 2017. The BH MRR audit evaluates the documentation practices of BH providers who are contracted with WellCare of Kentucky. WellCare then issued a Corrective Action Plan outlining required changes needed to be made within 90 days. The provider made the required changes and passed the follow-up audit.

In some cases, upholding Department and WellCare standards means that a provider must be terminated from the network. In these cases, WellCare provides a written notice to the provider of the decision to terminate which includes the reason for the termination and the effective date of termination. The notice also informs the provider about their right to appeal the decision, and provides information on how to request an appeal. Concurrently, we notify DMS of any decision to terminate a network provider as well as any Enrollees affected by the termination in accordance with the requirements in Section 28.10, Termination of Network Providers, of the Draft Medicaid Managed Care Contract.

Please see **Attachment C.18.d Contract Templates for Individual Practitioners and Facilities**, provided electronically, for our contract templates for individual practitioners and facilities.

e. Demonstrate progress toward developing network capabilities for statewide access by providing evidence of existing contracts or signed Letters of Intent with providers by provider type (for the Vendor and Subcontractor). Include the following information at a minimum.

Our network **exceeds all Department requirements for access to care**, and we continually monitor to ensure we uphold those standards. We include the following documents attesting to the capabilities of our existing statewide provider network as **Attachments C.18.e.i Provider Listing, C.18.e.ii Provider Count, and C.18.e.iii Provider Geographic Access Report**, provided electronically.

i. A Microsoft Excel workbook by provider type listing every provider that has signed a contract or Letter of Intent, including the provider's name, specialty(ies), address and county(ies), Medicaid Region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s).

WellCare of Kentucky's provider listing is included as **Attachment C.18.e.i Provider Listing**, provided electronically.

ii. A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county.

WellCare of Kentucky's provider count worksheet is included as **Attachment C.18.e.ii Provider Count**, provided electronically.

iii. A statewide Geographic Access report of all providers with LOIs color coded by provider type by Service Region.

WellCare of Kentucky's Geographic Access report is included as **Attachment C.18.e.iii Provider Geographic Access Report.**

f. Describe proposed Enrollee to provider ratios by provider type, as well as the Vendor's methodology for considering a provider's FTE when calculating network adequacy standards.

WellCare regularly evaluates our Primary Care Provider ratio to assure we are continually in compliance with contract section 29.7A, which limits the Enrollee to PCP ratio to no more than

1,500 members assigned to any single PCP. Our Enrollee to provider ratio is applied to providers who can serve as a PCP, which includes providers with specialties in family practice, general practice, pediatricians, internal medicine, advanced registered nurse practitioners, physician assistants and OB GYN within the Kentucky market.

The ratio is determined either at the provider's requested panel size, or up to the maximum limit of 1,500 Enrollees per provider, adjusted for the number of days per week they are in the office. If a provider indicates two days or fewer, their maximum capacity is set to 600, if they indicate four days or more, their maximum capacity is set to 1,500, and if they indicate 3 days, their maximum capacity is set to 900. This process accounts for FTE differences among providers and limits the number of members we assign to providers not practicing full time to assure members can get access to their primary care provider.

If a provider prescribes a maximum panel size during their enrollment through our Network Development department, or any time thereafter, limits are placed in the system to close the providers practice to any additional member assignments once that limit is reached. Likewise, once a provider reaches the limit of 1,500 our monitoring process stops the assignment of additional Enrollees until the panel size drops below the 1,500 Enrollee level maximum. The 1,500 member limit is adjusted based on information submitted on their practice roster, their provider add letter or on their initial enrollment application.

Each month individual provider volume is measured against a threshold to assure the system is functioning appropriately and to ensure the Enrollee assignment doesn't exceed the maximum 1,500 Enrollee limit or the predefined limit determined by the provider. We monitor these assignments with a panel report by unique provider, illustrated by A snapshot sample is shown **in Figure C.18-1**.

VENDOR_NAME	LAST_NAME	FIRST_NAME	Limit	ABD	TANF/CHIP	Total	Flag
A A CLINICS PLLC	JONES	KIMBERLY	1500	0	14	14	
A CARING TOUCH PEDIATRICS	PARROTT	MARK	1500	1	7	8	
A CARING TOUCH PLLC	BUSH	MORIA	1500	0	12	12	
A CARING TOUCH PLLC	TAYLOR	SHAWN	600	1	3	4	
A DAHHAN MD	DAHHAN	ABDULKADER	1500	154	826	980	
A JOSEPH OTT MD	OTT	AUGUST	1500	6	14	20	
A M FAHEEM MD PSC	FAHEEM	AMJAD	1500	1	15	16	
A PLUS FAMILY HEALTHCARE	ALFORD	STEPHANIE	1500	7	3	10	
A PLUS FAMILY HEALTHCARE	GEARLDS	CORY	1500	0	3	3	
A PLUS FAMILY HEALTHCARE	SOWDERS	BRITTANY	1500	2	67	69	
A PLUS FAMILY HEALTHCARE	VERTREES	KIMBERLY	1500	0	6	6	
A1 HEALTH CARE CLINIC	ARAIN	TARIQ	900	3	8	11	
AARON JONAN MEMORIAL CLINIC	BELL	CYNTHIA	1500	142	358	500	
AARON JONAN MEMORIAL CLINIC	BLACKBURN	ERICA	1500	8	557	565	
AARON JONAN MEMORIAL CLINIC	COLEMAN	SARAH	1500	40	15	55	
AARON JONAN MEMORIAL CLINIC	MORRIS	ERNEST	1500	9	8	17	
AARON JONAN MEMORIAL CLINIC	PAGTAKHAN-SO	LEONOR	1500	1	40	41	
AARON K JONAN MEMORIAL CLINIC INC	MURPHY	SARAH	1500	3	5	8	
ABACUS MEDICAL BILLING SERVICE	KING	SAMUEL	1500	6	1	7	
ACCESS FAMILY HEALTH CENTER	ABNER	BRIAN	1500	2	1	3	
ACCESS FAMILY HEALTH CENTER	ASHBURN	WILLIAM	1500	9	81	90	
ACCESS FAMILY HEALTH CENTER	BUNCH	SHANNON	1500	1	0	1	
ACCESS FAMILY HEALTH CENTER	BURCHETTE	LAURA	1500	7	0	7	
ACCESS FAMILY HEALTH CENTER	CARTER	RICHARD	1500	6	15	21	
ACCESS FAMILY HEALTH CENTER	COONEY	PAUL	1500	66	312	378	
ACCESS FAMILY HEALTH CENTER	MACK	STUART	1500	3	43	46	
ACCESS FAMILY HEALTH CENTER	MILLS	SARAH	1500	3	26	29	
ACCESS FAMILY HEALTH CENTER	PREWITT	CRYSTAL	1500	2	2	4	
ACCESS FAMILY HEALTH CENTER	SCHOOLCRAFT	ANITA	1500	6	68	74	
ACCESS FAMILY HEALTH CENTER	STARGEL	CHARLES	1500	54	181	235	
ACCESS FAMILY HEALTH CENTER	VAUGHN	LESLEY	1500	6	127	133	
ACCESS FAMILY HEALTH CENTER	WEBB	MATTHEW	1500	1	4	5	

Figure C.18-1 Sample Provider to Enrollee Assignments Report

In addition, WellCare regularly reviews our global Enrollee to provider ratios to assure we are not seeing material swings, and to validate the 1:1,500 ratio is never approached. We measure the PCP to Enrollee threshold against our Medicaid TANF/CHIP, ABD and ACA Expansion populations, but remove the Foster Care population as they are currently not being assigned a PCP. For all other specialties, our entire population is used when reviewing our ratios. An example of the report we use to monitor the global rations is provided in Figure C.18-2.

Specailties/Provider Type	Members	Provider (30hr FTE)	Ratio / FTE
HOSPITAL	433,313	218	1:1,988
PCP	**358,556**	**6,514**	**1:55**
PHARMACIES	433,313	1,472	1:294
LABORATORIES	433,313	90	1:4,815
RADIOLOGY	433,313	1,151	1:376
ALLERGY	433,313	113	1:3,835
CARDIOLOGY	433,313	625	1:693
DERMATOLOGY	433,313	132	1:3,283
DURABLE MEDICAL EQUIPMENT	433,313	527	1:822
GASTROENTEROLOGY	433,313	321	1:1,350
GENERAL SURGERY	433,313	660	1:657
NEUROLOGY	433,313	407	1:1,065
OB/GYN	433,313	861	1:503
ORTHOPEDIC SURGERY	433,313	487	1:890
OTOLOGY, LARYNGOLOGY, RHINOLOGY	433,313	198	1:2,188
PATHOLOGY	433,313	371	1:1,168
PSYCHIATRY	433,313	432	1:1,003
UROLOGY	433,313	257	1:1,686

Figure C.18-2 Global Ration Monitoring Report

g. Describe the Vendor's proposed methods for ongoing monitoring and assessment to ensure compliance with network adequacy and access to care standards, including tools used, the frequency of reviews, and how the Vendor will use findings to address deficiencies in the Provider Network. The response should also address how the Vendor monitors appointment availability and wait times. Provide samples of tools and/or reports.

Over the past eight years, WellCare of Kentucky has built and maintained a network that exceeds DMS' standards for providing timely access to care for all of the Commonwealth's Medicaid Enrollees. Continual and consistent monitoring of our provider network is vital to our efforts, enabling us to identify and quickly remediate any gaps in order to ensure that standards are kept and access to care is maintained. Our comprehensive ongoing monitoring and development of our network providers allows us to maintain and exceed Enrollees' satisfaction, access to care, and comply with DMS contract requirements for adequacy and access to care standards.

Assessing the adequacy of our provider network is a continuous process. Our Network Integrity Team performs monthly evaluations of the network using the tools and data sets described

below to identify potential gaps and the need for expansion activities. Our ongoing activities allow us to identify opportunities as they arise to respond proactively with enhancement strategies. WellCare's Network Integrity Team is responsible for collecting and analyzing network data, through the methods described below. Led by Provider Network Director Bonnell Irvin, our Network Management Team holds monthly Network Management and Development meetings to assess all provider types and identify if there are any issues, gaps in the network or other barriers to accessing care as well as any provider concerns that may impact their ongoing willingness to serve our Enrollees. While our leadership meets monthly to strategically address network compliance, our Kentucky-based staff, including PR Representatives, Service Managers, Enrollee Services and Enrollee Advocates, initiate action immediately to remove barriers to care for our Enrollees. We use the following tools, reports, and resources to monitor our network:

- *Monthly GeoAccess® Reports and Quest Cloud Analysis:* GeoAccess reports, as shown in **Figure C.18-3**, evaluate that time and distance standards are being adequately met at the provider level to meet the needs of Enrollees in each region. We run these reports using DMS-defined access standards. GeoAccess results are the key element reviewed during the quarterly Enrollee Access to Care committee meeting and an actionable plan results from the analysis.

Contract Terms		
Percent of Members Within	Standard (%)	Wellcare (%)
30 miles of a Hospital (urban)	95	100.00
30 miles of a PCP (urban)	95	100.00
45 miles of a PCP (rural)	95	100.00
60 miles of a Dentist	95	100.00
60 miles of a Hospital (rural)	95	100.00
60 miles of a Laboratory	95	100.00
60 miles of a Pharmacy	95	100.00
60 miles of a Radiology Services	95	100.00
60 miles of Vision Services	95	100.00
Selected Physician Specialties		
Percent of Members Within	Standard (%)	Wellcare (%)
45 miles of an OB/GYN	95	100.00
60 miles of a Cardiologist	95	100.00
60 miles of a Dermatologist	95	100.00
60 miles of a DME	95	100.00
60 miles of a Gastroenterologist	95	100.00
60 miles of a General Surgeon	95	100.00
60 miles of a Neurologist	95	100.00
60 miles of a Pathologist	95	100.00
60 miles of a Psychiatrist	95	100.00
60 miles of a Urologist	95	100.00

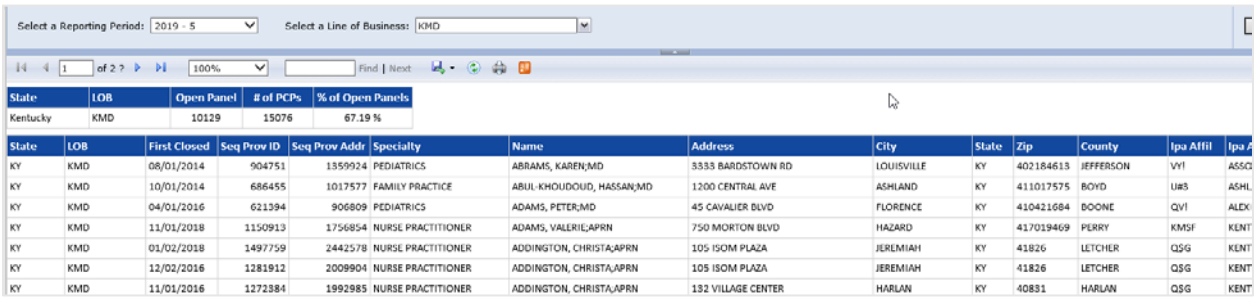
Figure C.18-3 Monthly GeoAccess Report ***(as of 1/18/2020)***

- *Zip Code Analysis for Enrollees without Access:* An analysis of Enrollees without access to specific specialties at the zip code level. The zip code analysis ensures that potential Enrollees in all applicable zip codes can be properly served.
- *Out-of-Network Monitoring:* On a monthly basis, the Health Services and Network Teams' out-of-network reports are reviewed to identify any trends that indicate access issues within the network. In such cases, this information will be assigned to Provider Relations for remediation.
- *Enrollee and Provider Grievances/Complaints:* Our associates (Enrollee Advocates, Enrollee Services Representatives and Service Managers) review, log and categorize grievances and complaints by cause, disposition and type for review and follow-up. Grievance/complaint information is shared with WellCare's Network Integrity and Quality Improvement Teams to monitor access to care, used by our Network Management team to identify the need and opportunities for expanding access to care, and allows our Provider Relations Team to follow-up and work with providers.

- *Enrollee and Provider Satisfaction Surveys:* WellCare conducts annual surveys which include key questions about the quality and adequacy of our provider network. Our Quality Improvement Team reviews the results of the survey and shares the results with our Network Management and Provider Relations teams to identify areas of opportunities for additional contracting as well as service improvements.

  Additionally, our health plans participate in the Consumer Assessment of Health Providers and Systems (CAHPS®) survey conducted annually by an independent National Committee for Quality Assurance (NCQA) certified vendor. Through this tool, we evaluate data related to Enrollees' perceptions of quality of care and service, including getting needed care and getting that care quickly. **For example, WellCare of Kentucky's 2018 HEDIS measure for Children Getting Appointments as Soon as Needed was the highest in the Commonwealth**.

- *Closed Panel Reports:* Our Provider Relations Team review monthly closed panel reports, as shown in **Figure C.18-4**, to identify providers with recently closed panels. PR Representatives outreach to each provider in an attempt to have them re-open their panel. Closed panel percentages are reviewed by specialty to determine if additional providers are needed. Our PR Representatives also visit our provider groups to review and verify their details, including panel status. We also have a Provider Accuracy Audit in place that samples network data reporting for analyzing and reporting on the information reported to us, including panel status.


Select a Reporting Period: 2019 - 5 Select a Line of Business: KMD

State	LOB	Open Panel	# of PCPs	% of Open Panels
Kentucky	KMD	10129	15076	67.19 %

State	LOB	First Closed	Seq Prov ID	Seq Prov Addr	Specialty	Name	Address	City	State	Zip	County	Ipa Affil	Ipa
KY	KMD	08/01/2014	904751	1359924	PEDIATRICS	ABRAMS, KAREN;MD	3333 BARDSTOWN RD	LOUISVILLE	KY	402184613	JEFFERSON	VYI	A55C
KY	KMD	10/01/2014	686455	1017577	FAMILY PRACTICE	ABUL-KHOUDOUD, HASSAN;MD	1200 CENTRAL AVE	ASHLAND	KY	411017575	BOYD	UI83	A5HL
KY	KMD	04/01/2016	621394	906809	PEDIATRICS	ADAMS, PETER;MD	45 CAVALIER BLVD	FLORENCE	KY	410421684	BOONE	QVI	ALEX
KY	KMD	11/01/2018	1150913	1756854	NURSE PRACTITIONER	ADAMS, VALERIE;APRN	750 MORTON BLVD	HAZARD	KY	417019469	PERRY	KMSF	KENT
KY	KMD	01/02/2018	1497759	2442578	NURSE PRACTITIONER	ADDINGTON, CHRISTA;APRN	105 ISOM PLAZA	JEREMIAH	KY	41826	LETCHER	QSG	KENT
KY	KMD	12/02/2016	1281912	2009904	NURSE PRACTITIONER	ADDINGTON, CHRISTA;APRN	105 ISOM PLAZA	JEREMIAH	KY	41826	LETCHER	QSG	KENT
KY	KMD	11/01/2016	1272384	1992985	NURSE PRACTITIONER	ADDINGTON, CHRISTA;APRN	132 VILLAGE CENTER	HARLAN	KY	40831	HARLAN	QSG	KENT

Figure C.18-4 Closed Panel Report

- *Out-of-Network Paid Claims:* The Network Management and Provider Relations teams monitor out-of-network paid claim reports to identify providers that are not currently contracted with WellCare and understand where there may be a network gap. This information is shared with the Network Management team to target recruitment activities.

- *Knowledgeable Associates:* Our locally-based PR Representatives and Community Relations Staff act as key resources for identifying gaps in the network. Our associates know their regions and are encouraged to immediately escalate to leadership any situation in which a provider is not available or does not exist to adequately meet an Enrollee's needs. As a result, we understand the provider landscape across each region of the Commonwealth, and we couple that with our understanding of the basic and specialized needs of our Medicaid Enrollees.

- *Quality Improvement Committee (QIC):* We hold quarterly QIC meetings attended by the following departments: Quality Improvement, Network Management, Regulatory, Health

Services, Executive Leadership, Credentialing, Appeals and Grievances, Claims, Medical Economics, Compliance, and Enrollee Services. During this meeting the Network Team reports on the state of the Network, including any gaps to be filled and other access and availability issues; provides information on barriers and action plans to address those barriers; and receives feedback from our internal partners on any network concerns. The Network Team uses this feedback to identify areas of opportunity within the management and execution of the Network and, when necessary, implements changes.

REMEDIATION OF ANY DEFICIENCIES

Our Network Management Team works quickly to address any deficiencies identified during the course of our network monitoring activities using a variety of methods:

- *Targeted Outreach:* We outreach to local providers to fill identified network gaps. Our field-based PR Representatives and Network Management staff personally contact non-contracted providers to determine impediments to contracting and look across borders to recruit out-of-state providers in bordering states with natural referral patterns.
- *Target Medicare Providers:* As described above, we use Quest Analytics tool to see if there is a Medicare provider of the provider type needed that is not listed on the KY State file. If located, we approach the practice by phone or in person in an effort to convince them to see Medicaid patients. If necessary, we may offer an additional financial incentive, including value-based payment (VBP) contracts, to take on the additional population of Enrollees.
- *Offer Incentives:* When deficiencies are related to lack of access to a specific provider type in a specific area, we may initiate an investment opportunity by giving incentives such as VBP contracts to providers to expand into the area.
- *Single Case Agreements:* Our Network Contracting team fills individual gaps using a single case agreement with an out-of-network provider, seek an alternative delivery method for that service and work with the Enrollee to find an appropriate alternative. This ensures seamless care for our Enrollees in places where there is a lack of any specific provider contract.
- *Existing Patterns of Care:* Our Network Integrity team closely reviews patterns of care to develop an understanding of provider referrals within each region and outreach to providers outside of those regions to support those patterns. In doing so we identified an out-of-network laboratory that several of our hospitals were using for a specific type of genetic testing. After evaluating the referral pattern, our Network Contracting team reached out and secured a contract with this laboratory.
- *Leverage Provider Partnerships:* Our Network Management and Provider Relations teams encourage partner network providers to extend hours and to expand access during initial contracting and ongoing conversations with the network. We have contracts with providers that offer increased reimbursement for providing after-hours care. To increase accessibility in Bowling Green, KY, for example, we negotiated a rate to allow Graves Gilbert Clinic to establish weekend hours for Enrollees.

APPOINTMENT AVAILABILITY AND WAIT TIMES

WellCare's network providers are contractually required to comply with appointment access standards. Providers who continuously fail to meet contract requirements, following active, supported remediation efforts, may be terminated. We have processes in place to monitor, and resolve any issues with, the timeliness of appointment access within our network. These include **Appointment Accessibility Surveys.** Our Network Integrity Team partners with an external vendor to conduct these telephone surveys to assess appointment availability, appointment wait time, and after-hours coverage. We re-audit any providers who fall short of standards and follow-up with a corrective plan as needed. Findings are shared with the Provider Relations Team to ensure appropriate follow-up and education is provided to providers failing to meet accessibility standards. We also review the aforementioned closed panel reports, out-of-network paid claims reports, as well as the Enrollee and Provider Satisfaction Surveys and the CAHPS® survey.

Our comprehensive monitoring program has shown results, with PCP and Specialty appointment availability through the 3rd quarter of 2019, far exceeding our goal of 90% compliance as shown in **Table C.18-1**. Telephonic surveys measured the ability to schedule appointments within 30 days for routine care and 48 hours for urgent care.

Table C.18-1 Telephonic Survey Results (through Q3 2019)

Provider Type	Urgent	Routine
PCPs	95.20%	98.00%
Pediatricians	98.41%	95.24%
Specialty Care Providers	86.42%	93.83%

h. Describe how the Vendor would respond to the network termination or loss of a large provider group or health system. Include information about the following at a minimum:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 28.10, Termination of Network Providers of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Our network monitoring program ensures providers are meeting Enrollee needs and program requirements. When performance or compliance issues are identified, we make every effort to bring the provider into compliance with required standards and avoid a termination that would disrupt our network. In some cases, however, upholding Department and WellCare standards may mean that a provider must be terminated from the network. **While we have never lost a hospital or large provider group in our eight years as a Medicaid MCO in the Commonwealth**, in the event of a network termination or loss of a large provider group or health system, ensuring minimal disruption becomes is top priority and WellCare has a formal plan in place to execute on all critical processes. Our responsibility to our Enrollees, DMS and the public

requires that in all aspects of network management and retention we are prepared to take steps to maintain the integrity and long-term, high performance of our provider network.

i. Notification to the Department and Enrollees.

Swift and proactive communication of the loss or termination of a large provider group or health system to both DMS and Enrollees is a critical step in maintaining network integrity and access to care. In accordance with DMS requirements in these events, WellCare notifies DMS by email within three business days of the termination. WellCare notifies Enrollees who have received a service from the terminating provider within the previous six months by mail within 15 days of the action taken if it is the Enrollee's primary care physician and within 30 days for any other provider. If the terminated provider was a contracted PCP, the notice includes information about selecting or being auto-assigned to a new PCP and how WellCare will assist the Enrollee to transition care to the newly assigned PCP. If the provider was a specialist, the notice includes information about how WellCare will assist the Enrollee to transition care to another specialist.

Concurrently, WellCare of Kentucky will provide a written notice to the provider of the decision to terminate which includes the reason for the termination and the effective date of termination. The notice also informs the provider about their right to appeal the decision, and provides information on how to request an appeal.

In 2018, our Special Investigations Unit (SIU) investigated a Durable Medical Equipment (DME) provider in our South Carolina affiliate provider network that was discovered to be using pre-signed copies of blank physicians' orders for WellCare members to receive Back Orthotics. The investigation also revealed that employees of the DME provider were completing the physicians' orders and also making addendums to members Medical Records. The investigation identified an overpayment of over $10,000. SIU coordinated with WellCare's South Carolina's market associates recommending that this provider be terminated. The market and SIU discussed the findings in this case and the market initiated a 'For Cause Termination' of the provider. This case was also referred to the state Medicaid Fraud Control Unit for investigation. WellCare made arrangements to move members with ongoing needs from this provider (such as rental equipment) to other DME vendors in network so they would not be impacted by the termination.

ii. Transition activities and methods to ensure continuity of care.

The provider-Enrollee relationship is an important cornerstone of care, and the relationship is even more critical for vulnerable populations. In the event of a provider termination or the loss of large health system, our top priority is ensuring continuity of care and continuing access to services for Enrollees. WellCare of Kentucky takes pride in working with our community and Enrollee outreach teams to prepare them for Enrollee discussions and questions. In addition to the 24-hour availability of our Enrollee portal and our outbound calls, Enrollees may contact Enrollee services, care managers or our Enrollee outreach team for assistance with PCP assignment and transition of care when a provider is terminated. In the case of a hospital termination, we review open authorizations for Enrollees that extend past the termination date so we can insure there is no lapse in treatment and we can transition care to another in

network provider if appropriate. For our Enrollees with more complex care needs, our care coordinators call the Enrollee directly to help them during the transition and ensure that authorizations are transferred and that any other needs, such as DME or other life-sustaining equipment, are taken care of and coordinated between the Enrollee and new provider at this time.

We encourage and facilitate Enrollee choice and we believe our broad network is why more Enrollees in Kentucky choose WellCare of Kentucky than any other MCO. When Enrollees do not make a proactive choice, our auto-assignment process assigns Enrollees to a new PCP. This algorithm includes the capacity to use prior relationship, family assignment, language spoken, travel and distance standards, and PCP quality tiers when auto-assigning a PCP. Upon assignment or selection of a new PCP, Enrollees are mailed a new Enrollee ID card. Enrollees may change PCPs at any time by contacting Enrollee services or through the secure Enrollee portal.

For example, in 2015 and 2016, our Illinois affiliate identified quality and performance issues at an independent practice association (IPA) that had more than 8,000 assigned members. Under the leadership of our affiliate's medical director, the provider engagement team developed an improvement plan, holding numerous coaching sessions over a period of months to improve quality. At the point that it became apparent the IPA was unwilling or unable to work with our affiliate to remediate the identified performance issues, the decision was made to terminate the IPA’s contract and our affiliate worked to successfully transition members to another practice. The emphasis during the termination process was to guarantee a smooth and uneventful transition for the Enrollees by establishing a team to manage the transition of services. The team identified high quality providers who were eligible and willing to assume additional Enrollees, matched Enrollees with a geographically proximate, high quality and culturally appropriate provider to minimize travel time and ensure a seamless transition. Personal outreach was made by Provider Relations Representatives to confirm capacity and develop a detailed Enrollee reassignment plan.

Enrollees with open authorizations or in a current course of treatment were systematically identified so Care Coordinators could begin working on transition plans. These Enrollees were tiered by acuity levels and plans to proactively reach out to complex and medically fragile Enrollees were made. Notification letters were sent to those Enrollees assigned to a terminated PCP, in a course of treatment or with open authorizations. Prior to sending the letter, Enrollee Services associates were provided a list of the identified high quality PCPs to facilitate PCP choice when Enrollees called. Enrollees who did not make a proactive PCP choice were manually reassigned to high quality PCPs in accordance with an established reassignment plan. Because of the advance work of our affiliate, Enrollees were moved seamlessly with no disruption to their care.

iii. Analyses the Vendor will conduct to assess impact to network adequacy and access, and how the Vendor will address identified deficiencies.

During our eight-year partnership with DMS, WellCare of Kentucky has not lost any large provider groups. However in the event of a loss or termination of a large provider group, our Network Management team runs GeoAccess reports to determine the effect of the loss on

network adequacy and access standards. If we identify deficiencies in the network, we use a variety of methods to address the deficiencies, including:

- Reaching out to local providers in the affected area who are not contracted with WellCare of Kentucky to bring them into the network, working to remove any barriers to contracting which may have existed and in some case offering incentive-based contracts
- Using the Quest Analytics tool to see if there is a Medicare provider in the area that is not listed on the KY State file that we may approach to join our Medicaid network
- Sign single-case agreements with out-of-network providers in the area until such time as the deficiency is remediated

The team also reviews Enrollee requests, provider referrals, competitive data, and works with PR Representatives and their knowledge of the local provider community to identify and contract with providers in the area to ensure that we maintain network access and adequacy standards.

C.18 Provider Network

- Attachment C.18.b-1 Dental Quarterly Network Adequacy Report (Provided Electronically)
- Attachment C.18.b-2 Dental After Hours Quarterly Network Adequacy Report (Provided Electronically)
- Attachment C.18.b-3 Vision Quarterly Network Adequacy Report (Provided Electronically)
- Attachment C.18.b-4 Vision After Hours Quarterly Network Adequacy Report (Provided Electronically)
- Attachment C.18.b-5 Sample Reporting Dashboard
- Attachment C.18.b-6 Sample JOC Agenda
- Attachment C.18.d Contract Templates for Individual Practitioners and Facilities (Provided Electronically)
- Attachment C.18.e.i Provider Listing (Provided Electronically)
- Attachment C.18.e.ii Provider Count (Provided Electronically)
- Attachment C.18.e.iii Provider Geographic Access Report

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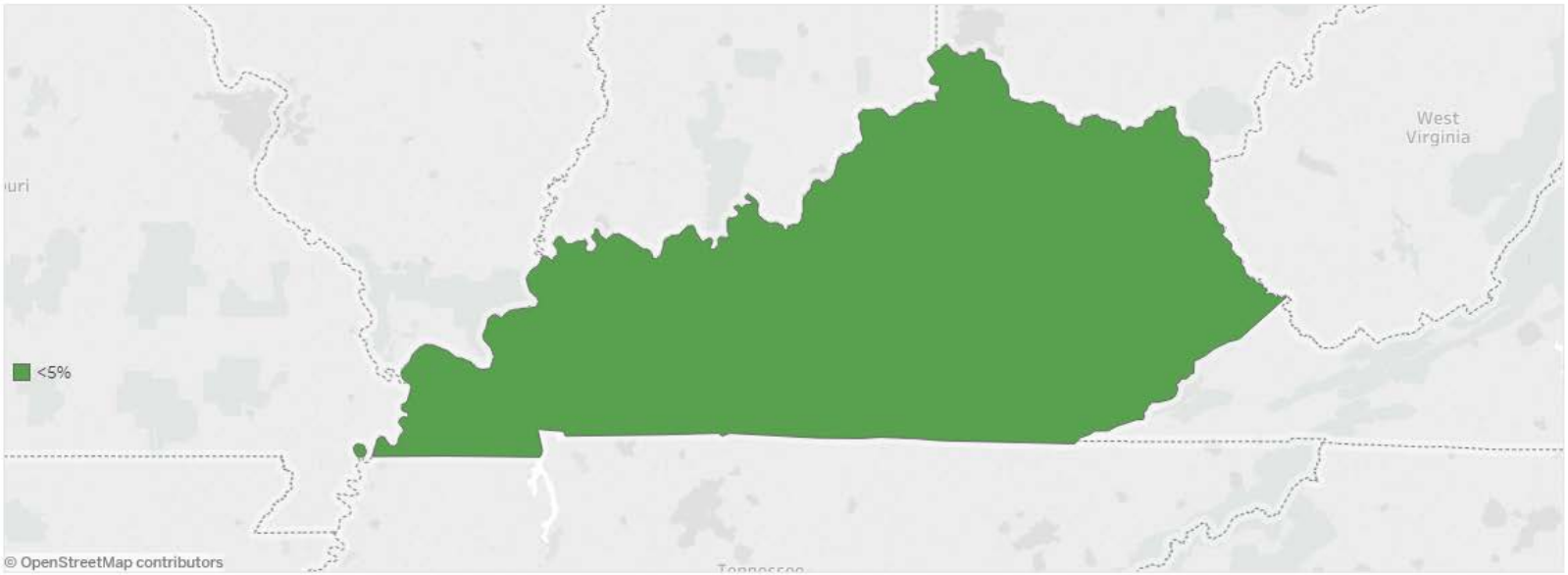
Ancillary Adequacy

Current Adequacy by State and County

Network Performance

Data Refreshed 1/13/2020

Vendors	Product	Line of Business	Market Status	Specialty
AVESIS	Medicaid	(Multiple values)	Current	(Multiple values)



Percent of Membership with Access

Vendors	State	County	County Class	Line of Business	Specialty	Standard	% With Access
AVESIS	KY	Adair	Null	KAB	DENTAL - PEDIATRIC DEN..	1 in 60 miles and 60 mins	100.0%
					DENTISTRY	1 in 60 miles and 60 mins	100.0%
				KHK	DENTAL - PEDIATRIC DEN..	1 in 60 miles and 60 mins	100.0%
					DENTISTRY	1 in 60 miles and 60 mins	100.0%
				KMD	DENTAL - PEDIATRIC DEN..	1 in 60 miles and 60 mins	100.0%
					DENTISTRY	1 in 60 miles and 60 mins	100.0%
			Rural	KAB	VISION MEDICAL	1 in 35 miles and 50 mins	100.0%
					VISION ROUTINE	1 in 35 miles and 50 mins	100.0%
				KHK	VISION MEDICAL	1 in 35 miles and 50 mins	100.0%
					VISION ROUTINE	1 in 35 miles and 50 mins	100.0%
				KMD	VISION MEDICAL	1 in 35 miles and 50 mins	100.0%
					VISION ROUTINE	1 in 35 miles and 50 mins	100.0%

Attachment C.18.b-5 Sample Reporting Dashboard

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KY/ NE Joint Operating Committee (JOC)

Meeting Information:

Dial in number: **(844) 531-9390** Access Code: **91614877**
Date: **October 25, 2019** Time: **12:30 – 1:30PM** Duration: 60 Minutes

Agenda

	Topic	
1.	**Operations:** • KY Eligibility Files o Avesis and WellCare teams continue to work on a full reconciliation of member eligibility	
2.	**Encounters**: Review of the encounter scorecards for KY and NE • KY care& caid- in line with historical data and SLAs • NE caid- in line with historical date and SLAs	
3.	**Network :** • NE Networks- No gaps • KY Network- No gaps – 2020 Medicare Expansion	
4.	**Delegation Oversight (CAPs,, SLAs):** • Delegation Scorecard Review Multifunction Scorecard_Avesis_Se	
5.	Action Items/New Items:	

Meeting Information:

Dial in number: **(844) 531-9390** Access Code: **91614877**
Date: **September 27, 2019** Time: **12:30 – 1:30PM** Duration: 60 Minutes

KY/ NE Joint Operating Committee (JOC)

Agenda

	Topic	
4.	**Operations:** • KY Eligibility Files o Avesis and WellCare teams continue to work on a full reconciliation of member eligibility	
5.	**Encounters:**  Avesis 0917 Scorecard - Medicaic  Avesis 0917 Scorecard - Medicar	
6.	**Network :** • NE Networks- No gaps • KY Network- No gaps – 2020 Medicare Expansion	
4.	**Delegation Oversight (CAPs,, SLAs):** • Delegation Scorecard Review  Multifunction Scorecard_Avesis_Au	
5.	Action Items/New Items:	

Meeting Information:

Dial in number: **(844) 531-9390** Access Code: **91614877**
Date: **August 23, 2019** Time: **12:00 – 1:30PM** Duration: 90 Minutes

Agenda

	Topic	
7.	**Operations:** • KY Eligibility Files o Avesis and WellCare teams continue to work on a full reconciliation of member eligibility	

KY/ NE Joint Operating Committee (JOC)

8.	**Encounters:**  Avesis KY& NE Provider Scorecard -  Avesis KY and NE Provider Scorecard -	
9.	**Network :** • NE Networks- No gaps • KY Network- No gaps	
4.	**Delegation Oversight (CAPs,, SLAs):** • Delegation Scorecard Review  Multifunction Scorecard_Avesis_Ju	
5.	Action Items/New Items:	

Medicaid Dashboard
Current Network
As of 1/18/2020

County Classification	County	PRIMARY CARE PROVIDERS	ALLERGY	CARDIOLOGY	DENTISTS	DERMATOLOGY	DURABLE MEDICAL EQUIPMENT	GASTROENTEROLOGY	GENERAL SURGERY	LABORATORIES	NEUROLOGY	OBGYN	ORTHOPEDIC SURGERY	OTOLOGY, LARYNGOLOGY, RHINOLOGY	PATHOLOGY	PHARMACIES	PSYCHIATRY	RADIOLOGY	UROLOGY	VISION PROVIDERS	HOSPITALS	Deficiencies
1	Ballard, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Caldwell, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Calloway, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Carlisle, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Crittenden, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Fulton, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Graves, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Hickman, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Livingston, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Lyon, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	Marshall, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
1	McCracken, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Christian, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Daviess, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Hancock, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Henderson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Hopkins, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	McLean, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Muhlenberg, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Ohio, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Todd, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Trigg, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Union, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
2	Webster, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Breckinridge, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Bullitt, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Carroll, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Grayson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Hardin, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Henry, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Jefferson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Larue, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Marion, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Meade, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Nelson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Oldham, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Shelby, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Spencer, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Trimble, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
3	Washington, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Adair, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Allen, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Barren, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Butler, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Casey, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Clinton, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Cumberland, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Edmonson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0

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4	Green, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Hart, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Logan, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	McCreary, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Metcalfe, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Monroe, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Pulaski, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Russell, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Simpson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Taylor, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Warren, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
4	Wayne, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Anderson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Bourbon, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Boyle, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Clark, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Estill, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Fayette, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Franklin, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Garrard, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Harrison, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Jackson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Jessamine, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Lincoln, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Madison, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Mercer, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Montgomery, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Nicholas, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Owen, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Powell, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Rockcastle, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Scott, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
5	Woodford, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
6	Boone, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
6	Campbell, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
6	Gallatin, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
6	Grant, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
6	Kenton, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
6	Pendleton, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Bath, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Boyd, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Bracken, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Carter, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Elliott, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Fleming, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Greenup, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Lawrence, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Lewis, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0

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7	Mason, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Menifee, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Morgan, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Robertson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
7	Rowan, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Bell, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Breathitt, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Clay, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Floyd, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Harlan, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Johnson, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Knott, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Knox, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Laurel, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Lee, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Leslie, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Letcher, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Magoffin, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Martin, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Owsley, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Perry, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Pike, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Whitley, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
8	Wolfe, KY	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	0
Deficiencies		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

19. Provider Payment Provisions

C.19. PROVIDER PAYMENT PROVISIONS

a. **Describe the Vendor's claims adjudication process and capabilities in maintaining high standards in claims processing.**

b. **Provide information about the Vendor and any entity proposed to process and pay claims. As part of the response, address the following:**

   i. Policies and procedures to meet performance standards and prompt pay requirements for all provider types.

   ii. Market specific strategies for addressing potential provider payment issues, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education.

   iii. Proposed average days to payment from claims submission for the Vendor's proposed claims platform for medical and pharmacy claims. Provide the Vendor's last calendar year's report on the "average number of days to pay providers."

c. **Describe the Vendor's methodology for ensuring claims payment accuracy standards will be monitored and improved through audit. At a minimum, address the sampling methodology, the process for auditing the sample, documenting of results, and activities conducted to implement changes or required corrective actions.**

C.19. PROVIDER PAYMENT PROVISIONS

WellCare of Kentucky will comply with the Department of Medicaid Services' expectations and requirements as specified in Section 29 Provider Payment Provisions and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

a. **Describe the Vendor's claims adjudication process and capabilities in maintaining high standards in claims processing.**

WellCare has more than 30 years of experience in the successful and timely processing of claims and paying providers accurately. This commitment is reflected through our efforts in helping our network providers and enrollees by completing the cycle of service from provider to enrollee, and back to the provider in the form of timely and accurate payment. As an incumbent in Kentucky for 8 years, WellCare has an ongoing effort to improve provider satisfaction related to claims processing by improving the electronic claims submission process, thereby reducing manual intervention and sustaining consistent, accurate payment. The success of this effort is evident through our high auto-adjudication rate **(90.27% for Kentucky Medicaid claims in 2019),** which supports efficiency. WellCare of Kentucky proposes to pay or deny professional medical claims within 10 calendar days from claim receipt on average and institutional clean claims within 15 days, consistent with our 2019 performance. Our subcontractors that are delegated for claims processing are held to the same high standards and must comply

91.6% of our Kentucky providers would recommend WellCare to other providers.

with all contractual requirements from the Department for claims processing timeframes and payment.

Our claims department includes processors and analysts who understand the impact our claims processing has on the provider network, and our core commitment to our “Enrollees First” philosophy. The leaders of the claims department, Brian Pogue, VP of Payment Integrity and Claims and Thomas Everett, Senior Director of Claims, are highly experienced with Brian and Tom having a combined total of over 40 years of experience in claims processing. Our leaders work in close collaboration with our Kentucky COO, Ben Orris who provides local leadership and oversight to claims processing. Ben is supported by Julie Crousore, Sr. Manager, National Account Management team; who lives in Bowling Green, Kentucky and has been part of our WellCare of Kentucky team since the launch of the managed care program in 2011. Over the past 8 years, Julie has been instrumental is providing operational support and guidance to ensure timely claims processing in Kentucky. She has been closely associated in working with all provider types ranging from hospitals, FQHC/RHC's, non-par providers to behavioral health providers, to resolve any issues related to claims or any operational issues that create provider abrasion. We have several additional roles and associates who work with participating and non-participating providers to submit paper and electronic claims and then process them in a timely and accurate manner. WellCare claims systems, submission control tools, billing and payment applications, and standard operating procedures support claims processing for both participating and non-participating providers. These roles include Provider Relations (PR) professionals, Claims and Configuration staff, and Operations Account Representatives (OAR).

The OAR team, who is managed by Julie Crousore, consists of experienced claims professionals who conduct billing education and are empowered to efficiently resolve issues identified by providers or their PR representatives. The unique engagement of these locally-focused individuals provides high-touch collaborative relationships with our providers to ensure seamless claim submission. They work with providers to educate them on how to submit claims appropriately through a combination of training, education, audits and call campaigns. They also meet with the providers in person to assist them in understanding the system and solve any initial issues they may have regarding claim submission.

In 2018, we encountered IT infrastructure issues impacting timely claim processing for several months. We immediately worked on a root cause analysis and developed a remediation plan to the Department of Insurance. We invested in our tools and processes that allowed WellCare's Claims Operations to emerge as an improved and stronger entity that tracks metrics more effectively and identifies potential issues much earlier in the process. The new addition of our state of the art Claims Command Center also allows us to track claims end to end, in real time and identify issues in workflow from the moment claims come through the door, at insertion to the claims processing system, and all the way through to payment. Additional electronic inventory control algorithms within the Claims workflow system promote a first in, first out methodology that increases urgency as each claim ages. In addition to real-time monitoring, reporting of aging inventory is reviewed multiple times a day by Claims leadership to assure all workflows are operating with maximum efficiency and that there is sufficient staff available to process each day's inventory. The issues were resolved and our performance has met all requirements in 2019.

OUR CLAIMS ADJUDICATION PROCESS AND CAPABILITIES

The key components of WellCare's claims and encounter processing solution, which apply to all service types including participating and non-participating providers (inpatient, outpatient, professional, etc.) include:

Claims Submission: The provider submits claims in either paper or electronic format from a variety of submission avenues. Though we accept paper claims by mail, approximately 94% of our claims are received electronically and we promote electronic submission whenever possible because of the efficiency it offers. We identify the high-volume submitters of paper claims on a monthly basis and target them for individual outreach to educate them on the value of electronic submission. This proactive outreach to providers is performed by our Electronic Data Interchange (EDI)-Operations team and ImageNet (our preferred clearinghouse vendor) to help these providers convert to free electronic submissions. We receive electronic claims from clearinghouses, direct data entry of claims via our web portal, paper claims and Coordination of Benefits Agreement (COBA) claims for enrollees with primary Medicare coverage.

When the paper claims are received, ImageNet scans the paper claims, assigns them a scanning control number (SCN), and converts them to an 837 format established to meet HIPAA requirements for the electronic submission of healthcare claim information. This capture is done by the optical character recognition (OCR) technology and then both the 837s and the scanned images are validated by ImageNet. In this process, the original source data is captured, even if the file or an individual claim/encounter is rejected, and this initial submission becomes the reference point for all tracking and reconciliation functions. This approach ensures that requirements of data needed for clinical purposes as well as reporting needs (such as "Received but Unadjudicated Claims") are able to be met. For non-electronic submissions, we provide acknowledgement of receipt of claims to the provider within 15 days, pay the claim or notify that the claim is denied or contested to the provider within 20 days.

For electronic claims, our secure provider portal is an easy to use, no cost, and direct data entry (DDE) claim submission tool. This tool is currently being used to successfully transition providers that traditionally have submitted paper claims to move to electronic submissions. We assist all providers, including non-traditional providers such as those who provide home modification or pest control services in the use of the electronic tools for claims. The tool collects the required information from the provider to create an electronic claim or encounter that complies with the EDI 837 format and meets the Department's encounter submission requirements. For electronic submissions, WellCare of Kentucky provides an acknowledgement of the receipt of the claim within 24 hours. We send the provider a status through a standard healthcare claim response (277U response).

Front-End Claims Input Business Rules: In this phase a series of steps (edits) is applied to validate that the claim has the right information to process correctly. We utilize Standard National Implementation Process (SNIP) edits which are national standard edits that validate compliance with HIPAA. These SNIP edits include any syntax issues, validation of enrollee, provider, vendor ID, and other critical data elements such as National Provider identifier (NPI) validation. The providers receive an "accepted status" for claims that pass these edits. If claims fail these edits, the providers receive a "rejected status" and the provider can resubmit the

claim. In addition, a rejection details comment is sent (or a paper rejection letter in the case of paper claim submission), advising the provider of the rejection reason, along with other pertinent claim identification information. For electronic claims, providers receive an electronic response real-time.

Pre-Core Processing System: During this phase, all claims that have been accepted go through an additional series of validations to check for logic and clinical consistency. These edits ensure that claims are adjudicated correctly based on commonly accepted and published clinical guidelines. If the claim fails these edits, a manual review is required prior to being sent to the Core Processing System (CPS). The claims which pass the edits are loaded to the CPS for further processing. There are instances in this phase where a claim is also rejected because it cannot be adjudicated due to various reasons such as enrollee ineligibility, enrollee not found, invalid provider information, missing or invalid claim data.

Core Claims Processing: This phase is called the Core processing phase because it is where the full pricing and adjudication of all provider claims is completed. Any pended claim is tracked and routed for resolution within the claims timeliness standards. To ensure correct payment, validations completed in this phase include National Correct Coding Initiatives (NCCI) edits created by CMS to promote national correct coding methodologies and control improper coding and payment, benefit limit and accumulator edits that match against amounts already paid, payment rate determination according to individual provider contracts, coordination of benefits and third party liability coordination, high dollar claim reviews, and other edits necessary to fully adjudicate and determine the payment amount for a claim.

Prepayment Claims Editing - The next phase involves validation of the adjudicated claims. Once the claim is adjudicated we execute a final set of edits checking for clinical consistency, fraud, waste and abuse, and other processing components to ensure and validate proper payment for services rendered.

Provider Payment: The final phase of the claims processing and payment processing is provider payment. WellCare generates payments six days a week for our providers with the exception of a check run that falls on the last day of the month or a closed holiday. The frequency of this payment cycle improves processing turnaround times and increases provider satisfaction. **As evidenced through our quarterly Provider Satisfaction Survey data, with 91.6% of respondents in our 2018 survey stating they would recommend WellCare of Kentucky to other provider practices.** We offer providers a choice to indicate their preference for electronic or paper transactions for payment, so they can be paid by Electronic Funds Transfer (EFT) or a check and the Remittance (835 or Paper). We process a full reconciliation file to ensure that all intended payments were made and track the payment transaction information.

The providers for our delegated subcontractors also have the ability to submit claims via a clearinghouse, data entry into the web portal, or by paper including the standard CMS claim forms (CMS 1500 or UB-04). Our subcontractors have systems that are designed to apply specific specialty benefits, clinical edits (where needed), provider contracts and pricing, data validations, service code verifications and authorization rules to claims. Their claims systems also tie in to claims enrollee eligibility, state specific benefits, frequency limitations and exclusions (where applicable), and enrollee medical diagnoses and history. System adjudication

rules are specific to State requirements and include pre-authorization requirements, clinical review requirements, administration review and/or auto adjudication which helps to ensure that the appropriate amount, duration, scope and medical necessity benefits are applied to each claim and pre-service request. On a regular basis, our subcontractors review their systems and policies for any changes or updates to covered procedure codes and benefits, and make any modifications based on regulatory guidelines.

CAPABILITIES IN MAINTAINING HIGH STANDARDS IN CLAIMS PROCESSING

Increase Auto-Adjudication and Automation For Payment Accuracy

WellCare strives to increase auto-adjudication and automation for medical and behavioral health claims which is a key element to ensuring compliance with prompt pay and accuracy standards. This allows us to handle fluctuations in claims volume receipts and ensure accuracy through consistent and speedy payment. Automation starts with claim receipts where WellCare evaluates critical data elements to ensure the claim as been submitted accurately and should be accepted by Medicaid. This includes validating that the provider is eligible to be paid by Kentucky Medicaid. Additional automation occurs through auto adjudication (AA) by means of our highly configurable claims processing system that allows claims to adjudicate and pay without manual intervention. WellCare also creatively leverages technology to replicate the repetitive processing mechanics on select claim types to achieve our high auto-adjudication rate of 90.27% in 2019.

Our unwavering dedication to automation drives our best practice for high auto adjudication (AA). The AA rate is monitored, reviewed, and reported daily to all levels of management with the purpose of identifying any deviations from the norm. When deviations occur, our Claims Command Center with highly specialized claims subject matter expertise performs a root-cause analysis to identify the drivers and mitigate with the appropriate teams or areas that can influence the metric. In order to meet this initiative, we have several tools and methods at our disposal to improve auto-adjudication rates:

- *Review of claim pend trends:* By analyzing this data, business rules that drive claim pends are evaluated for modification to reduce the number of pended claims
- *Usage of automated scripts (Macros):* Where repetitive claims processor mechanics/steps exist, a macro that mimics the steps a processor takes to un-pend a claim is executed. Claims then adjudicate without manual intervention, thereby increasing the accuracy and consistency of claims processing.
- *Paper to EDI Campaign:* WellCare works with providers who submit paper claims and offers assistance to submit claims electronically. Electronic claims submission reduces the overall time from submission to payment.

As we continue to increase the auto-adjudication rate, we maintain our commitment of accuracy and prompt service to our providers in accordance with 42 C.F.R. 447.46 and 42 C.F.R. 447.45. WellCare has a well-defined strategy we deploy for the claim payment process to ensure it is ready at the time of contract implementation. WellCare has more than 30 years of experience in the successful and timely processing of claims and paying providers accurately.

INVENTORY CONTROLS AND MONITORING

CLAIMS PATH - Claims Path is an industry leading workflow management application that streamlines critical business processes and prioritizes inventory. Our workflow management application is customizable and scalable to meet the business needs. The claims processing system includes applications that control the receipt, adjudication, staging of open claims and assignment to resources. Claims Path increases visibility of work items such as clean and pended claims and reduces effort needed to manage tasks separately. This workflow management system automatically assigns work to skilled processors based on expertise and knowledge. This sophistication allows claims to be processed accurately and timely, ensuring we meet the Department's payment goals. Each type of claim has a profile status and indicators that drive inventory queuing via first in, first out (FIFO) criteria to ensure timely completion. Claims that are at risk of missing prompt pay are reported to Management and sent to a specialized team who provides immediate action and resolution. This oversight ensures all claims are processed in accordance with the Department's prompt pay guidelines.

Capacity Model- Our claims processing workload model ensures that proper capacity is available through well-trained associates to finalize claims in order to meet all state requirements. A variable cost model is used to predict workload and productivity requirements. Important data includes membership, product type, claims per Enrollee, claims per hour, and auto-adjudication rates. Through daily performance monitoring, supported by a suite of reporting tools, and technology to monitor claims, WellCare is diligent in ensuring we have the right capacity to continually meet the claims turnaround times.

Claims Command Center and Inventory Governance

As a way of tracking performance standards and prompt pay requirements, WellCare's Claims Command Center (CCC) monitors claims inventory from end to end as well as in the various phases of the claims workflow. With this workflow management application we successfully identify and address any areas of opportunity (as referenced earlier) in meeting our turnaround time for claims payment. This monitoring includes performance metrics (e.g., month-to-date turnaround time, auto-adjudication rates and production outputs) and ensures acceptable production capacity is made available. This monitoring is important because it ensures that every claim is tracked from receipt through and including load to the Core Processing System (CPS) or rejection , to payment and ultimately to encounter submission. With real time reporting and complete line of sight of all provider claims, WellCare's claims forecasting provides the ability to immediately respond to any situation that might pose a risk.

The CCC developed a specialized claims training and quality curriculum to ensure that staff at all levels are kept abreast of claims improvement initiatives. The team manages all of the step action tables (training documents) based on the state, line of business and specific policies in place based on market and regulatory requirements concerning claim payment. These step action tables are stored online for easy access and are always available. The Claims team uses monitoring tools as leading indicators to improve accuracy and provider satisfaction, including:

- Top denials by provider including dollars and volume - Enables proactive communication to providers to reduce denials.

- Daily monitoring of inventory as compared to prompt pay statutes
- Identification of top providers with the highest clearing house rejection rates – EDI team partners with providers to educate them
- Claims Interest
- Pre-Payment Audits to prevent payment anomalies

Any activities that may affect claims output are addressed at our claims center monitoring meetings that occur three times a week or ad hoc as needed, that include all levels of claims leadership and our analytics team. Monitoring meetings have a prescriptive agenda that addresses trends, current inventory status, claims metric goals and any open issues so they can be resolved quickly to ensure that we meet contractual and regulatory requirements.

b. **Provide information about the Vendor and any entity proposed to process and pay claims. As part of the response, address the following:**

Prompt and accurate payment of claims is essential to maintain strong provider participation and reducing administrative burden. Our approach to meeting the Department's expectations and requirements centers on our mission to serve our enrollees and providers through consistent, prompt, and accurate payment of claims set forth in 42 C.F.R. 447.46 and KRS 304.17A-700-730.

> **On March 1, 2017, WellCare of Kentucky conducted a Provider Focus Group in Lexington, KY. Practice representatives were asked a series of questions relating to their experience in working with us. We got a consistent response of those in attendance that WellCare of Kentucky was the most timely and accurate payer of claims and the plan that was most accessible.**

WellCare views subcontracting as a long-term business strategy where we selectively choose highly qualified subcontractors to complement and enhance the services we provide to our enrollees and providers. Our approach to determining what activities are sub-contracted is strategic, tailored to individual state needs and designed to enhance our operations while protecting enrollees and providers. Our subcontractors are specialists in their respective fields and, because they work frequently with Medicare and Medicaid populations, they demonstrate broad and deep knowledge of the various populations and program requirements. Our ability to create a seamless experience in the delivery of benefits and services through our subcontractors is rooted in our Delegation Oversight Program, which is designed to achieve the WellCare of Kentucky goals related to rigorous oversight of subcontractors.

In order to ensure quality services are provided to enrollees and providers, it is our policy to thoroughly evaluate and certify work performed by subcontractors. Our formal evaluation occurs prior to initiating delegation with a prospective subcontractor and annually thereafter. Our monitoring of subcontractor performance and compliance is a formal, ongoing process that occurs throughout the year. Through our monitoring and oversight, activities we conduct include:

- Evaluating prospective subcontractors' abilities to perform activities to be delegated

- Ensuring subcontractors are financially stable through annual financial solvency audits coordinated by our Delegation Oversight team and conducted by our Finance Department
- Executing written contracts with subcontractors specifying the activities and reporting responsibilities delegated to the subcontractors and providing for the revocation of delegation or other sanctions if subcontractors' performance is inadequate
- Conducting pre-delegation audits after contracting and before the effective date to evaluate if subcontractor's policies and procedures demonstrate the ability to perform activities as per contractual and regulatory requirements coordinated by our Delegation Oversight team
- Monitoring performance with the same rigor previously outlined through our Claims Command Center. Additionally, our subcontractor is held to a minimum quality and accuracy standards. Their compensation structure rewards them for better quality and penalizes them for poorer quality. Monitoring subcontractor performance on an ongoing basis and subject them to formal review according to a periodic schedule consistent with industry standards
- Conducting annual audits that include review of data universes to determine adherence with contractual and regulatory requirements coordinated by our Delegation Oversight team
- Initiating focused audits as risks and/or non-compliance are identified, these audits are conducted by our Delegation Oversight team
- Continuous monitoring of subcontractor's performance and adherence to regulatory requirements through receipt of monthly self-reported scorecards independently evaluated by our Delegation Oversight team
- Identifying deficiencies or areas for improvement and issuing corrective action plans

PHARMACY VENDOR

WellCare's pharmacy operation is a hybrid model with a number of critical pharmacy functions performed in-house by WellCare personnel coupled with services performed by our contracted pharmacy benefits manager (PBM) CVS. Under our hybrid model, we retain in-house responsibility for coverage determinations, redeterminations, formulary development and management, Pharmacy and Therapeutics (P&T) Committee, quality, retrospective drug utilization reviews, rebates, medication therapy management, and enrollee and provider calls. Our PBM is responsible for pharmacy claims, pharmacy network development and explanations of benefits.

MEDICAL AND BEHAVIORAL HEALTH CLAIMS VENDOR

Concentrix, our medical and behavioral health claims processing vendor, uses WellCare's single integrated management information system (MIS) and claims processing workflows are designed to accurately process all claim submissions. WellCare's new claims processing control tool called Claims Path, is designed to prioritize claims according to age, priority with the distinction of Professional and Institutional claims. Through claim prioritization, flexible work queue design, processor skill set matching, and automated work delivery, Claims Path brings greater real time operational efficiencies in day-to-day claims operations. It provides all levels of the management team with improved visibility and control over dedicated claims

management activities and streamlines the claim processors' tasks. Our Claims Command Center oversees and manages our claims turnaround dashboard, to ensure compliance with the required timeframes for claims processing. The dashboard is updated daily upon completion of each check run and reflects the percentage of claims processed within each of the State of Kentucky's timeliness requirements. This capability allows us to meet or exceed timeliness and accuracy standards specifically for our provider claims.

DENTAL AND VISION VENDOR

WellCare has extensive experience coordinating care with entities that have a special expertise in managing dental benefits for Medicaid enrollees. We believe we serve as an asset to our contracted Dental Benefits Manager by leveraging the power of primary care physicians (PCPs) to facilitate strong preventive care and referral to ensure enrollees get the oral and vision health care they need. Day to day operations are managed and overseen by our Network Performance team. In addition, our Delegation Oversight team conducts monitoring through annual audits, focused audits as needed based on risk and identified issues, and review of monthly self-reported metric-based scorecards. Adherence with regulatory requirements, such as timeliness, are independently evaluated by the Delegation Oversight team through file reviews during annual and focused audits. Avesis, our dental and vision vendor reports their performance scores to WellCare of Kentucky monthly to ensure all standards are met.

ENSURING SUBCONTRACTS COMPLY WITH REIMBURSEMENT RATE REQUIREMENTS

Our dedicated Claims Audit unit, a team independent of our Claims and Delegation Oversight teams yet highly integrated, is responsible for ensuring our subcontractors comply with reimbursement rate requirements. They do so using a variety of methods, including:

- *Contracts:* WellCare's contracts contain specific language detailing the requirements for reimbursement rates. The language specifies that subcontractors' contracts must not contain terms for reimbursement at rates that are less than the published Medicaid fee for service rate in effect on the date of service.
- *Contract Enforcement:* WellCare uses the contract to enforce financial and payment accuracy requirements. We develop corrective action plans (CAPs), track adherence to these CAPs, and perform a second audit. Subcontractors who continue to perform poorly are subject to further disciplinary action including revocation of claims payment functions.

ENSURING ONGOING SUBCONTRACTOR PERFORMANCE AND COMPLIANCE WITH CONTRACT STANDARDS

WellCare's success with subcontractor oversight begins with the pre-delegation process and continues with a collaborative performance management system. Delegation Oversight's audit and monitoring activities include, but are not limited to, the following:

- Executing the Delegation Oversight audit and monitoring plan, including cross-functional collaboration to monitor the subcontractor's operational metrics
- Performing analysis and trending of data submitted by subcontractors to identify potential anomalies and areas of non-compliance

- Confirming on a monthly basis that subcontractors remain eligible for participation in the Medicaid and Medicare programs
- Ensuring that written agreements with each subcontractor are maintained and clearly specify the entities' responsibilities, reporting requirements, and appropriate State and Federal clauses

CONTINUOUS MONITORING OF SUBCONTRACTOR PERFORMANCE TO ENSURE CONTRACT COMPLIANCE

WellCare formally monitors subcontractor performance real-time. WellCare monitors and trends transactional data then analyzes results of monitoring and auditing activities and solicits appropriate corrective action plans when deficiencies are identified. WellCare has a suite of reporting tools that allow transparency into monitoring and auditing activities performed, status of audits and monitoring plans, metrics on outstanding corrective action plans, and trending of subcontractor performance through scorecards. This layered approach to oversight allows WellCare to ensure subcontractors are performing in accordance with contract provisions. WellCare conducts monthly Joint Operating Committee (JOC) meetings with national subcontractors to monitor performance with key performance indicators, communicate critical information and provide performance feedback – WellCare to the subcontractor and subcontractor to WellCare. JOC meetings are specific to the functions delegated and include participants from the subcontractor, National Ancillary, Enrollee Services, Encounters, Delegation Oversight, Clinical Services, Claims, and Compliance.

i. Policies and procedures to meet performance standards and prompt pay requirements for all provider types.

WellCare understands that prompt payment of claims is important to our providers. This is evidenced by our 95% compliance rate average (as reported to the Kentucky Department of Insurance for the 1st and 2nd Quarter of 2019) with Kentucky's prompt payment rules. To ensure we continually adhere to Kentucky's prompt pay guidelines, WellCare employs a robust claim adjudication process that incorporates claim editing guidelines ensuring that "clean" claims are paid or denied within the statutorily required 30 day timeframe. We house hundreds of policies and procedures regarding specific Kentucky Medicaid provider types with direct references and links to specific Medicaid billing guidelines and regulations (including prompt pay). These policies and procedures are contained within a central repository for all Claims staff to access. Additionally, all of our Claims staff are notified of any changes to these documents with material information changes communicated by live training and team meetings. Our core policy and procedure for prompt pay is located in **Attachment C.19.b.i Policies and Procedures.**

ii. Market specific strategies for addressing potential provider payment issues, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education.

As an incumbent in Kentucky for the last eight years, we have learned that having a local, high-touch model is critical to addressing provider payment concerns from our providers. Our local

teams, in collaboration with our Claims Department, work diligently to address any issues brought to our attention. Our strategy is focused around our Provider Engagement Model.

Having built and maintained a comprehensive and diverse statewide network of providers over our eight years as an MCO for Kentucky's Medicaid Managed Care program, WellCare of Kentucky has developed a trusting relationship with our network providers by ensuring they have the support they need to provide the highest quality of care to the Enrollees they serve. Over that time we have developed and refined our Provider Engagement Model (PEM), one that combines "high touch" with "high tech" through a combination of the most extensive physical presence of any MCO in the Kentucky Medicaid Managed Care Program along with 24/7 provider support available through multiple channels. It includes:

- Six regional offices throughout the Commonwealth staffed with experienced and dedicated provider relations representatives who live in, work in, and understand the communities they serve
- Quality and Operations staff dedicated to supporting network providers and available to assist in meeting program quality goals and resolving payment issues at the individual provider or system level

The centerpiece of the WellCare Provider Engagement Model is the Provider Relations (PR) Representative. Our PR Representatives are based throughout the state, working out of our six regional offices. These individuals serve as the primary point-of-contact for network providers focusing on primary care, behavioral health, and specialty care. Every provider has a dedicated PR representative responsible for supporting his or her practice or center.

Understanding that different types of providers face unique challenges, WellCare of Kentucky has four specialized PR representatives called Hospital Service Specialists (HSS) dedicated solely to supporting the 149 hospitals in our network. HSS team members are typically recruited from institutions so they are more familiar with their operating model and their unique support needs. The HSS team typically conducts monthly Joint Operating Committee (JOC) meetings with each institution in which an interdisciplinary team from both the institution and WellCare work collaboratively to review financial performance, quality metrics, pharmacy utilization, and any potential provider payment issues, including but not limited to underpayments, overpayments, pre-and post-claims editing policies and provider billing education.

To ensure effective and efficient support of all issues, PR representatives and HSSs engage various professionals at WellCare of Kentucky who are tasked to perform specific functions on behalf of network providers. In addition to Operations Account Representatives (OARs), this includes Patient Care Advocates (PCAs), Provider Operations Coordinators (POCs) and the Claims Resolution Team:

- *Operations Account Representatives (OARs)* are experienced claim professionals who conduct billing education and are empowered to efficiently resolve issues, including the ability to perform real-time, on-site claims adjustments at provider offices. OARs monitor claim utilization and denial rates and provide one-on-one training when billing errors are identified. The OAR team in Kentucky is led by Julie Crousore. This team attends calls with

providers and meets face-to-face during events like our Provider Summits to make adjustments and correct issues in real-time if possible.

- *Provider Operations Coordinators (POCs)* led by our Director of Provider Operations, Pat Russell in Kentucky, work to assure accurate and timely loading of all provider contracts and demographic data. They routinely reconcile provider rosters with our systems to make updates needed to provider records. They interface directly with providers along with PR representatives.
- *Claims Resolution Team* members research complex claim issues including applicable state and federal policy to ensure the market is accurately applying claims policies. The team, under the leadership of Elizabeth Caudill, is engaged any time we encounter a claims dispute trend where there is conflicting information or ambiguity on how the policy should be applied and we need to perform more comprehensive research on the appropriate implementation of payment policy.

It is this dedication to prompt, direct, and accountable provider service--from a coordinated team of highly skilled, locally-based provider relations representatives--that has resulted in WellCare of Kentucky earning the highest provider satisfaction of any MCO in the Commonwealth. Going forward, we are committed to maintaining that standard and continuing to look for new ways to better support our providers and resolving any potential provider payment issues as expeditiously as possible.

UNDERPAYMENTS, OVERPAYMENTS, PRE-AND POST-CLAIMS EDITING POLICIES AND PROVIDER BILLING EDUCATION

WellCare utilizes claims editing technology through industry-leading partners, Optum and Cotiviti, for payment accuracy solutions. By evaluating medical claims prior to the check cycle against the thousands of correct coding edits maintained by our vendors, we achieved $8.90 in savings (avoided overpayments) per member per month in 2019 across all Medicaid markets. We established claims editing policies which include:

Auto Denials – Edits based on industry standard correct coding, state, and national policy to detect claims that deviate from established payment policies.

Pre-Pay Analytics – Predictive analytics engine that generates a quantifiable improper payment risk score for every claim submitted. Examples include NCCI, MUE, duplicates and established payment policies. Simultaneously, it utilizes multiple improper billing variables to compare provider billing practices to peers as well as their own previous billing history.

Provider Peer Review – Board Certified physicians using an advanced analytic engine look at our historical professional claims data and identify providers with high cost surgical claims or that have atypical billing patterns based on targeted CPT codes and request medical records for review.

Fraud Waste and Abuse (FWA) - Methods are in place to detect and prevent waste and error through auto denials, prepay analytics (algorithms, provider flags, predictive modeling, medical record review), provider peer review (specialized medical reviews addressing atypical billing patterns). A component to our FWA detection is the continuous ideation cycle that evaluates claims payment trends for new and questionable billing practices.

Overpayments- In addition to the edits which are in place prior to claim payment for correct coding, clinical edits, and fraud, waste, and abuse edits, WellCare's overpayment identification process continually reviews claims for potential overpayments. This process includes determining whether other primary coverages (coordination of benefits) may exist for the enrollee, our post-payment fraud, waste, and abuse validations, and other payment review processes to identify overpayments and potentially fraudulent submissions. The recovery team tracks and reports on all claims in both detailed (claim level) and aggregate levels. WellCare understands and will meet the requirements of overpayments as specified in 42 C.F.R. § 438.608(a) (2). We will coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in Medical Loss Ratio (MLR) calculations and capitation rate setting. An overpayment can occur due to reasons such as retroactive enrollee termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, and non-covered benefit(s) among others. WellCare proactively identifies and attempts to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, we follow the contracted time frame for participating providers, for non-participating providers we follow DHHS recovery guidelines. In all overpayment instances, we send out a notification letter to providers before recovery. To remain compliant at all times, WellCare will report overpayments of potential fraud promptly to the state according to 42 C.F.R. § 438.608(a) (2).

Underpayments - In the instances that underpayments are identified due to retroactive rates, enrollee eligibility, or notification of other insurance, WellCare of Kentucky processes adjustments in compliance with state regulations to ensure providers are made whole. Our comprehensive claims processing system has the ability to do mass adjustments of adjudicated claims with any specified criteria either at the Department's request or WellCare of Kentucky's discretion.

Provider Billing Education

Understanding the unique billing issues faced by providers transitioning from fee for service to managed care, we employ our "high tech, high touch" Provider Engagement Model (PEM) as discussed in detail above, which combines extensive local staff supports, meeting providers where they are, with high-tech web-based tools.

High-Touch: The centerpiece of the WellCare Provider Engagement Model is the locally based Provider Relations representative (PR Rep). These individuals live in their assigned region and serve as the primary point-of-contact for network providers. Our PR Reps are supported by our local Operations Account Representatives (OAR), who are experienced claim professionals who conduct billing education for all providers through in-person classroom, Webinar, and on-line training to ensure that all providers understand how to effectively process and submit clean claims. OARs are empowered to efficiently resolve issues, including on-site claims adjustments at provider offices. When a provider presents a claims issue to his or her Provider Representative, the Representative is able to access an OAR team member to address the issue. If the matter can be resolved with no additional research, the OAR team member has the authority to immediately process the claim for adjudication. If further research is required, the OAR team member handles the matter until it is resolved, keeping both the provider and PR

Representative informed of the actions being taken. In addition, if further training of the provider or staff is required the OAR arranges for and performs the training until the provider is confident they understand how claims submission works and is successful in the process.

The OAR team specializes in Operational issues related to the provider. The OAR team strives to ensure that Providers are being reimbursed accurately for their services. What makes the OAR team unique is their ability to process adjustments on claims locally in the market. This allows the provider to receive quick and efficient turnaround time. In addition, to prevent errors from reoccurring, they can analyze, identify and correct the root cause in some cases or work directly with the teams that can make the correction. The OAR team member handles the matter until it is resolved, keeping both the provider and PR Representative informed of the actions being taken. In addition, if further training of the provider or staff is required the OAR arranges for and performs the training until the provider is confident they understand how claims submission works and is successful in the process. With the support of the OAR team, our year to date Claims Adjustments Rate for Kentucky is 2.45%.

Finally, we also have a dedicated Provider Claims Services Center for telephonically handling most claim disputes and provider billing inquires with the ability to make adjustments in real time with no additional transfer or callbacks required. This service is readily available to all providers. Provider Support Service associates receive an additional 160 hours of training specific to claims and can make real time adjustments to a claim if an error is detected. The success of our "one-touch" process is demonstrated by our year to date first call resolution rate of 92.9% in Kentucky, 91% in Nebraska and 90.6% in Missouri.

A large orthopedic practice in Northern Kentucky submitted a termination notice siting numerous unresolved claims issues with WellCare. The OAR team along with the PR team held numerous onsite and teleconference meetings with this provider and assisted their billing team with each claim to determine if there was an error in the payment or an error in the billing. Within a few weeks of these meetings occurring, the practice rescinded their termination notice and the relationship strengthened. The OAR team was able to adjust some claims for the Practice as well as share educational opportunities with the Practice so that they could submit corrected claims for payment. The OAR and PR team continues to meet monthly with this group, however there are minimal concerns brought to the meetings

High-Tech: We use our on-line tools and resources for provider education to support our PEM. Our approach to provider education is thoughtful and delivered using the same formats we use for our own associates. They have access to a library of self-directed on-line training including billing procedures, claims processing, and payment timeframes (how to file a claim, how to submit a correct claim, electronic funds transfer, and electronic remittance advices for claims payment), dispute resolution process and timeframes (how to file an appeal if a claim is denied, complaints and grievances). Our enhanced provider portal includes a "chat session" feature, allowing providers to obtain assistance in real-time with claims or other issues. We take a consultative and supportive approach with providers, offering them Performance reporting such as Provider Report Cards and Portal Claims Interface Reports (this interface allows medical

homes to view all claim data at the Enrollee level for each service provided in any modality.), which they can access anytime through the portal.

iii. Proposed average days to payment from claims submission for the Vendor's proposed claims platform for medical and pharmacy claims. Provide the Vendor's last calendar year's report on the "average number of days to pay providers."

MEDICAL

WellCare of Kentucky proposes to pay or deny professional medical claims within 10 calendar days from claim receipt on average. WellCare of Kentucky proposes to pay or deny institutional medical claims within 15 calendar days from claim receipt on average. Last calendar year, 2018, WellCare of Kentucky had an average of less than 10 calendar days for professional claims and less than 15 calendar days for institutional. We are confident we can meet or exceed this goal based on our experience doing so across our 12 existing Medicaid programs. We leverage our mature processes and systems, as described above, to pay claims accurately and timely and in compliance with the Department's prompt pay standards.

PHARMACY

We propose to pay or deny pharmacy claims within 10 calendar days from claims on average. Our pharmacy provider payment process is automated so that we adhere to all state and federal prompt pay guidelines. In the event a claim is paid beyond those guidelines, applicable interest is automatically calculated and paid.

LAST CALENDAR YEAR'S REPORT

Attached please find our Claims Report in **Attachment C.19.b.ii Claims Report** reflecting our Claims processing time and our TAT for 2019.

c. Describe the Vendor's methodology for ensuring claims payment accuracy standards will be monitored and improved through audit. At a minimum, address the sampling methodology, the process for auditing the sample, documenting of results, and activities

PROCESS OF AUDITING CLAIMS

A critical component of continuous claims process improvement is our auditing function. We perform claims audits in accordance with all applicable rules and regulations. The audit program is designed to minimize risk by increasing the accuracy of claims processing through performance feedback and root cause analysis. This program identifies deficiencies and works to resolve them for improved claims processing and payment. A dedicated Claims Audit team is responsible for reporting the financial accuracy of medical claim payments. This internal control activity supports early detection and corrective action of potential financial risk. Our independent registered accounting firm (Deloitte & Touche, LLP), internal audit team and senior management of WellCare monitor the findings. The objectives of the Claims Audit team are to provide reports that assist in effectively trending payment accuracy, to identify payment

and financial accuracy measures for root cause analysis, and to request and monitor corrective actions.

Our skilled Claims Audit Specialists audit pre- and post-adjudicated claims against processing requirements that vary by audit type referenced below. In addition to being master researchers, our auditors are specialists in the market they are auditing. Annually, our Claims Audit team performs a financial accuracy audit of all subcontractors' delegated claims payment. As part of this review, the Claims Audit team checks for proper reimbursement at rates specified by the provider contracts and the contract with WellCare. If the subcontractor's financial accuracy and payment accuracy scores do not meet expected performance levels of 99% and 95%, respectively, a second audit is performed. If the reaudit produces unacceptable accuracy scores, the subcontractor is placed on corrective action and monitored through the Delegation Oversight Committee. Claims to audit are assigned by state, product and audit type. Audits are assigned and stored in our audit repository. Auditors assess errors of three different types: financial (dollar impact), payments (incorrect payment results) and clerical (non-financial) levels.

The following types of audits are performed by the WellCare Claims Audit team:

Sarbanes-Oxley Compliance Audit (SCA): The SCA process is designed to ensure the system logic complies with state and federal guidelines, designated contracts, changes approved by management (in the form of business decisions) and department processes and procedures. The SCA process also ensures that decision documents are approved within our compliance guidelines and that all items are implemented appropriately.

User Compliance Audit (UCA): UCA's are conducted to identify opportunities to improve financial accuracy through the clarification of training and desk procedures and staff training as well as associate performance management.

Targeted Compliance Audit (TCA): TCA's are performed on new operating activities or areas of concern.

High Dollar: This audit is a pre-payment review on claims with a net paid amount of over $100,000 and is performed to minimize the financial risk on high dollar claims by validating the payment amount before the claim adjudicates.

Delegated Entity (DE): The DE audit works directly with the Delegation and Oversight team to ensure payment accuracy for our delegated vendors. We monitor compliance with applicable standards in accordance with federal and state requirements. WellCare has established the Delegation Oversight Committee (DOC) to be responsible for functions that we delegate to third parties. The DOC must ensure appropriate performance measures are in place to ensure we can accurately assess whether delegated entities are in compliance with federal and state requirements.

SAMPLING METHODOLOGY

Our Claims Audit sampling methodology varies by audit type to ensure proper monitoring and drive improvement.

Sarbanes-Oxley Compliance Audit (SCA): A statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- five percent (5%), assuming an error rate of three percent (3%) in the population of managed care claims comprises the monthly audit sample. The additional level of stratification by dollar amount allows a complete representation to ensure all claims according to amount paid are equally reviewed.

- Sampling methodology for Sarbanes-Oxley Audit:
- 80 claims per State are selected randomly based on the prior month universe of claims
- The sample is stratified to include 20 claims by claim type and dollar stratum:
    - 20 Professional Claims </= $100 Paid
    - 20 Professional Claims > $100 Paid
    - 20 Institutional Claims </= $1000 Paid
    - 20 Institutional Claims > $1000 Paid

User Compliance Audit (UCA): A statistically valid sample of paid or denied claims is pulled for both WellCare of Kentucky claims examiners and subcontractors. The sample for our internal staff is pulled weekly, by associate, to be able to give timely feedback on quality. A Quality goal of 99% financial accuracy is part of each associate's performance rating. Claims examiners that meet the quality and productivity goal are provided bonus quarterly. Our subcontractor UCA sample is pulled monthly by subcontracted site.

Targeted Compliance Audit (TCA): Methodology and sampling varies based on the target being performed. Target audits are generally based on a statistically valid sample of both paid and denied claims talking into account a ninety-five percent (95%) confidence level and assumption error rate of five percent (5%).

High Dollar: The sample includes 100 percent of Pre-paid claims with a paid amount greater than $100,000.

Delegated Entity (DE): A random sample of 200 claims is selected for each entity. The sample time period is from the time of the last sample through current.

DOCUMENTING RESULTS

At WellCare, we have multiple methods for monitoring performance and ensuring transparency. These include Operation dashboards, Reports sent to Senior Management and the comprehensive scorecards generated for individual markets.

In an effort to assist the operational units with the management of identified claims risk, the Claims Audit department uses an application to record mitigation plans. Payment errors are logged and tracked in the centralized audit tool called the Audit Workbench to ensure corrective actions and mitigation plans have been provided. A report of all affected claims is also created and tracked to verify that appropriate action was taken on all impacted claims.

This application is used by all areas of operations in tracking the root cause and mitigation plan for claim payment errors identified through our audit processes. The application includes a module for generating control reports to identify the final disposition and corrective action of the error.

The process used to record the error disposition and action plan within the application is as follows:

- The Claims Audit team enters payment errors daily.
- The operational unit responsible enters the root cause and mitigation plan for each error.
- The overall dollar amount and claims volume resulting from the error are entered to determine the impact and track the correction of the erroneous payments. Each mitigation plan explains the process of updating or adjusting the correct claim payments in WellCare's system, and if necessary, the Payment Recovery Team will issue a work order ticket to collect any erroneous payments.
- Errors will remain open until the mitigation plan has been completed and all necessary claim adjustments have been made.

Claims Audit associates validate that risk mitigation plans are complete which are important elements in completing corrective actions are. All of this activity is captured in the Audit Workbench tool. Depending on the severity of the risks, a mitigation process is planned. Once the risks are identified, weekly meetings are held by the Claims Audit and Operations teams to review the status of necessary actions. The pending risks are presented to area management or senior management for mitigation. Finally our IT department completes a monthly report that tracks mitigation plan action log activities and open items.

Overall, the audit results can lead to adjustment of claims, root cause determination and corrective action plans. The action plan and the claims to be adjusted are monitored through the Open Action Log and adjustment reports.

Claims Financial Accuracy

Claims financial accuracy measures the accuracy of dollars paid to Providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. WellCare of Kentucky has a goal of ninety nine percent (99%) financial accuracy. We have successfully met this goal for our KY SCA sample with a 99.1% in 2018 and 98.5% year to date in 2019.

Claims Payment Accuracy

Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed. WellCare of Kentucky has achieved 96.25% payment accuracy in 2018 and 96.9% payment accuracy year to date 2019 for our KY SCA sample.

Corrective actions

Our Claims Audit department is a key control to mitigating claims financial risk in coordination with Internal Audit. Quarterly, a risk area summary report is reviewed by the Risk Champion (the area leader champions the mitigation plan) to ensure that WellCare's Enterprise Risk Management (ERM) plan is up to date. The ERM report shows that in our risk assessment management plan each risk event has a representative risk mitigation activity, key performance indicators and acceptable range or target to measure success. The Claims Audit department, in

its monthly executive performance report, will rely on corrective action management reports to document and direct corrective actions. The errors are identified in the dashboard which is shared with Operations and Executive teams monthly as it relates to identified claims accuracy errors controlled through an Audit Tool. The log of claim errors that have mitigation plans on file and those that have yet to be completed is also shared with the Executive team.

C.19 Provider Payment Provisions

- Attachment C.19.b.i Claims Policies and Procedures
- Attachment C.19.b.ii Claims Report

State Addendum E:	Kentucky
Policy Name:	Prompt Pay
Policy Number:	C6-CL-MD-006
State Approval Date:	N/A

Kentucky State Specific

Definitions:

Claim: A "claim" means any: bill for services, line item of service, or all services for a Member within a bill.

Clean Claim: Pursuant to Kentucky Revised Statute (KRS) 304.17A-700, "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

1. A clean claim from an institutional provider shall consist of:
    a. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
    b. Entries stated as mandatory by the NUBC; and
    c. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.
2. A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
3. A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs.
4. A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

Policy:

A. In accordance with the Balanced Budget Act ("BBA") Section 4708, WellCare shall implement Claims payment procedures that ensure 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims. In addition, WellCare shall comply with the Prompt Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended. Any conflict between the BBA and Commonwealth law will default to the BBA unless the Commonwealth requirements are stricter.

In accordance with Kentucky Managed Care Organization (MCO) Contract Section 30,2, "Prompt Payment of Claims", in accordance with 42 C.F.R. 447.46, WellCare shall comply with the timely claims payment requirements of 42 C.F.R. 447.45. WellCare shall implement Claims payment procedures that ensure 90% of all Provider Claims, including to I/T/Us, for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims. In addition, WellCare shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and KRS 304.99-123, as may be amended. The date of receipt is the date the MCO receives the claim, as indicated by its date stamp on the claim or other notation as appropriate to the medium used to file a claim and the date of payment is the date of the check or other form of payment. WellCare shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested. Any conflict between federal law and Commonwealth law will default to the federal law unless the Commonwealth requirements are stricter.

In accordance with Kentucky MCO Contract Section 30.1, "Claims Payments", WellCare shall only accept from providers the uniform claim forms approved by the Department and completed according to Department guidelines.

B. Claim payment time frames pursuant to KRS 304.17A-702:

1. Except for claims involving organ transplants, WellCare shall reimburse a provider for a clean claim or send a written or an electronic notice denying or contesting the claim within thirty (30) calendar days from the date that the claim is received by WellCare or any entity that administers or processes claims on behalf of the WellCare. Clean claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the claim is received by WellCare or any entity that administers or processes claims on behalf of WellCare.

2. Within the applicable claims payment time frame, WellCare shall:

   a. Pay the total amount of the claim in accordance with any contract between WellCare and the provider;

   b. Pay the portion of the claim that is not in dispute and notify the provider, in writing or electronically, of the reasons the remaining portion of the claim will not be paid; or

   c. Notify the provider, in writing or electronically, of the reasons no part of the claim will be paid.

C. WellCare shall pay interest if it fails to pay, deny, or settle a clean claim as required pursuant to KRS 304.17A-730. The interest obligation shall not apply if the failure to pay, deny, or settle a claim is due to, or results from, in whole or in part, acts or events beyond the control of WellCare, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbance, riot, or complete or partial disruptions of facilities.

D. Acknowledgment of receipt of claim, inaccurate or insufficient claim information, and claim status information pursuant to KRS 304.17A-704:

1. Within forty-eight (48) hours of receiving an original or corrected claim submitted electronically, WellCare, its agent, or designee shall acknowledge the date of receipt of the claim by an electronic transmission to the provider, its billing agent, or designee that submitted the claim;

2. Within twenty (20) calendar days of receipt of an original or corrected claim submitted by mail or other non-electronic means, WellCare, its agent, or designee shall acknowledge the date of receipt of the claim to the provider, its billing agent, or designee that submitted the claim.

   i. For claims containing all necessary information and having no errors, WellCare shall make available confirmation of receipt of the claim to the provider, its billing agent, or designee that submitted the claim. Acknowledgment may be in writing or WellCare, its agent, or designee may list the claim and date it was received on a file that can be accessed electronically by the provider, its agent, or designee.

   ii. Claims that contain errors or lack necessary information shall be acknowledged by an electronic transmission or in writing to the provider, its billing agent, or designee that submitted the claim.

3. At the time of acknowledgment under paragraph (a) or (b) above, WellCare, its agent, or designee, shall notify the provider, its billing agent, or designee that submitted the claim, in writing or electronically, of all information that is missing from the billing instrument, any errors in the billing instrument, or of any other circumstances which preclude it from being a clean claim.

4. When WellCare, its agent, or designee has notified a provider, its billing agent, or designee that submitted the claim, that a claim contains errors, upon receipt of a corrected clean claim WellCare shall adjudicate the corrected clean claim within the applicable claims payment time frame for a clean claim established in KRS 304.17A-702.

5. WellCare shall inform providers of the status of a claim either through:

   - Notation on the remittance; or
   - Allowing providers to check claim status electronically at any time following an electronic submission of the claim to WellCare, or by contacting WellCare for claims submitted non-electronically.

E. Ninety five percent (95%) of all clean claims shall be paid or denied within 30 calendar days of receipt of the claim. Ninety-nine percent (99%) of all clean claims shall be paid or denied within 90 calendar days of receipt of the claim. Claims paid beyond the 30th day shall be subject to interest payments beginning the 31st day, with the exception of claims involving organ transplants.

F. Pursuant to KRS 304.17A-730, payment of Interest on Clean Claims, with the exception of clean claims involving organ transplants, shall be as follows:

1. For claims that are paid between one (1) and thirty (30) days from the date that payment was due under KRS 304.17A-702, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under KRS 304.17A-702;

2. For claims that are paid between thirty-one (31) and sixty (60) days from the date that payment was due under KRS 304.17A-702, interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due under KRS 304.17A-702; and

3. For claims that are paid more than sixty (60) days from the date payment was due under

   KRS 304.17A-702, interest at a rate of twenty-one percent (21%) per annum shall accrue from the date that payment was due under KRS 304.17A-702.

G. Clean claims involving organ transplants:

In accordance with 806 KAR 17:360, WellCare shall be in compliance with KRS 304.17A-702(1) for a clean claim involving an organ transplant if the claim is paid within:

(a) Sixty (60) days of receipt of the claim; or

(b) Three (3) business days of the check date if the check issued for payment of the claim is dated on the 58th, 59th, or 60th day after the claim is received.

Clean claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the claim is received by WellCare or any entity that administers or processes claims on behalf of WellCare.

H. Payment of Interest on clean claims involving organ transplants:

- Twelve percent (12%) annual interest is to be paid on all clean claims paid between the 61st and 90th date of receipt.
- Eighteen percent (18%) annual interest is to be paid on all clean claims paid between the 91st and 120th date of receipt.
- Twenty-one percent (21%) annual interest is to be paid on all clean claims paid on or after the 121st date of receipt.

Summary of Applicable Guidelines and Procedures:

- Claims are to be processed in accordance with the terms of the member's plan of benefits, the provider's contract with WellCare, and WellCare authorization requirements. The Benefits Master List ("BML") can be accessed at the below link:

  http://wellcareportal.wellcare.com/Operations/BenefitsDetermination/Pages/Home.aspx

- Authorization requirements may be found in the:
  - Quick Reference Guide (QRG) located at:

    https://www.wellcare.com/Provider/QuickReferenceGuides

  - Authorization Lookup Tool located at:

    https://www.wellcare.com/Kentucky/Providers/Authorization-Lookup

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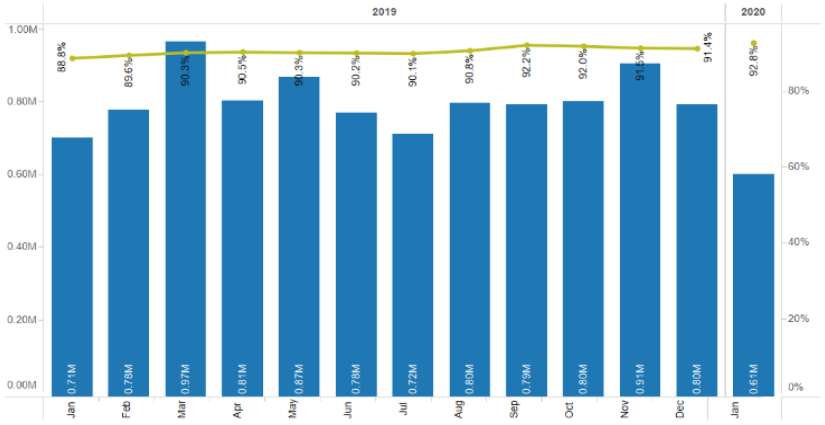
Claims Operations ScoreCard

Operations Reporting & Analytics

Refresh Date:Thursday, January 23, 2020

Date: Last 2 years | Product: Medicaid | State: Kentucky

Total Claims & Blended AA Rate



Adjudication Rate

	2020 Auto Adjudicated			2020 Manual	2019 Auto Adjudicated			2019 Manual
	Core Adjudicated	Scripted	Bots	Manual Rate	Core Adjudicated	Scripted	Bots	Manual Rate
Jan	72.1%	18.6%	2.1%	7.2%	72.0%	14.6%	2.2%	11.2%
Feb					73.1%	14.4%	2.2%	10.4%
Mar					73.9%	13.7%	2.6%	9.7%
Apr					73.3%	14.6%	2.6%	9.5%
May					68.2%	19.3%	2.8%	9.7%
Jun					72.6%	14.6%	3.0%	9.8%
Jul					71.8%	15.9%	2.3%	9.9%
Aug					71.5%	17.5%	1.8%	9.2%
Sep					71.2%	18.9%	2.1%	7.8%
Oct					72.9%	17.3%	1.7%	8.0%
Nov					71.1%	18.7%	1.7%	8.5%
Dec					70.3%	18.6%	2.5%	8.6%
Total	72.1%	18.6%	2.1%	7.2%	71.8%	16.5%	2.3%	9.3%

Total Claims Processed

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2020	606,389												606,389
2019	705,932	782,024	967,797	805,714	871,559	775,268	715,439	800,295	794,930	804,678	906,777	795,117	9,725,530

Avg Turnaround Time

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2020	6.1												6.1
2019	7.8	8.6	7.0	6.6	6.9	6.7	6.8	6.6	6.6	6.9	7.2	6.6	7.0

EDI Rate

Claims TAT

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2020	0 - 10 Days	91.7%												91.7%
	11 - 20 Days	5.4%												5.4%
	21 - 30 Days	2.9%												2.9%
	31+ Days	0.1%												0.1%
2019	0 - 10 Days	87.2%	86.5%	90.4%	89.7%	88.5%	88.6%	89.7%	90.0%	90.2%	90.8%	89.0%	89.8%	89.2%
	11 - 20 Days	2.8%	6.4%	2.5%	3.6%	5.9%	7.3%	5.4%	5.2%	3.6%	2.1%	2.1%	3.9%	4.2%
	21 - 30 Days	8.3%	5.5%	6.2%	5.8%	4.3%	3.4%	4.5%	4.4%	5.3%	5.5%	8.0%	6.1%	5.6%
	31+ Days	1.7%	1.6%	0.9%	0.9%	1.2%	0.7%	0.4%	0.4%	1.0%	1.6%	0.9%	0.3%	1.0%

20. Covered Services

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C.20. COVERED SERVICES

a. **Provide a detailed description of how the Vendor's operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor's response should address:**

   i. Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.

   ii. Approach for coordination with carved-out services (e.g., transportation and transitions to long term supports and services).

   iii. A description of any value-added services the Vendor proposes to provide to Enrollees.

b. **Provide the Contractor's approach to assisting Enrollees to access direct access services and second opinions, and referrals for services not covered by the Contractor.**

c. **Describe the Vendor's proposed approach to the following:**

   i. Interfacing with the Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

   ii. Coordinating with the Department to establish collaborative agreements with state operated or state contracted psychiatric hospitals and other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. Describe potential challenges and methods to address such challenges.

   iii. Complying with the Mental Health Parity and Addiction Equity Act.

d. **Describe initiatives the Contractor will implement to identify trends in provider-preventable conditions and to educate providers who are identified as possibly needing support in better addressing those conditions.**

C.20. COVERED SERVICES

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 30 Covered Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in Attachment X Contract Compliance Matrix, provided electronically. Through our partnership with DMS since 2011, we have provided covered services for Enrollees in the Commonwealth as a leading managed care organization (MCO). As such, we will continue to provide or arrange for the provision of covered services to Enrollees in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of covered services. Our commitment to coordinated care ensures that the care of new Enrollees is not disrupted or interrupted, including the continuity of care for new Enrollees receiving healthcare under fee-for-service (FFS) or transitioning from another MCO prior to enrollment with WellCare of Kentucky.

Today, we proudly serve more than 430,000 Enrollees, their families, and caregivers through six Regional offices across the Commonwealth. The following section describes their covered services and additional areas of Care Coordination support provided by the WellCare of Kentucky team.

a. Provide a detailed description of how the Vendor's operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor's response should address:

Since the beginning of managed care in the Commonwealth, our operational structure and practices have supported the integrated delivery of services across our staff, contractors, systems, call centers, and all available resources to provide a seamless experience for our Enrollees, providers, and DMS. Even back in 2011, we knew that producing the best clinical, quality, and cost outcomes for the Commonwealth required a fully integrated model of care for our Enrollees. That goal meant developing an in-house behavioral health team to better guide the comprehensive care of our Enrollees across the healthcare continuum. Today, our operational structure and integrated care team continues to deliver significant results through this fully integrated approach to care that covers the physical, behavioral, pharmacy, and social services needs of our Enrollees. We accomplish this through our intentional, thoughtful, and local model that addresses the following:

- *Structure and staffing:* Our locally staffed health plan and call centers have been serving Enrollees in Kentucky since 2011. As the largest MCO in the Commonwealth, we have focused since the beginning on a collaborative and transparent partnership with DMS, our providers, community partners, subcontractors, and other MCOs to ensure the highest quality care delivered in the right setting at the right time for all Medicaid Enrollees. This experienced local team is supported by our corporate parent, WellCare Health Plans, Inc. (WellCare) bringing scalability, quicker implementation, and best practices gathered from our 30 years' experience serving Medicaid Enrollees in 12 states. All purpose built to deliver the best outcomes for Enrollees.
- *Integrated technology and data sharing platform:* Our innovative, fully integrated data platforms, CareCentral Care Management system and provider portal, share data in real-time from all internal and external systems, a single claims processing system, e.g., pharmacy, medical, behavioral health data), authorizations, advanced analytics, care plans, care opportunities eligibility, and Admission, Discharge, and Transfer (ADT) feeds, encounters, social determinants of health (SDOH) issues, and our Community Connections database. Single sign on systems and our Enrollee 360 view ensures that everyone who touches an Enrollee understands their whole person needs. We can share data with providers to enrich care plans, value-based contracting, and improve quality.
- *Engagement:* Early, frequent, high touch engagement is core to our model and key to delivering the best outcomes to our Enrollees. We understand that it is critical to find all Enrollees to be able to serve them and we accomplish this early engagement through our Enrollee welcome, on-boarding and initial assessment including engagement of the family or caregiver where applicable. For those Enrollees who are hard to reach or locate we engage our REACH (Unable to Contact) program.

- *Programs:* We deliver rich population and person-centered programs to Enrollees through multiple channels that include medical, behavioral, and social aspects. By in sourcing BH, pharmacy, UM and Enrollee calls our face-to-face programs are custom built for Kentucky based on our in market experience since 2011 partnering and collaborating with DMS, incorporating stakeholder feedback gathered from deep relationships throughout the Commonwealth, participating in multiple high touch forums, summits, and advisory councils. This deep local experience is augmented by our unique, industry leading system custom-built for Medicaid from our 30 years' national experience and includes our unique risk stratification model.

We have One Team and One Goal—to treat the whole person. This approach goes beyond a diagnosis by leveraging our unique Community Connections program to support Enrollees requiring assistance with their social needs (e.g., finances, housing, utilities, group support) to focus on improving their health.

Under the guidance of our leadership team, which includes our Medical Director, Dr. Howard Shaps, and our Behavioral Health Medical Director, Dr. Marketa Wills, the WellCare of Kentucky team leverages both our administrative and clinical expertise through the following operational structures and practices to support the integrated delivery of services.

WELLCARE OF KENTUCKY STAFF

Integrated Care Team (WellCare at Home)

Our fully integrated in-house WellCare at Home care team is cross-trained to manage co-morbid conditions and serve as the Enrollee's whole-person healthcare guide as they navigate and address their physical, behavioral, pharmacy, and social needs. The integrated care team, depicted in **Figure C.20-1**, documents, reviews, and refers to clinical information CareCentral—our integrated clinical platform. A key feature of the platform that aids integration is our Enrollee Care Compass profile, a 360-degree Enrollee view that allows us to address issues with evidence-based interventions and help providers close critical care gaps. We assist Enrollees to access whole person care. This includes accessing their Primary Care Provider (PCP), mental health counselors, opioid use disorder and substance use disorder (OUD/SUD) treatment providers, local pharmacists, and of course, connecting them to vital community resources through our Community Connections program. Community Connections goes beyond traditional managed care to address Enrollees' SDOH needs for housing, healthy food, education, and transportation. Through a single, integrated technology system, we are better able to determine where the most critical needs exist throughout the Commonwealth and improve the lives of our Enrollees.

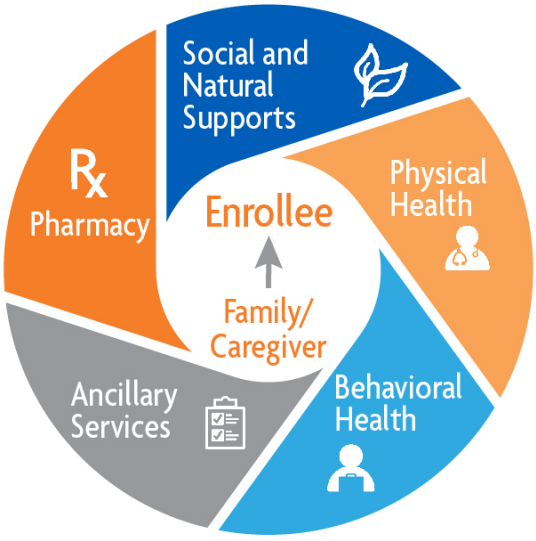

Figure C.20-1 Integrated Care Team

WellCare at Home: Driving Integration

Through coaching and education, Enrollees in care coordination experienced a 22% reduction in emergency department utilization 12 months following their enrollment compared to the 12 month period prior to their enrollment.

Care Coordinators, licensed mental health clinicians (LMHC), work with a multidisciplinary team (MDT) of provider partners, Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FHQC), and hospitals to coordinate follow-up care and facilitate the Enrollee's integrated whole-person needs through a comprehensive, Enrollee-focused care plan. These Enrollee-driven care plans are available in CareCentral and on the provider portal for easy access. Our regionally based integrated care team pods include pharmacists, prevention and population health coaches, community health workers (CHW), quality practice advisors (QPA), patient care advocates (PCA), and community advocates. Our PharmDs collaborate with the utilization management team for Enrollee discharge planning and support Care Coordinators with medication management reviews.

Our goal, while working alongside the Enrollees, PCP, family, specialty providers, OUD/SUD treatment providers, behavioral health counselors, psychiatrists, and others, is to create and maintain an integrated and supportive approach that addresses the Enrollee's complete set of needs, which means not just behavioral health issues but their physical health issues as well. This includes the following:

- *Health Promotion and Wellness.* Our Enrollee-driven prevention education and engagement programs help promote and reward continued healthy lifestyle decision-making as well as encourage those to start. Each prevention and population health program includes foundational elements, such as telephonic and in-person coaching, mailers and reminders, health education information on our website, the Enrollee portal, and MyWellCare smartphone application; text message and email reminders; and social supports through our Community Connections Help Line (CCHL).
- *Assessments and Screenings.* We immediately identify Enrollees who require Care Coordination and disease management using our initial health screening questionnaire. Identified Enrollees then receive a Health Risk Assessment (HRA) to help us accurately capture their information, needs, and care gaps. The HRA is provided on inbound and outbound phone calls including the welcome call as well as on the Enrollee portal. Subsequently, an Enrollee Needs Assessment (ENA) includes a more in-depth, complex screenings for children and adults, assessing them for physical and behavioral health conditions (e.g., depression, anxiety, ADHD, SUD), as well as unmet social needs that may be affecting their health and quality of life. Enrollees identified with serious mental illness (SMI) or serious emotional disturbance (SED), and those with co-occurring OUD/SUD, mental health, and medical needs are automatically enrolled in Care Coordination.
- *ID/Strat and Data Analytics.* Our ID/Strat algorithm uses predictive technology to identify at-risk Enrollees and direct them to the appropriate level of care based on a risk-level of high, medium, or low; variables taken into account include re-admission risk, HRA results, SDOH needs, chronic diagnoses, claims, medication adherence, pharmacy history, and demographics. This confluence of information allows us to identify and connect to Enrollees

using any or all of this data including information like HRAs and medications that are more timely, coupled with less timely but more comprehensive administrative data. We share this data with the MDT through the secure provider portal. Providers have access to care gap and HEDIS quality reports, clinical practice guidelines (CPG) tailored to treating co-morbidities, and receive support, training, and education from our provider engagement team on providing integrated services for our Enrollees.

- *Managing the Multidisciplinary Team (MDT).* Using the Enrollee Care Compass and person-centered care plan as the guide for the whole-person care experience, our CMHC, FHQC, and other provider partners work alongside our integrated care team to provide face-to-face Enrollee Care Coordination interactions whenever possible, participate in MDT meetings and rounds, coordinate referrals across all types of providers (e.g., physical and behavioral, primary care, and specialty care), monitor adjustments to the care plan, and collaborate with community and social support providers.

UTILIZATION MANAGEMENT TEAM

Often, when a company carves out behavioral health, utilization management decisions are determined strictly by mixed-services protocols leading to denials based on silos of care (i.e., the need being labeled as a physical health need or a behavioral health need.) This fragmentation can leave the provider with difficulty navigating between multiple entities and the Enrollee lacking needed care. At WellCare of Kentucky, we do things differently. Our UM nurses and social workers look at Enrollee needs holistically. If a provider is requesting inpatient psychiatric care, we train and alert our social workers to co-morbid physical conditions that may be triggering the Enrollee's psychiatric condition. Our system shows a real-time, single integrated view of the Enrollee regardless of their primary condition. Our UM staff are then able to confer with the MDT of nurses, psychiatrists, and other medical professionals to help the provider determine the best course of treatment and ensure the Enrollee receives clinically guided care to match their specific co-morbidities. And upon discharge, the integrated discharge team creates a plan that addresses both physical and behavioral health needs. Because of our single integrated platform and integrated staff, we can establish medical necessity and facilitate Enrollee transitions without further burdening the providers or Enrollee in the process.

LOCAL LEADERSHIP TEAM

Our leaders remain deeply committed to empowering our regional teams with decision-making authorities based on local knowledge and expertise. The majority of our team that started the managed care program in 2011 remains intact to this day, living and working in the communities we serve. Together, we established our in-house behavioral health team in 2013 and helped DMS expand covered services for the behavioral health community, ensuring that the people of Kentucky in all regions have better access to comprehensive, whole-person care. We broadened the delivery system by bringing CMHCs into our network and educated providers on our new services and claims processes. Today, our colleagues at DMS know our leadership staff, just as our Enrollees know their Care Coordinators and field teams in their local communities.

Our local Kentucky leaders and regional teams across our six offices, depicted in Figure **C.20-2,** have the authority and autonomy to make rapid-cycle decisions, allowing us to be responsive to the comprehensive needs of our Enrollees. For example, the scope of decision-making includes the following:

- Deploying staff and resources throughout the local market to support our Enrollees and providers as we coordinate integrated services for physical and behavioral health, such as field Care Managers, QPAs, PCAs, and provider network professionals
- Managing our provider network to expand access to behavioral health providers, medication-assisted treatment (MAT), and dental services, to name a few
- Allowing for flexibility in the channels of care delivery and communication based on regions and community variances
- Making decisions about value-based purchasing (VBP) programs with our providers to incentivize co-located services that address Enrollee co-morbidities and chronic conditions

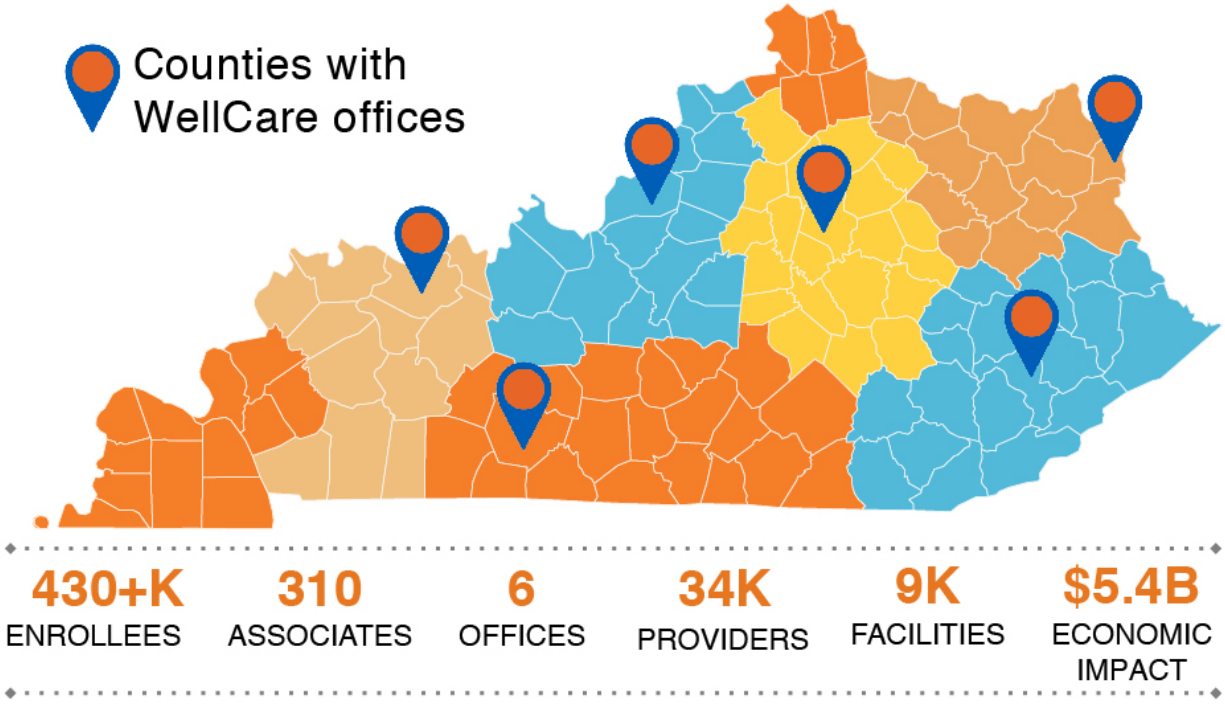

Figure C.20-2 WellCare of Kentucky Integrated Support across the Commonwealth

WELLCARE OF KENTUCKY SUPPLEMENTAL SERVICES

When we made the commitment to develop an in-house behavioral health team back in 2013, WellCare of Kentucky created the capabilities of providing the integrated delivery of services in collaboration with our providers to meet the whole-person needs of our Enrollees. Our highly qualified supplemental service partners complement and enhance the services we provide. We integrate these service providers into WellCare of Kentucky's operational structure to ensure a streamlined experience that addresses their comprehensive, whole-person needs, such as dental and vision.

Our integrated care team coordinates services with local partners when an Enrollee has a need and works to ensure that services with the local provider meet their satisfaction. We store all Enrollee data, including appointments and services provided by local partners in CareCentral, updating the Enrollee's care plan to make it available to the entire MDT. Our Chief Operating Officer (COO), Benjamin Orris, and our Chief Compliance Officer (CCO), Rebecca Randall, oversee the functions and services supplied by our local partners and work to establish processes for the two-way coordination of services and secure exchange of information. For clinical functions, Dr. Wills, Dr. Shaps, and our directors of pharmacy, behavioral health, quality, and population health, work with local partners on the design of a coordinated system to ensure that all parties involved in the care process, including the MDT, access the latest Enrollee date and are working to help them achieve their personal goals and meet their healthcare needs.

For example, since 2011, we have partnered with Avesis Incorporated to coordinate and provide comprehensive dental and vision services for our Enrollees. As these services play a critical role in the overall health of our Enrollee population, our Care Coordinators proactively identify their needs in these areas, particularly for those individuals who have not received dental work or vision correction assistance in the past. We connect them to Avesis services and ensure that we document Enrollee appointments and results in CareCentral. In addition, we co-develop initiatives with our local partners that focus on addressing the integrated clinical needs of our Enrollees. Through a quality outreach program with Avesis, we provide a monthly list of Enrollees who have not received a diabetic retinal eye (DRE) exam. Avesis engages the Enrollees in telephonic outreach and mailings that promote vision health and provide instructions for connecting with their team to receive the annual eye exam.

WELLCARE OF KENTUCKY SYSTEMS

Our fully integrated data platforms, CareCentral and the provider portal, share data in real-time from all internal and external systems, including claims (e.g., pharmacy, medical, behavioral health data), authorizations, care plans, care opportunities eligibility, and Admission, Discharge, and Transfer (ADT) feeds, encounters, SDOH issues and our Community Connections database. We developed CareCentral in house to meet our specific needs and store all behavioral health, physical health, utilization management, and authorizations into a single 360-Enrollee profile view we refer to as Enrollee Care Compass. As depicted in **Figure C.20-3,** the Enrollee Care Compass provides a complete view of the Enrollee's health journey, including medication history, social service needs, claims history, authorizations, personal goals, assessments, interventions, and care plans. Our Care Coordinators and utilization management staff have one-click access to this complete picture of an individual Enrollee's needs across the entire spectrum of care when considering authorization decisions and utilization trends. We pay all behavioral and medical claims for all services out of a single multi-purpose claim system. Enrollee data from CareCentral updates the provider portal, allowing an Enrollee's MDT members to view their information and make updates to the care plan.

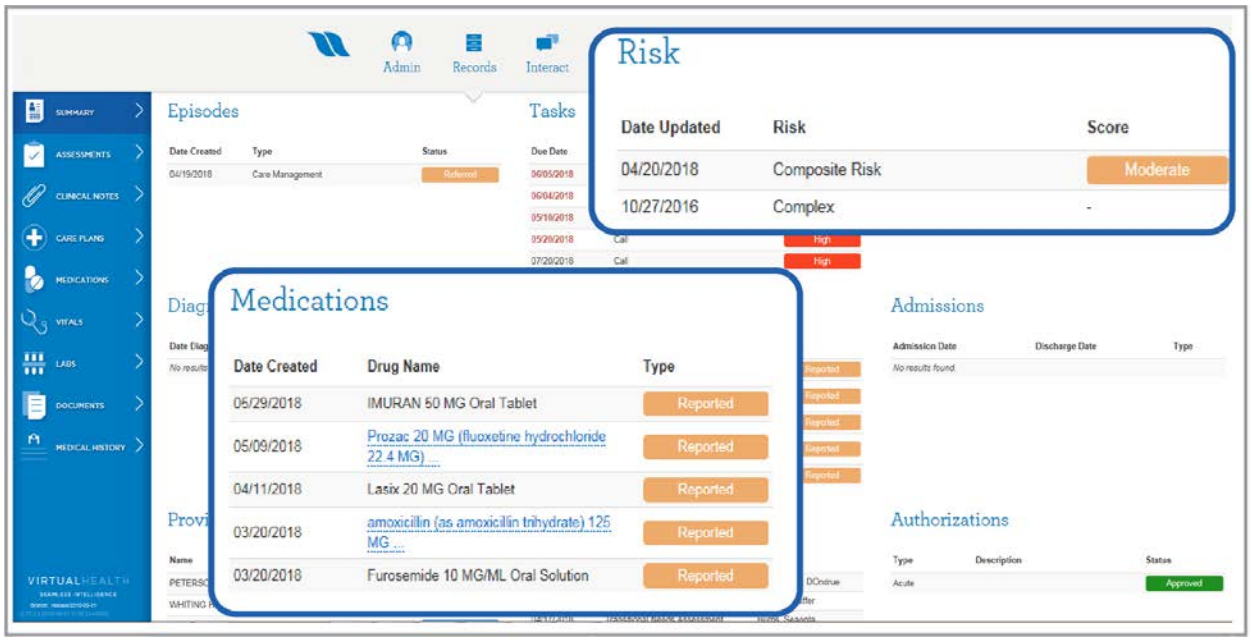

Figure C.20-3 CareCentral Clinical Platform

WELLCARE OF KENTUCKY CALL CENTERS AND ENROLLEE SUPPORT

Our Enrollee Call Center, Nurse Advice Line (NAL), and Behavioral Health Services Line all play an important role in the integrated delivery of services and support for whole-person care across behavioral, physical, pharmacy, and social needs. Our dedicated staff of professionals are educated on the Kentucky-specific Medicaid program and cross-trained to identify both physical and behavioral health issues for referral to the appropriate Care Coordination staff member for follow-up engagement that addresses their comprehensive needs.

As our Enrollees' first point of contact, our Enrollee Service Representatives (ESRs) are key to ensuring we deliver whole-person care. Using our sophisticated ESR tools including our knowledge management platform, CAREConnects, integrated platforms and interactive analyzer, our ESRs get a complete picture of our Enrollees' healthcare needs. Our **knowledge management platform** uses a response algorithm to help ESRs identify resources such as transportation partners specific to Enrollee needs. Our premier **CAREConnects** customer service tool provides ESRs with a complete view of the Enrollee's needs and the capabilities to meet them. Our **integrated platforms** with bi-directional information feeds enable coordination of Enrollee needs across all domains, providing all Enrollee-facing staff with the comprehensive, holistic view of their medical, pharmacy, behavioral health, and social needs including demographics, medical history and clinical and behavioral health information. Our interaction analyzer recognizes word and phrase combinations signaling a possible crisis situation, and alerts the ESR to take appropriate action such as keeping the caller on the line, alerting a supervisor, and engaging the NAL or Behavioral Health Services Hotline. ESRs begin training on their first day of hire and build upon their knowledge and skills through ongoing training courses related to both customer service skills and knowledge of Medicaid covered benefits. The rigorous training requirements through our learning and education hub—WellCare University— include more than 160 training hours and a score of 85% or higher on all

assessments to successfully become a certified ESR supporting our Enrollees in the Commonwealth. In addition, all ESRs receive training to recognize critical behavioral health issues and connect them to crisis services. We have a high level of overall responsiveness due to our “no-wrong door” point of entry for phone calls, whether a call is from an Enrollee, provider, or caregiver. To ensure each crisis was managed and to assess for any other needs, a local behavioral health Care Coordinator follows up within 24 hours (next business day) of a crisis line call, after the original reason for the call has been addressed.

We staff the NAL and Behavioral Health Services Line with qualified healthcare professionals, including registered nurses, social workers, and LMHCs who understand the importance of addressing an Enrollee's whole-person needs. Once a caller's needs have been identified, we determine the appropriate acuity level and follow standard protocols for routine, urgent, emergency, and crisis situations. Call center representatives have full access to the Enrollee Care Compass, which includes the Enrollee's integrated care plan, medications, interventions, assessments, and personal goals, enabling them to grasp the caller's background and determine steps to address their immediate needs and engage them in further assistance through their integrated care team.

Understanding the Enrollee's background through the context of their Care Compass profile, our integrated care team members provide follow-up support that takes into consideration their complete medical history and current interventions and medications for both physical and behavioral health. As an extension of our Care Coordination services, call center staff can assist with appointments and transportation requests, enroll individuals into our Healthy Rewards program, and reach out to Care Coordinators when additional support is required.

COMMUNITY CONNECTIONS PROGAM

Developed to support the integrated delivery of services in the Commonwealth in 2011, the Community Connections program addresses our Enrollees' SDOH needs to improve their quality of life, sustain well-being, and allow them to focus on improving their health. Our Community Connections program leverages a rich registry of community supports, secure connections, community engagement and the Community Connections Help Line to remove social barriers to health care. Our CCHL is staffed with peer coaches who provide information about community social service organizations, guide and encourage individuals to access community resources, and develop the Community Connections database. This detailed database now consists of over 70 social service categories available for our Care Coordinators and CCHL staff to assist Enrollees with removing social barriers to achieve positive health outcomes.

i. Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.

Since 2011, WellCare of Kentucky has been a leader in removing social barriers to care. We have maintained that reputation by implementing innovative approaches that ensure Enrollees experience whole-person care that integrates medical, behavioral health, pharmacy, and SDOH needs. We know that the most significant barriers that keep people from accessing their covered medical and behavioral health benefits are the things that impact their lives outside of the doctor’s office. A mom who cannot buy groceries this month is not thinking about follow-up

for her son's ADHD medication. That is why we integrate social determinants of health into every aspect of our approach ensuring Enrollees experience whole person care that integrates their medical and behavioral health benefits. We do that by making sure our internal staff, providers and other stakeholders have access to our propriety, locally developed database of available community services beyond Medicaid covered services to address SDOH, including transportation, housing and food insecurity, utility assistance, interpersonal violence, and more.

Enrollees often need help accessing these social services, therefore we added the CCHL – a peer-staffed call center for all community members to help access social services and to track referrals to make sure callers get the services they need. Often it is not enough just to connect Enrollees to services because in many cases those services are limited or challenged with their own funding reductions. This is why our Community Connections model was built to go beyond a referral program to addressing sustainability of the social safety net through the use of Community Impact Councils (CIC) and targeted Community Health Investments. Both of these program work within our communities to identify gaps in the social safety net and find sustainable solutions to solving those gaps so our Enrollees have access to all the services they need to experience whole-person care and improve their health outcomes. A more detailed discussion of CICs and the Community Health Investment program is available in our response to question C.24 Population Health Management.

Enrollees experience streamlined, whole-person care guided by a single integrated care team, using one set of common clinical systems, tools, and data. Enrollee SDOH needs are stratified into our Identification and Stratification process described below, helping our integrated Care Coordination team to identify individual SDOH needs, which are included in the Enrollee care plan and in CareCentral. Our Enrollee Services Representatives use this information as well as other Enrollee care need information prioritized by need and grouped by family to provide personalized assistance when Enrollees call our Enrollee Service line. As the single accountable entity, WellCare of Kentucky provides a consistent framework for the model of care, ensuring data sharing across provider partners (e.g., CMHCs, FQHCs, state agencies, PCPs). Working together to support the Enrollee, the multi-disciplinary team (MDT) removes the fragmentation that Enrollees face, and a single Care Coordinator helps them navigate what can be a complex healthcare system. Through this person-centered model, we help Enrollees advance on their journey toward better health facilitated by a single local Care Coordinator, a single ID card to use, a single care plan, and a single phone number to call when they need help or have questions.

In 2018, we invested more than $531,000 in community health initiatives in Kentucky, with particular focus on access to healthcare, nutritious food, and transportation. We are proud to have piloted this Community Connections model first in Kentucky in 2011 and witnessed firsthand its positive impact on the Commonwealth. Our community engagement partners work with local organizations to address social barriers and provide a deep, supportive safety net infrastructure for those who need it most—including individuals who are not WellCare Enrollees. Due to the program's success, WellCare has adopted the Kentucky model at their health plans nationwide.

Making a Local Impact on SDOH

Since launching the Community Connections program in Kentucky, we have connected more than 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in emergency department visits, and a 53% decrease in inpatient spending.

The following section describes our innovative approaches to ensuring a whole-person care experience for our Enrollees—which remains the cornerstone of our model of care—through the domains of Enrollee, provider, and system transformation.

INNOVATIVE APPROACHES FOR THE ENROLLEE WHOLE-PERSON CARE EXPERIENCE

Act for Opioids Program

Developed in 2019, WellCare now offers a fully integrated, comprehensive ACT for Opioids Program, which includes a full suite of components that help us prevent and treat OUD for our Enrollees. In fact, the OUD program is a direct result of the hard work, dedication, and success of the pharmacy "lock-In" program implemented in Kentucky back in 2016—now referred to as our One Provider-One Pharmacy Program. Our new innovative approach expands Enrollee eligibility to include frequent ED use in addition to the standard 3 scripts, 3 MDs, 3 pharmacies.

It Takes a Village: Tackling the Opioid Epidemic in Kentucky

Today, we offer a brand new ACT for Opioids Program powered by the innovation and resources of WellCare Health Plans, Inc. Realizing that it takes the effort of an entire community to make impactful change, we partner with the Department, DHBDID, the 14 regional CMHCs, and local treatment providers to help Enrollees with OUD address ALL of their whole-person needs. To contribute, WellCare of Kentucky donated $100,000 to Volunteers of America to build a new addiction treatment program for new and expectant mothers in rural areas with no resources. We also provided hyper-local grants totaling $35,000 to OUD Recovery Programs across Kentucky such as Addiction Recovery Care (ARC).

The ACT for Opioids program strives to decrease inappropriate opioid use, identify at-risk Enrollees and abnormal prescribing patterns, effectively treat and manage those diagnosed with OUD, and drive down costs through a combination of evidence-based interventions and testing of new, innovative opportunities. We simplify the sometimes complex messaging to Enrollees, providers, family members, and friends while giving communities a rallying cry. We recognize that there is no magic bullet—yet—and commit to the relentless pursuit of answers

to this debilitating and costly national epidemic. For our Enrollees, we deliver comprehensive education, benefits, services and supports in a respectful, stigma-free approach that ensures those struggling with physical and emotional pain are offered pathways to responsibly pursue a confident, "better you," from prevention through recovery.

To date, we have experienced great results in Kentucky that show we are headed in the right direction—including the following downward trends in utilization of services:

- Inpatient admissions for Enrollees has decreased by 5%
- ED visits for Enrollees ages 19-30 decreased by 9.5%
- Inpatient costs for Enrollees ages 19-30 decreased by 29%

In 2018, WellCare of Kentucky saw a 27% drop in opioid utilization, with a 47% increase in MAT services, a 25% increase in maintenance medications, and a 33% decrease in emergency department (ED) utilization. In addition, WellCare now supports more than 12,000 high-risk Enrollees nationwide enrolled in the One-Provider-One Pharmacy program to monitor opioid utilization and guide their treatment and recovery with the support of specialized Care Coordination services. **Table C.20-1** describes our alignment with DMS for tackling the opioid epidemic and the new components of our ACT for Opioids Program.

Table C.20-1 ACT for Opioids Program

WellCare of Kentucky	ACT for Opioids Program Components
Alignment with: • Department and DHBDID Goals • Local stakeholders, such as the University of Kentucky (UK) and University of Louisville • CHFS' Kentucky Opioid Response Effort (KORE) • State Health Improvement Plan (SHIP)	In preparation to implement our new ACT for Opioids Program components, our Kentucky leadership team has reviewed both the Cabinet for Health and Family Services' Kentucky Opioid Response Effort (KORE) goals and the goals set forth by the Department of Public Health's State Health Improvement Plan (SHIP). As our team is rolling out new components, and planning on additional rollouts as soon as possible, we align with the KORE's mission and five major goals, which include preventing opioid-related overdoses and helping the following groups of Enrollees: those who survived opioid-related overdose, pregnant and parenting women, justice-involved individuals, children, transition-age youth, and families. Our programs, including specialized Care Coordination initiatives, tailor to the needs of special populations, such as high-risk pregnant Enrollees at risk of Neonatal Abstinence Syndrome (NAS), and children and youth in the foster care system. To support SHIP goals, we have components in place that support drug takeback programs and increase access to lifesaving medications and MAT across the Commonwealth.
New Program Implementations	WellCare of Kentucky will be rolling out the following new initiatives: • Predictive Analytics for the early identification of Enrollees at-risk of OUD based on the industry standard 3-3-3+ED protocol

WellCare of Kentucky	ACT for Opioids Program Components
	• Low Back Pain Management Program to support prevention and treatment protocols for the leading cause of opioid use • Expanded One Provider-One Pharmacy Program referral to integrated Care Coordination • Improved access to MAT providers • Partnership with the Kentucky Court Appointed Special Advocates (CASA) Network to help children in foster care and their families • Expanded use of the Screening, Brief, Intervention, and Referral to Treatment (SBIRT) model, which guides providers to rapidly assess the severity of OUD, engage in immediate feedback, and refer the Enrollee to a local treatment program • cCBT platform known as MyStrength, which provides Enrollees with interactive clinical programs and self-management tools empowering them to reduce the self-destructive cognitive and behavioral patterns caused by OUD • Clinical first fill edits for tighter review (except for cancer and other appropriate diagnoses) • Provider profiling on MEUs • Enhanced access to Narloxone
Additional Programs for Future Implementation	WellCare's ACT for Opioids Program offers an extensive suite of programs that our leadership team is evaluating for implementation in the Commonwealth as they become available, including: • Prescription Disposal Program through a partnership with DisposeRx • Alternative Pain Management Treatment Program (e.g., acupuncture, chiropractic services) • Peer Support Program that provides financing to train and match individuals with peers with lived experience to increase their engagement with OUD, physical, behavioral health, and pharmacy providers and social services • OUD-targeted P4Q programs to incentivize providers for OUD identification, treatment support, and referrals • On-demand mobile peer support for substance use through MAP Health
Community Connections in Kentucky	Our Community Connections model partners with local social services to eliminate daily stressors that serve as catalysts for substance use as well as barriers to treatment. The SHIP acknowledges income, education, and access to care as the three underlying SDOH leading to substance abuse. These partnerships address a spectrum of needs, including childcare challenges, housing instability, food insecurity, domestic violence, literacy challenges, and unemployment.
Funding for OUD/SUD Community-Based	WellCare of Kentucky has provided and continues to provide grant funding for over 20 different local programs, organizations, and CMHC

WellCare of Kentucky	ACT for Opioids Program Components
Organizations	initiatives, including the following: The Healing Place; Operation UNITE; Children, Inc.; Chrysalis House, Inc.; Knott Drug Abuse Council; UK Faces of Abuse Conference; Brighton Center; Audubon Area Community Services; Independence House; The Ridge Behavioral Health System Winter Workshop; Bluegrass Care Navigators Healthy Start Project; The Gene Duffy Foundation; Four Rivers Behavioral Health Moms Bridging Gaps Program; Project Daris; Twenhofel Middle School Youth Center; and Volunteers of America.

WellCare's Specialized OUD Care Coordination: From Addiction to Recovery

A 49-year old Enrollee was referred to Kentucky's specialized care coordination program after six treatment attempts for heroin addiction. Our care coordinator met the Enrollee at a residential treatment program, continued telephonic check-ins, and maintained contact as the Enrollee moved to a sober-living program. The care coordinator encouraged provider visits to follow up on hepatitis and routine medical care. The Enrollee has maintained sobriety post-discharge and is attending an intensive outpatient program, daily self-help groups, medical appointments, and is now actively seeking employment to re-enter the workforce.

ENROLLEE IDENTIFICATION AND STRATIFICATION ALGORITHM (ID/STRAT)

WellCare of Kentucky is better able to target and customize our Care Coordination process through our data-driven engine that enables us to facilitate the right care, at the right time. Our proprietary risk scoring and stratification process quickly and efficiently identifies Enrollees with a high level of physical, behavioral, and pharmacy need to be enrolled in Care Coordination services that address the whole person. Through rapidly assessing a variety of variables and Enrollee information from across our integrated data platforms, the ID/Strat algorithm identifies priority populations, such as those with emerging risk factors or high-risk needs (e.g., high-risk pregnancy, OUD/SUD). Driven by our predictive algorithm, the system automatically processes an Enrollee's re-admission risk, HRA results, chronic diagnoses, co-morbidities, medications, claims data, location, race, and ethnicity when identifying those who require more intensive Care Coordination support. **Figure C.20-4** highlights the ID/Strat process for which Enrollees are assigned a risk score of low, medium, or high.

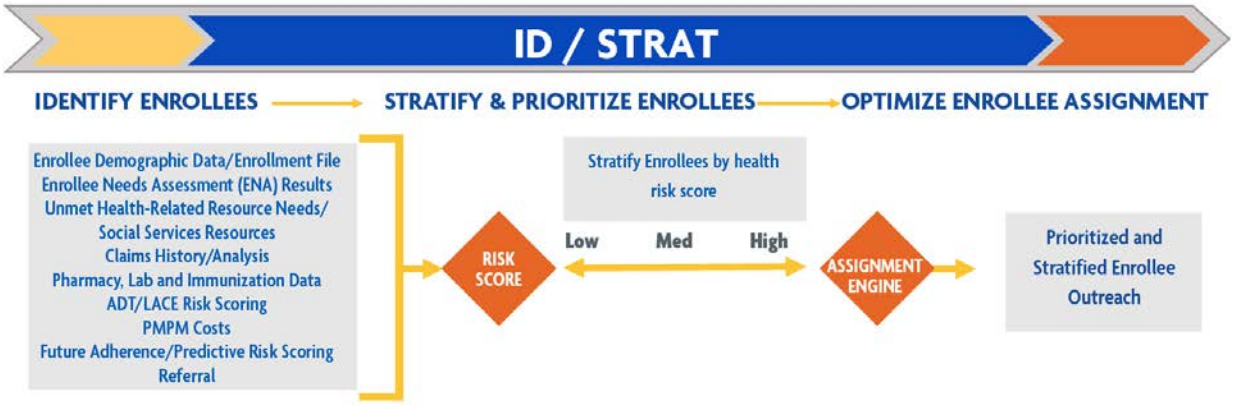

Figure C.20-4 Identification and Stratification Process (ID/Strat)

These identification methods apply a combination of screening assessments, data aggregation, and analytics combined with predictive analysis and risk scoring. An additional advantage of the tool is its capability to identify behavioral health risks often overlooked by more traditional identification models and in-person screenings. The system builds on information that is presented over time, creating a complete picture of Enrollee needs while providing insights in the meantime, using early indicators like HRAs and Rx, which are supplemented with more complete information from claims, and SDOH needs. The following describes additional features of the ID/Strat algorithm:

- Our modified LACE+ Index Scoring Tool for Risk Assessment of Hospital Readmission system alerts our clinical staff about an Enrollee's condition. Updated at the time of admission with the latest information, the LACE+ score helps to identify Enrollees most at risk for readmission and those that would benefit from enhanced discharge planning and community supports
- An emerging feature of our ID/Strat tool includes social service risk determined through our unique approach to cataloging and tracking Enrollee utilization of social service resources. We leverage this data to stratify Enrollees based on the severity and complexity of their health needs, and coordinate care that addresses their comprehensive physical, behavioral, pharmacy, and social needs

CARE COORDINATION/QUALITY MEASURES FOR SMI AND CO-MORBIDITIES

Our integrated care team and executive leadership team continually strive to identify new initiatives and programs that facilitate innovative solutions to treating Enrollees with co-morbidities that include serious physical health issues. In 2014, WellCare of Kentucky initiated a co-management program monitoring physical and behavioral health conditions for Enrollees with SMI and five or more chronic medical conditions—the SMI+5 Program. With a focus on the reduction in preventable Emergency Department visits and admissions associated with behavioral health needs and improving 7-day and 30-day follow-up rates, as well as improving physical health outcomes for individuals with SMI, the SMI+5 Program targeted adult Enrollees with SMI and five additional chronic medical conditions (e.g., asthma, COPD, diabetes, hypertension, heart disease, and AIDS).

SMI+5 Integrated Program Success

Now a fully integrated part of our care coordination process, the results of the original SMI+5 program were significant, including a 31% decline in total cost of care for Enrollees, driven largely by a 66% decrease in inpatient expenses and a 10% decrease in ED visits.

With an emphasis on local, face-to-face, integrated Care Coordination, we reduced Enrollee Emergency Department utilization, as well as hospital admissions and readmissions, and improved Enrollee frequency of visits to the Primary Care Provider and psychiatrist (as well as medication adherence). All Care Coordinators participating in the SMI+5 program received training on motivational interviewing, Enrollee safety, and documentation, as well as condition-specific training (e.g., schizophrenia, bipolar disorder, anxiety, depression, suicide assessment and prevention, OUD/SUD, asthma, COPD, diabetes, hypertension, and obesity). This program supported targeted and high frequency interventions for medication management, home delivery of medication, and monitoring of compliance through home health providers. Throughout the process, we emphasized the importance of addressing SDOH, ensuring that services were identified and accessed, with further intervention taking place if necessary.

Today, our integrated care teams apply these strategies throughout our regional pods located across the Commonwealth. As a result, our Enrollees have experienced positive physical health outcomes, including **a 44.3% reduction in pneumonia admissions; 17.2% reduction in COPD admissions; 64% reduction in admissions for children with asthma; and a 51.8% reduction in admissions for adults with asthma.**

Included within this approach, we track, monitor, and engage our providers to close Enrollee care gaps for the following HEDIS measures:

- *APP.* Metabolic Monitoring for Children and Adolescents on Antipsychotics with two or more antipsychotic medications (can be the same one filled twice) should have HbA1C test or blood glucose test and LDL-C or cholesterol panel completed annually.
- *AMM.* Antidepressant Medication Management for Enrollees diagnosed with major depression, treated with medication, and remaining on medication for at least 12 weeks or six months.
- *SAA.* Adherence to Antipsychotic Medication for Individuals with Schizophrenia who are dispensed medication and remain on it for at least 80% of their treatment period.
- *SMC.* Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia should have an LDL-C test annually.
- *SMD.* Diabetes Monitoring for People with Diabetes and Schizophrenia should have an LDL-C test and HbA1C (not blood glucose) test annually.
- *SSD.* Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications should have an annual diabetes screening (HbA1C or blood glucose test).

Integrated Support for Enrollee with Hypertension and Depression

In 2018, a 58-year-old WellCare of Kentucky Enrollee was admitted to a behavioral health inpatient facility after increasing feelings of depression leading to suicidal thoughts. The Enrollee was feeling hopeless due to grief over the loss of her significant other and several of her friends. Unfortunately, she was also out of work with no job prospects, causing her to worry that her sister would ask her to leave the household for not contributing to the rent and other expenses. After learning about her situation, our integrated care team spoke with her, listened to her needs, and set a path forward to help her address her issues step-by-step. We began the process by connecting her to a qualified therapist to help her understand and treat the ongoing grief she was feeling. We then connected her to several local job training programs using the Community Connections database, helping give back some of that hope she had previously lost. With a diagnosis of hypertension, we also treated her physical health needs and saw that she received a home blood pressure monitor and education on using the device to assist her with managing the condition. Lastly, we provided education on diet and exercise plans, which helped her develop healthy habits while learning new coping skills in therapy to manage her grief.

ENHANCED CLINICAL PHARMACY PROGRAM

As part of the integrated care team, our clinical pharmacists and pharmacy technicians, led by our Pharmacy Director, Thea Rogers, PharmD—who specializes in psychiatry—lead our Enrollee medication management reviews. Our PharmDs collaborate with the utilization management team for the discharge planning process and support field-based Care Coordinators performing medication reviews. To support our Enrollees' pharmacy needs and to ensure we approach the management of their medications as a team from a whole-person care perspective, we developed a behavioral health polypharmacy program within our already robust pharmacy services. On a monthly basis, we identify Enrollees with more than one antipsychotic medication. This process takes into consideration an Enrollee's age—for example, we identify elderly Enrollees with conditions, such as dementia, who are prescribed multiple antipsychotics. Once identified, we collaborate with their PCP and the prescriber to request a medication review. **In 2018, we targeted over 400 Enrollees with a success rate of 60% -- meaning approximately 250 Enrollees no longer met the criteria**. In addition, our Pediatric Antipsychotic Utilization Program identifies potential drug therapy issues, including excessive doses and multiple medications for children ten years or younger. When an issue is identified, we engage the provider with evidence-based recommendations and guidance. **In 2019, we performed targeted medication reviews for over 850 Medicaid Enrollees under the age of ten.**

Pharmacy Integration Makes a Difference

In addition to our behavioral health focused pharmacy programs, we offer a robust suite of clinical services, such as medication adherence outreach for physical health issues (e.g., such as asthma and diabetes), our Healthy Living Medication Management Therapy (MTM) Program, and access to the prevention and treatment services driven by WellCare's national ACT for Opioids Program. Also, in Kentucky, 95% of pharmacies are on the EQuIPP (Electronic Quality Improvement Platform for Plans and Pharmacies) network—a pharmacy benchmark system that provides performance data associated with quality measures. Compared to the national benchmark, our local pharmacies on the EQuIPP platform performed better in improving medication adherence for diabetes in the Medicaid population.medication adherence for diabetes in the Medicaid population.

COMMUNITY CONNECTIONS PROGRAM TO ADDRESS SDOH

Identifying and addressing SDOH through our Community Connections program is a critical element of the whole-person care experience and care planning process. The program, led by Elizabeth Starr, Enrollee Services Manager, partners with community-based social services in Kentucky to help Enrollees eliminate daily stressors that serve as barriers to treatment, such as childcare challenges, housing instability, food insecurity, domestic violence, literacy challenges, and unemployment.

We incorporate the SDOH needs identified during the assessment process into the person-centered care plan within the Enrollee Care Compass in CareCentral. Care Coordinators use motivational interviewing skills to help each Enrollee and their families or caregivers set personal goals and develop an action plan inclusive of their SDOH needs. As we guide the Enrollee through the Care Coordination process to address their physical, behavioral, and pharmacy needs, we simultaneously leverage the Community Connections database to connect them to local social services provided by community and faith-based organizations across the Commonwealth.

All Enrollees (regardless of enrollment in Care Coordination) can call our toll-free CCHL at any time for assistance accessing the nearly 330,000 Kentucky resources listed to mitigate the Enrollee's social barriers to health. Our 'close-the-loop' process ensures Enrollees receive the recommended services with the desired impact on clinical and non-clinical goals. The database organizes community resources by zip code and county, based on 70 categories of potential social need. We leverage education materials (flyers and cards) to target our Enrollees and inform them of this free service, though we will assist anyone who calls, even if they are not a WellCare of Kentucky Enrollee. The hours of the CCHL are Monday through Friday, 9 a.m. to 6 p.m., across all U.S. time zones.

Helping Enrollees Manage Chronic Conditions Through Transportation Access

Since launching the Community Connections model in Kentucky, our team has made over 48,000 referrals to transportation services across the Commonwealth. Over 25,000 of those referrals were made for trips to grocery stores, employment, and assisting those with accessing necessary resources such as food pantries, and agencies that may assist with financial assistance for rent and utilities. Continually voted a top priority and need across different counties at our Community Impact Councils (CIC), we know that Enrollees with whole-person care needs, such as chronic physical health conditions like diabetes, hypertension, and asthma, need to consistently attend medical appointments with their care team and PCP to properly manage their conditions and behavioral health diagnoses. The CIC hosted in Muhlenberg County resulted in a medical voucher program (MVP) in partnership with Pennyrile Allied Community Services, Inc. (PACS), which was later extended to the remaining PACS service regions. On average, we found that Enrollees accessing PACS transportation services have 3.5 chronic conditions, including 66.2% with hypertension; 34.1% with asthma; 35.9% with diabetes; and 31.4% with obesity. In addition, we found Enrollees to have 1.5 behavioral health conditions, including 42.8% with depression, 53.4% with a mental illness, 18.0% with severe mental illness, 12.4% with bipolar disorder, and 16.2% with substance use issues.

Upon one year of increased transportation services in the region for Enrollees with diabetes, we found a 17.4% reduction in emergency visit costs; 12.6% reduction in emergency visits; 41.4% reduction in non-emergent emergency visits; 38.9% reduction in inpatient admissions; and 36.3% reduction in hospital stay days. For Enrollees with asthma, we observed a 43.2% reduction in inpatient admissions, 63.9% reduction in hospital days, and 72% reduction in visits related to asthma exacerbations.

MOBILE HEALTH APPLICATIONS FOR SELF-DIRECTED CARE

We believe Enrollees should be able to access care when they need it, where they need it. For that reason, WellCare of Kentucky has invested in mobile solutions that provide services such as self-directed care and computerized cognitive behavioral therapy (cCBT) to address their physical and behavioral health needs.

MyStrength. An online, evidence-based behavioral health therapy platform, in **Figure C.20-5**, MyStrength provides Enrollees with interactive clinical programs empowering them to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges, while also supporting the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care. MyStrength's integrated model includes computerized cognitive behavioral therapy (cCBT), mindfulness, motivational interviewing and Assertive Community Treatment (ACT) protocols with personalized pathways that facilitate user interaction, mood trackers, and additional tools to measure effectiveness and improvement. **MyStrength has shown the following benefits upon implementation: a 43% rapid symptom reduction within the first two weeks of engagement, 83% as effective as face-to-face therapy at a fraction of the cost, and a 70% cost reduction in total expenses for Enrollees.**

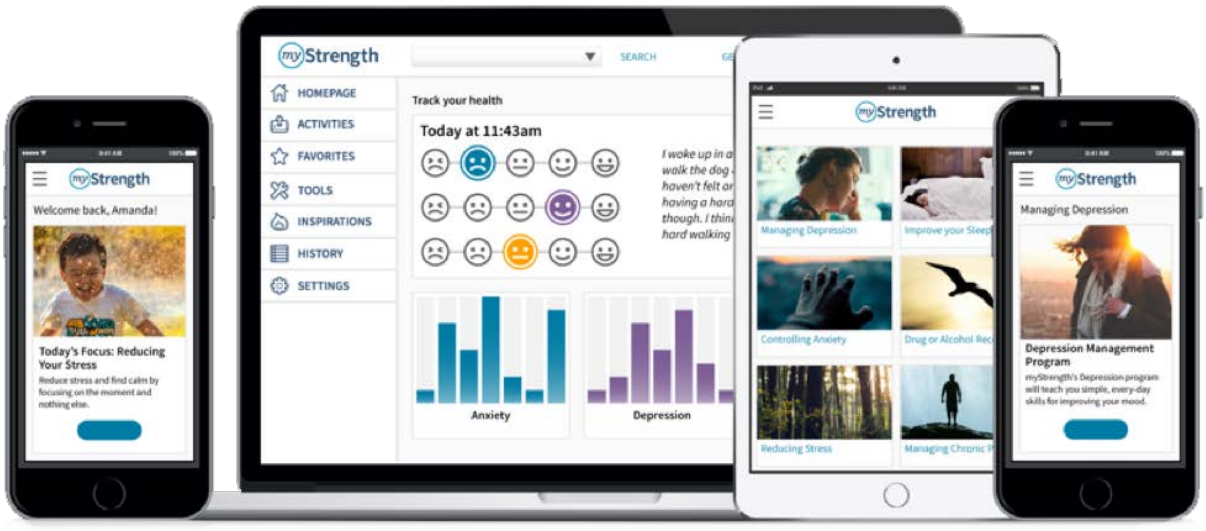

Figure C.20-5 MyStrength Behavioral Health Therapy Platform

Baby's First Text Messaging Program. Baby's First is our text messaging program. Mothers can easily sign-up with the help of their Care Coordinator or by texting BABY1 to 52406. Enrollees receive up to six text messages per week that provide guidance from birth to 15 months postpartum. Program guidance includes links to videos, questionnaires, and other resources that cover topics, such as child development, daily care tips, vaccinations, wellness visit reminders, breastfeeding instructions, home safety measures, nutrition and healthy eating, and developmental milestones, to name a few.

"The Baby's First program conveniently connects new mothers who are on the go to the tools they need to ensure their babies have the best start in life. It also supports new mothers who face barriers to certain resources due to social determinants of health, such as lack of transportation or food insecurity, that impact health outcomes. Now they can access the support they need anywhere at no cost to them, which helps to eliminate obstacles and promote healthier communities."

– JESSICA ANDERSEN, QUALITY IMPROVEMENT
MATERNAL CHILD PROJECT MANAGER, WELLCARE OF NEBRASKA

JOOL Health Coach. Last year, we collaborated on a new program for our foster care youth with JOOL Health Coach, a personal coaching smartphone application that encourages youth to check in with their peers and engage in healthcare services. With tailored tracks specific to different populations, Enrollees have access to a transition-aged youth pathway for those with OUD/SUDs. JOOL includes OUD/SUD assessments, resources, and referral information to help youth and their families easily learn about their conditions and the local treatment options available in their community.

Maternity Smartphone Application (Pacify). At the touch of a button, our new app, Pacify, offers expecting and new mothers unlimited 24/7 video access to certified dieticians and lactation consultants. Enrollees receive breastfeeding support and guidance from these specialized providers for any health issues their babies may be experiencing such as colic, digestion, and transitioning to solid foods, to name a few. As part of our ongoing focus on continuous quality

improvement and ensuring Enrollees receive the care they need, Pacify aims to improve health outcomes while also reducing costs to the healthcare system. Push notifications include helpful alerts for health and safety tips beneficial to both mothers and their babies.

AbleTo. The AbleTo program is a virtual CBT solution providing weekly coaching sessions with a coach and professional therapist to handle the behavioral health components of co-morbidities. The team helps the Enrollee set goals and build a program tailored to their personal needs. Coaching sessions occur twice a week at a time convenient to the Enrollee.

Fit4D. Supporting youth and adolescents with Type 1 and Type 2 diabetes, Fit4D is a support tool that includes chat messaging and push notifications. Through personalized education and coaching services, Fit4D supports Enrollees by teaching self-management behaviors and guidance for following treatment and care plan recommendations, as well as participating in preventive services. Health coaches speak to both the guardian and the Enrollee, or for older participants, help supplement diabetes treatment and education as Enrollees learn to manage treatment on their own.

MAP Health Management. This tool provides mobile peer support for SUD. MAP is a national vendor that matches Enrollees with a peer with the same lived experience as they go through detox and need support for their triggers. Addiction is a chronic disease—MAP's peer recovery support services extend the care continuum to match the chronic nature of the disease. Following are the goals for the tool:

- Improve long-term engagement across SUD Enrollee populations to facilitate early intervention, motivate Enrollees to seek treatment when appropriate, reduce the impacts of relapse, and direct care needs such as readmission when appropriate
- Reduce out of network utilization for SUD treatment
- Capture and report on longitudinal outcomes data, including social determinants of health, on SUD populations and treatment programs

We understand that Enrollee engagement is key to recovery success, which is why providing this real-time, 24/7 access to support and ability to triage for additional services is critical. This connectedness helps Enrollees feel less alone and isolated.

PEER SUPPORT PROGRAM

Based on WellCare's national model, our peer support program provides financing to train and match individuals to peers with lived experience who facilitate increased engagement with the Enrollee's physical, behavioral, and OUD/SUD services. Peers have the ability to help Enrollees make their own decisions on a day-to-day basis—relating to them in a way that a clinician or therapist may not be able to—and work with them to stay on track with their medications and treatment plan. WellCare's health plan in Hawaii recently funded training for eight peer specialists, and we welcome the opportunity to apply this model in the Commonwealth.

DIGITAL LIBRARY

Using the Enrollee portal, WellCare of Kentucky website, or the MyWellCare mobile smartphone application, Enrollees, families, and caregivers have access to our digital library, which includes information on mental health, substance use, self-help tools such as cCBT, and

our vignette series of People Like Me that provides stories from those with lived experience with mental health and substance use.

INNOVATIVE APPROACHES FOR PROVIDER TRANSFORMATION

Led by our provider engagement team, we support and guide our providers, which includes CMHCs, Federally Qualified Health Centers (FQHC), physician practices, and hospital partners, along the complex continuum of integrated services. We help providers who take the initiative to evolve their practices into co-located offices or advanced Behavioral Health Homes (BHHs). This innovative approach to provider transformation leverages collaboration between our quality team and provider representatives, process support from data analytics and project managers, and ongoing team meetings between WellCare of Kentucky and the provider to implement the transformation plan.

VALUE-BASED PURCHASING (VBP) CONTRACTS FOR INTEGRATED SERVICES

We incentivize providers and CMHCs through VBP contracting and alternative payment models (APMs) that promote, track, and reward whole-person care integration activities, such as using PCP-behavioral health integration toolkits, applying preventive measures and behavioral health screenings, facilitating access to care for physical and behavioral health conditions, managing chronic conditions (e.g., HbA1c control, medication adherence), and meeting HEDIS measures. **Table C.20-2** describes the integrated physical and behavioral health HEDIS quality measures of our current Kentucky Pay-For-Quality (P4Q) Program that providers receive financial compensation for when meeting compliance standards for assigned Enrollees.

Table C.20-2 VBP HEDIS Measures and Participating CMHCs

VBP HEDIS Measures	Participating CMCHC Partners
• AMM—Antidepressant Medication Management • SAA—Adherence to Antipsychotics • FUH—Follow-up after BH Hospitalization • SMC—Cardiovascular Monitoring for Enrollees with Schizophrenia • SMD—Diabetes Monitoring for Enrollees with Schizophrenia and Diabetes • SSD—Diabetes Screening for Enrollees with Bipolar Disorder or Schizophrenia Taking Antipsychotic Medications • APM—Metabolic Monitoring for Children taking Antipsychotics	• Four Rivers Behavioral Health • Pennyroyal Center • River Valley Behavioral Health • Centerstone of Kentucky • Communicare Mental Health Center • Lifeskills • Adanta Group Behavioral Services • Bluegrass • North Key Community Care • Pathways • Comprehend • Cumberland River Behavioral Health • Mountain Comprehensive • Kentucky River Community Care

All CMHCs, FQHCs, and providers receive a tip sheet, and ongoing care gap reports to help them meet the required standards of care. In addition, the P4Q Program allows providers to earn incentive payments for closing care gaps, ensuring medication adherence, and engaging in preventive health services. **Through education and support, CMHC providers have contributed to helping WellCare of Kentucky close over 730 Enrollee care gaps from January through March of 2019, which will result in nearly $30,000 of financial incentive payments to our providers.**

INTEGRATED PROVIDER PLATFORM

Our fully integrated provider portal includes advanced reporting tools that share meaningful and actionable Enrollee data to support CMHCs, FQHCs, and behavioral and physical health providers as they facilitate integrated services. Our Care Management platform, CareCentral, includes our Enrollee Care Compass application—a 360 view of the Enrollee, which includes the person-centered care plan, care gaps, interventions, medications, SDOH, and utilization history that is pushed out to the provider portal. Through integration of Enrollee data with our network providers, they have access to Enrollee data and the ability to update care plans using the provider portal, which is then accessible in the Enrollee Care Compass' person-centered care plan and available to the entire MDT. The Enrollee 360 profile reflects the results of the initial HRA, and the Enrollee Needs Assessment (ENA), which includes behavioral health and SUD

WellCare of Kentucky supports providers with reporting tools to help them facilitate the whole-person care experience, such as care gap heat maps to identify health issues by zip code, care gap reports and appointment agendas with potentially missed diagnoses, and a scorecard that assesses their performance providing integrated services and a whole-person care experience.

screenings, care needs, co-morbidities, and identifies high-risk Enrollees with serious mental illness (SMI) or serious emotional disturbance (SED).

CareCentral uses branching logic to automatically generate interventions and action steps for the Care Coordination team based on the results of these assessments. Through the portal, the entire MDT stays connected through a unified workflow centering on the updated care plan and interventions tailored specifically to each Enrollee. Alerts for overdue and follow-up actions are sent out to ensure providers stay on track and perform the necessary steps toward meeting the Enrollee's health and personal goals. In addition, we have aligned our metrics and reporting capabilities to track and analyze integrated, whole-person services for utilization, HEDIS measures, claims data (e.g., medical, behavioral, pharmacy), readmissions, ED use for all diagnoses, cost of care, and shared savings.

PROVIDER INTEGRATION SUPPORT AND TRAINING

We support the progression toward a co-located, integrated medical office, or a more advanced BHH. In some cases, this approach involves leveraging the industry best practice referred to as the Collaborative Care Model. This model evolves the whole-person care experience to the next level by creating a formal MDT led by the PCP and supported by a behavioral health Care Coordinator and network psychiatrist to treat mental health and substance abuse conditions using evidence-based diagnoses, treatment, and follow-up care. **Table C.20-3** describes the support, training, and resources for our partners and other network providers.

Table C.20-3 Provider Resources

Resources	Description
WellCare Of Kentucky Staff	Our support team proactively guides providers as they advance to a co-located office or BHH. We meet them at their offices to engage in training and conduct readiness assessments. Our provider services team includes a wide array of subject matter experts who work together to support the transformation process, including medical directors, quality practice advisors (QPAs), field Care Managers, operations account representatives, practice transformation specialist, claims specialists, behavioral health coordinators, pharmacists, and staff specializing in electronic medical record (EMR) integration and reporting.
Provider Training	Our training program includes a readiness assessment that outlines the different phases of the process, including milestones and key change concepts based on patient-centered care, continuous quality improvement, and sustainable business operations. We help each practice analyze their current workflow to reduce unnecessary testing, facilitate smart referrals for whole-person support, and leverage their Enrollee data to gain insights into quality, cost, and utilization performance. We work with each practice on quality improvements, educating providers on the VBP contract and tracking whole-person HEDIS

Resources	Description
	quality measures, such as LDL Cholesterol, Follow-up within 7 days after Mental Health Hospitalization, and Diabetes Screening for Enrollees using Anti-Psychotics. Training includes the use of integrated screening tools, clinical practice guidelines (CPG), Care Coordination and management, working with the MDT, participating in cross-training for physical and behavioral person-centered care, and caring for Enrollees with co-morbid conditions. In addition, we train providers on identifying the social support needs of our Enrollees using reports that track social data and care needs and plugging the Enrollee into community resources through our Community Connections model and closed-loop referral system.

Leveraging Lessons Learned and VBP Incentives from WellCare Health Plans

In Arizona, WellCare implemented a shared savings arrangement with Catalytic Health Partners that aligned with the Substance Abuse and Mental Health Services Administration's (SAMHSA) six levels of behavioral health integration. This partnership has resulted in improved outcomes for Enrollees receiving whole-person care, including a 36% decrease in ED visits, a 47% decrease in PHQ-9 depression scores, a 91% increase in blood pressure improvements, and an estimated $1.1 million in medical and pharmacy savings.

INNOVATIVE APPROACH TO SYSTEM TRANSFORMATION IN KENTUCKY

WellCare of Kentucky has been a pioneer in system transformation since 2011. Our infrastructure includes an extensive network of qualified, experienced behavioral health providers and relationships with the CMHCs, FHQCs, and other providers in each region of the Commonwealth. This network ensures that Enrollees have access to an environment that proactively encourages and supports a fully integrated experience for whole-person care. As the healthcare system in the Commonwealth continues to evolve, we continue to promote innovative approaches that improve the whole-person care experience for our Enrollees, including co-located offices and BHHs. Along with some of our most progressive and highest performing provider partners in the Commonwealth, we believe in a shared vision for the future state of behavioral health environment, in which "reverse integration" at an Enrollees behavioral health provider facilitates access to mental health care as well as Primary Care Providers and even specialists to treat their co-morbid physical health conditions, such as Hepatitis C, diabetes, asthma, and hypertension. We offer practice transformation teams that guide the transition to a BHH through an implementation plan, project managers, a readiness

Figure C.20-6 P4Q Incentives

assessment, quality tracking and HEDIS measures, literature, a sample is illustrated in **Figure C.20-6**, and a thorough evaluation of current business practices.

These BHHs will give our providers the ability to coordinate true, whole-person care for Enrollees with severe behavioral health conditions, OUD/SUDs, and intellectual and developmental disabilities (IDD). In addition, we can facilitate direct access to our Community Connections program and database from the BHH, enabling providers treating the comprehensive needs of our Enrollees to connect them to local partners in their community that address SDOH.

Our current BHH initiatives are driven by VBP P4Q contracts that incentivize behavioral health providers, FHQCs, and CMHCs through a per member/per month (PMPM) payment for coordinating integrated services that facilitate a whole-person care experience. We also understand that this can be a daunting task for individual providers and even large provider groups, which is why we remain flexible with our support options. For example, if a provider lacks the time, energy, or resources to transition their practice to a BHH, we encourage them to implement partial system transformation, such as the addition of a co-located therapist in a PCP office to support their Enrollees behavioral health needs.

WellCare's Behavioral Health Home Model Sees Impactful Results in Florida

WellCare's health plan in Florida was the first MCO in the state to remove contract barriers for integrated providers, allowing behavioral health providers to bill for PCP services delivered through their programs. Through a partnership with the Peace River Center, WellCare supports the state's first Behavioral Health Home (BHH) backed by a VBP contract, applying a monthly PMPM payment to incentivize coordinating medical and behavioral health care for comorbidities. As a result, 100% of Enrollees with comorbidities received behavioral health screenings and referrals, 100% received depression screenings, 68% of Enrollees with hypertension had their symptoms adequately controlled, and 78% documented body mass index (BMI) scores.

ii. Approach for coordination with carved-out services (e.g., transportation and transitions to long term supports and services).

WellCare of Kentucky coordinates with carved-out services, such as transportation and transitions for long-term supports and services, with DMS and community organizations that provide support for our Enrollees through our Community Connections program. In addition, our fully integrated Care Coordination team provides comprehensive guidance and support for physical health, behavioral health, pharmacy, and SDOH, working closely with our Enrollees to identify gaps in care, and when applicable, to coordinate their carved-out services managed by DMS or other local organizations. We track access to carved-out services in CareCentral,

Transportation Helps Enrollees Adhere to Medical Appointments

Today, WellCare of Kentucky provides referrals to over 220 organizations providing NEMT, with 48,000 total referrals made to date, helping ensure that our Enrollees maintain their treatment plans and attend appointments that help them treat chronic medical conditions.

ensuring that the Enrollee's person-centered care plan accurately reflects the services they have received. We share the care plan with state agency care managers, local health departments, and other entities supporting our Enrollees, including waiver programs.

Our goal is to always assist Enrollees through identifying, coordinating, and referring them to the appropriate carved-out service and incorporate their activities, information, and results into their person-centered care plan within the CareCentral platform. This approach includes the following components.

Enrollee Engagement and Education. We inform Enrollees of the carved-out services available to them through a variety of communication channels including direct outreach to the Enrollee, the Enrollee portal, the WellCare of Kentucky website, the MyWellCare smartphone application, and the Enrollee Handbook. The Enrollee Handbook includes guidelines describing the available carved-out services, accessing those services, and coordinating services. The provider engagement team informs providers in each region of the Commonwealth about accessing carved-out services for our Enrollees, enabling them to facilitate referrals and engage in educational opportunities when applicable. Enrollees can contact their Care Coordinator, the Enrollee Services Line, or CCHL to discuss accessing their carved-out services. As stated, our Care Coordinators understand the needs of our Enrollees, and typically know when an individual requires access to a service not covered by WellCare of Kentucky.

Community and Stakeholder Relationship. Our leadership team manages carved-out services at the local level with our partners and community organizations in Kentucky. The Community Connections program, which connects our Enrollees to community resources and support, was piloted when we launched it in Kentucky in 2011. It has now evolved into one the most significant initiatives for WellCare across the country. WellCare of Kentucky's community engagement staff live and work in the regions they support to develop and maintain partnerships with peer organizations throughout the Commonwealth, including schools, faith-based organizations, and food pantries.

WellCare Staff Training. We train all Enrollee-facing staff on managing carved-out services and coordinating Enrollee benefits and all provider-facing staff on the authorization and referral process. We regularly update staff and our subcontractors in the Commonwealth on changes in benefits, and carved-out services as they occur. By streamlining training for all internal departments, including Enrollee Services, Utilization Management, Care Coordination, and Provider Relations, our staff fully understand the available carved-out services and the coordination process to support integration.

Table C.20-4 describes our approach to providing a few of the specific carved-out services mentioned by DMS.

Table C.20-4 Kentucky Carved-Out Services

Carved-Out Service	Description
Transportation	As Non-Emergency Medical Transportation (NEMT) is currently facilitated by the Kentucky Transportation Cabinet, Office of Transportation Delivery (contracted by DMS) and not the MCOs, we have a process in

Carved-Out Service	Description
	place to seamlessly coordinate services that enable our Enrollees to easily access transportation. As our goal is to prevent appointment cancellations, and help our Enrollees manage their chronic conditions, we assist them with the required paperwork, information, and sending their transportation requests to DMS. Understanding that sometimes, an Enrollee may not qualify for NEMT services, we leverage our Community Connections team to connect the Enrollee with external, non-profit community agencies that provide transportation to medical appointments. We also engage the Enrollees friends and family, if available, to find the best and most easily accessible option. **Today, we offer referrals to over 220 organizations providing NEMT, with 48,000 total referrals made to date.** In addition, we believe that the direct-to-consumer telehealth model taking effect in July will help alleviate some of the transportation burden through easier access to care. **We also believe that when the direct-to-consumer telehealth model becomes effective in July, this may alleviate some of the transportation burden.**
Long-Term Support and Services (LTSS)	With the understanding that LTSS is not managed by the MCOs in Kentucky, we coordinate services for our Enrollees and cover services for 30 days while they transition back to their community. Our Care Coordinators assess Enrollees for comprehensive needs (including LTSS) and make the appropriate referral to the FFS program where they are put on a waiting list. We coordinate PCP sign-offs for home care, coordinate covered and LTSS services, and educate providers and LTSS providers of the Enrollee's needs. We also coordinate with the providers regarding alerts for emergency department or inpatient admission or when Enrollee needs are not being properly met. Following acute events, we help Enrollees transfer to their least restrictive setting of choice and re-engage the community LTSS system where appropriate. In addition, we identify and assist Enrollees through covered services that support and sustain their living situation at home, such as durable medical equipment (DME), nurse aids to assist with activities of daily living (ADL), wheelchair ramps, and safety devices.
Specialized Kentucky Programs (e.g., HANDS, First Steps)	Our Care Coordinators assist Enrollees with accessing special state programs, such as Kentucky's Health Access Nurturing Development Services (HANDS), a home visiting program for expecting mothers and new parents, and the First Steps early intervention program for children with developmental delays. We connect Enrollees to programs, such as HANDS, through our Baby Steps maternity program described in Section 20.a.iii. To coordinate these services, we make a referral directly to the service provider and assist the Enrollee with the scheduling and logistics of the evaluation.

Carved-Out Service	Description
	Through the Community Connections database, our Care Coordinators provide referrals to over 150 parenting resources and 290 different parenting-related activities, such as Free Healthy Baby Classes. **In 2018, we made over 5,000 referrals to local parenting resources.** In addition, we offer referrals to five organizations offering autism services and connect Enrollees to autism-related activities, such as Autism Safety Day and an Autism Support group.
Waiver Service Programs	For Waiver Service Programs, we educate our Enrollees about the different programs, and at the Enrollees request, we coordinate with the Home Health Agency in their community that performs waiver assessments through a referral that allows them to begin the process of qualifying for the program.

iii. A description of any value-added services the Vendor proposes to provide to Enrollees.

As an experienced managed care partner to the Commonwealth, we offer access to an extensive suite of Value-Added Services (VAS) for our enrollees. At the heart of our integrated whole-person care model, these services help our Enrollees fill in critical gaps and support structures typically not covered under the umbrella of traditional benefits. Our thoughtful selection is tailored to the Kentucky population and represents what we believe are the best services capable of supporting the at-risk populations in the Commonwealth and addressing their whole-person needs for them and their families.

We develop VASs through an ongoing assessment of our Enrollees' needs—a process supported by our corporate partners at WellCare and our Community Connections model that addresses the social determinants of health having an impact on our Enrollees at a regional level. Feedback from our network of providers informs VAS development. Our VASs meet unmet social needs while focusing on education and prevention, helping individuals avoid unnecessary visits to the ED or the local hospital, and thrive through accessing resources available in the local community, thus improving health outcomes.

These services help Enrollees prevent chronic health conditions, support positive behaviors that may prevent or delay chronic disease, and improve their overall quality of life. As stewards of our Enrollees' health and satisfaction of services, our fully integrated Care Coordination team is responsible for identifying an individual's needs and helping them access the appropriate VASs. We guide them along the continuum of care, engaging them with physicians to address their whole-person needs, de-escalate health crises, and connect them to local peer and support networks, all of which is supplemented by VASs that contribute to overall health and well-being.

The following section describes the VASs provided to our Enrollees in the Commonwealth:

IMPROVING HEALTH OUTCOMES

Boy Scouts of America (BSA). As one of the largest youth organizations in the United States, the BSA operates through more than 2.4 million youth participants and nearly one million adult volunteers. We facilitate a free annual membership for Enrollees ages 6-18 to the BSA, which includes the member fee for health and accident insurance, as well as $25 toward uniforms. The goal of the BSA is "to train youth in responsible citizenship, character development, and self-reliance through participation in a wide range of outdoor activities, educational programs, and, at older age levels, career-oriented programs in partnership with community organizations."

Scouting values and education incorporate trustworthiness, good citizenship, and outdoor skill development. Local educational and club memberships such as the BSA help children, youth, and young adults develop a positive self-image, self-esteem, and healthy behaviors. In addition, young adults and scout leaders serve as mentors for younger children enrolled in the program, helping to teach positive behaviors that they can leverage in other areas of their life, such as school and sports programs.

Behavioral Health Services Hotline. The service hotline provides Enrollees with 24-hour support with drug and alcohol abuse and behavioral health concerns. Applying a person-centered approach to service, our hotline representatives provide crisis triaging to assess the Enrollee's need for crisis services, urgent care, or connection to their Care Coordinator and MDT for immediate engagement. Our high level of overall responsiveness rests on our "no-wrong-door" point of entry for phone calls, regardless if a call comes from an Enrollee, provider, or caregiver. To ensure we manage the crisis and assess for any other needs, we follow up with Enrollees within 24 hours (next business day) for all calls made to the hotline.

Girl Scouts of America (GSA). GSA is a youth organization for children in the United States and American girls living abroad. We provide our Enrollees ages 6-18 with a free annual membership, as well as for adult Enrollees seeking to become a troop leader or participate in GSA activities. We provide $25 toward uniforms. The GSA prepares girls to empower themselves and promotes compassion, courage, confidence, character, leadership, entrepreneurship, and active citizenship through activities, such as camping, community service, and learning first aid.

Home-Delivered Meals Program. Enrollees discharged (within 14 days) from an inpatient hospital, rehabilitation, skilled nursing facility, or behavioral health facility can receive ten meals per authorization. Home delivered meals help Enrollees support a healthy lifestyle through nutritious "whole" food to help with the recovery process following discharge.

Maternity Smartphone Application. At the touch of a button, new mothers have unlimited video access, 24/7, to certified dieticians and lactation consultants. Enrollees receive breastfeeding support and guidance from these specialized providers for any health issues their babies may be experiencing such as colic, digestion, transitioning to solid foods, to name a few. As part of our ongoing focus on continuous quality improvement and ensuring Enrollees receive the care they need, while the app aims to improve health outcomes while also reducing costs to

the healthcare system. Push notifications include helpful alerts for health and safety tips beneficial to both mothers and their babies.

MyStrength. An online, evidence-based behavioral health therapy platform, MyStrength provides our Enrollees with interactive clinical programs empowering them to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges, while also supporting the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care. MyStrength's integrated model includes computer-based cognitive behavioral therapy (cCBT), mindfulness, motivational interviewing and Assertive Community Treatment (ACT) protocols with personalized pathways that facilitate user interaction, mood trackers, and additional tools to measure effectiveness and improvement.

JOOL Health Coach. We are piloting a personal coaching smartphone application that encourages youth to check in with their peers and engage in healthcare services. It is tailored to specific populations and gives Enrollees with an SUD access to a transition-aged youth pathway. JOOL includes SUD assessments, resources, and referral information to help youth and their families learn about their SUD and the local community treatment options available.

Figure C.20-7 MyWellCare Smartphone Application

MyWellCare Smartphone Application. Our free MyWellCare mobile smartphone application, compatible with Apple and Android devices and shown in **Figure C.20-7**, enables Enrollees to assume more responsibility for their health through familiar tech capabilities and functions. Enrollees can call the Enrollee service number on the back of their ID cards if they have questions or require assistance downloading the application. Enrollees can view open care needs displayed together with their provider's phone number, which they can tap to call and schedule appointments. We continually add new functionalities to our digital applications to keep pace with our Enrollees' increasing utilization and feedback regarding their online experience. In 2018, as a result of **our proactive approach and updated functionality, WellCare of Kentucky experienced a YoY increase of 476% in downloads of the mobile app for Kentucky Medicaid Enrollees from 2017-2018. The top features used in 2018 were Find A Provider, Messages, and ID card.**

Over-the-Counter (OTC) Benefit. Each head of household is eligible to receive $10 worth of OTC items each month. Enrollees can choose from over 150 items to be mailed directly to their home with no prescription required. This benefit is intended to promote self-directed prevention, reduced unnecessary use of the ED, and on-going medical management. The OTC benefit includes traditional products (e.g., pain relievers, vitamins) but also includes eyeglass kits, reading glasses, and assistive aid devices such as pill containers or magnifying glasses to improve medication adherence and avoid errors in taking medications, which could result in preventable hospitalizations. In addition, by offering mail-order OTC delivery, we can provide

expanded access and time-saving opportunities for our Enrollees. **Nationally, over 230,000 Enrollees access OTC benefits, resulting in home supply deliveries for an average annual spend of $25 million.**

Respite Services. Caregivers of Enrollees receive 200 hours of in-home respite services and a maximum of five days out-of-home respite per plan year. This program supports the caregivers of chronically ill Enrollees who require relief from the responsibilities and stress of caring for their loved ones. Time away combined with in-house assistance helps relieve the caretaker's burden, providing them with the ability to maintain a healthy lifestyle, attend work, and address their personal needs that are often sacrificed based on their level of support as a caregiver.

Sports Physical. We offer sports physicals, which consist of a visit to a medical doctor for an examination to assure that Enrollees are in adequate physical condition to play a sport that interested them. Children and youth receive one free sports physical per plan year, provided by a PCP, to encourage improvements in health and wellness, and connection to friends.

Vision Benefit. Enrollees age 21 and over receive a pair of glasses every 12 months.

Healthy Rewards Program. Our Healthy Rewards Program rewards Enrollees who complete preventive health, wellness, and engagement milestones with their choice of a reloadable debit card, gift card, or e-gift card. The program serves to improve health outcomes through cash-value incentives for managing their health needs and risks. The Healthy Rewards debit card is credited upon completion of specific activities and services, thus increasing the availability of funds to be used for the Enrollee's overall healthcare.

WellCare Of Kentucky's Healthy Rewards program is available to all our Enrollees across the Commonwealth. Nationally, as many as 200,000 Medicaid Enrollees are engaged in the program, with 50,000 activating their Healthy Rewards Accounts (25% overall utilization).
To date, Enrollees have received over $1 million in redeemed rewards.

Bonus Rewards for Expecting Mothers

We incentivize our pregnant mothers with rewards for completing pregnancy and postpartum care visits with their providers and maintaining overall health throughout their pregnancies. As part of our Healthy Rewards program, pregnant Enrollees receive bonus rewards, which they can apply to receive a stroller, pack-n-play, car seat, breast pump, or six-packs of diapers. At a national level, we currently have more than 50,000 Enrollees participating in the Prenatal Incentives Rewards program — equating to over $200K used for the purchase of maternity-related items.

In addition to the foregoing Value Added Services, WellCare's core programs include services that are available to selected Enrollees to improve health status, increase self-sufficiency and reduce disparities, including the following:

Disease Management Programs. Our disease management programs support Enrollees with the following health conditions: asthma, coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression, diabetes, HIV, and high blood pressure. We assign our Enrollees to the appropriate disease management program based on their chronic conditions to monitor their health and maintain well-being. We provide support services, health coaching, and coordination with local programs and support groups that help them address the condition and improve their quality of life.

Maternity Care Program. The WellCare Baby Steps program improves maternal health and birth outcomes through the delivery of services by multidisciplinary, integrated Care Coordination and Care Management services team for all pregnant Enrollees, regardless of risk level, from conception and up to a minimum of 60 days postpartum. The program covers a variety of services to manage Enrollees who are pregnant and deliver positive birth outcomes for both the mother and the infant, including a reduction in preterm births, NICU admissions, NAS newborns, and Caesarian section (C-section) rates. Program interventions include Enrollee education and incentives, OB provider education and incentives through our value-based payment arrangements, BH integration, and partnerships with community organizations, including WIC and HANDS.

Progeny NICU Program. We partner with Progeny Health to improve the health outcomes of our NICU population in Kentucky to assist in maintaining exceptional quality for our tiniest Enrollees. Progeny assists in streamlining the care plan and service provision for the NICU population while also providing support through the first year of life. Our experience with our Progeny partnership has seen a positive trend in readmissions and reduction in average length of stay.

INCREASE SELF-SUFFICIENCY AND REDUCE HEALTH DISPARITIES

College-Bound Dormitory Room Items (Foster Care). Provides dorm room items to foster care children who are college bound. Items include bedding, flatware, bathroom items, etc. This benefit is also available to children in the foster care system who are continuing their educating and attending college.

College Scholarship. Scholarship award for Enrollees age 18 and up who are entering college. We award ten $1,000 scholarships per year (includes trade schools, college, and universities). This benefit is also available to children in the foster care system who are continuing their educating and attending college.

Criminal Record Expungement. Through this benefit, we pay for the $40 certification fee required to file for the expungement of an Enrollee's minor felony or misdemeanor charge from their record. This benefit helps the Enrollee obtain a fresh start in their community, such as with obtaining employment that requires a background check.

Foster Care Transition Kit. Provides a travel bag to Enrollees that they can use when they transition from a foster home, including toiletries, pajamas, and a book. The transition kit helps children in the foster care system transitioning into another foster home facility.

IMPROVE HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES

SafeLink Smartphone Program. Our SafeLink program provides our Enrollees with modern technology capable of facilitating an easier communication process with their WellCare of Kentucky team, local physicians, and community support resources. While many Enrollees can afford smartphone technology, we do realize that both phones and monthly data plans can be expensive and that some Enrollees may not have the means to consistently afford a smartphone or have restrictions that limit their ability to engage with their team.

The program includes the following features:

- Care Coordination support, including reminders for health appointments, wellness screenings vaccines, and immunizations, and assistance with appointment setting. This is particularly important for our high-risk pregnant Enrollees and those with chronic conditions.
- A free smartphone that includes 1000 monthly calling minutes; unlimited text messages; 1GB of monthly data; voicemail, caller ID and call waiting; technical support; direct access to our Enrollee Services Call Center; and direct access to 911.

IMPROVE HEALTH OUTCOMES AND ADDRESS SOCIAL DETERMINANTS OF HEALTH

Community Connections Help Line (CCHL). Our Community Connections model, led by Elizabeth Starr, partners with nearly 335,000 community-based social services in Kentucky to help Enrollees eliminate daily stressors that serve as barriers to treatment, such as childcare challenges, housing instability, food insecurity, domestic violence, literacy challenges, and unemployment. The CCHL, open 9am-6pm EST, Monday through Friday, connects Enrollees and non-WellCare individuals to these services.

- *WellCare Works.* As part of our Community Connections program, we offer employment assistance through WellCare Works.
- *WellCare Works Employment Tools* are designed to help Enrollees jump-start their job search, secure their GED or fill a digital gap for Enrollees who might not be able to use physical job sites.
- *WellCare Works Volunteer Opportunities* have been identified by our Local Community Engagement team. **This includes over 226unique activities and 64,000 volunteer opportunities in 2020**.
- *Local Community Engagement Partners* work directly with WellCare of Kentucky Enrollees every day and are our "feet on the street" for WellCare Works. **Since January 2019, 725 community partners have been trained and 13 partnerships across the Commonwealth have been built to help connect Enrollees to WellCare Works. Year to date WellCare Works has been accessed by 850 WellCare of Kentucky Enrollees across 109 Kentucky counties.**

Steps2Success. The Steps2Success program provides education and reading mastery benefits for Enrollees that help prepare them for success in school, academics, and a lifelong learning experience. Having the advantage of extensive knowledge, vocabulary, and the test-taking required in the school system to succeed, skilled readers and learners can carry these skills forward through college, adulthood, and their working life. Success in reading and academics helps improve self-esteem, and health literacy expands participation in health activities and positive behaviors. The Steps2Success program includes the following components:

- *Job Training and Financial Education.* We provide job training and financial education classes for Enrollees to address education, employment, and economic barriers. This includes 12 tutoring services for children, youth, and adults up to age 21.
- *Reading Scholarships.* We award 200 reading scholarships to Enrollees in pre-Kindergarten through the 12th grade to help them improve reading skills.
- *General Education Development (GED) Exam Preparation Program.* We provide a free GED Exam for Enrollees age 16 and over, not currently enrolled in high school, not a graduate from an accredited high school, and have not received a high school equivalency certificate or diploma. To help ensure testing success, Enrollees must complete the required GED coursework at an adult testing center.

Steps2Success Program Helps Enrollee Take First Step Toward A Nursing Career

A WellCare Enrollee learned about our GED Exam Benefit during a community event in Georgia hosted by the Savannah Housing Authority. Prior to the event, the Enrollee wanted to become a Certified Nursing Assistant (CNA) but learned that a high school diploma would be required before she could be accepted into the CNA training program. During the event, a WellCare team member spoke about the GED exam preparation program and using one of our vouchers, the Enrollee signed-up for her GED exam. After passing the exam, she enrolled in the CNA training program and graduated three months later. She then transitioned to a two-year program at Savannah Technical School to earn her Associate's Degree in surgical technology.

XtraSavings Program. Our XtraSavings Program provides Enrollees with access to monthly discounts not available to the general public. This program includes the following benefits:

- *OTC4Me.* Discounts on more than 500 OTC items our Enrollees use every day, such as vitamins, toothpaste, diapers, and more. Enrollees enjoy a 20% discount on their first order and then receive a 10% discount on each subsequent order.
- *CVS Discount Card.* The CVS ExtraCare Health Card saves Enrollees and families 20 percent on thousands of CVS pharmacy brand health-related items. The 20 percent discount applies to regularly priced items of $1 or more purchased at any CVS pharmacy location or online.

b. Provide the Contractor's approach to assisting Enrollees to access direct access services and second opinions, and referrals for services not covered by the Contractor.

WellCare of Kentucky follows a standardized, well-defined approach for assisting Enrollees who need access to direct access services, second opinions, and referrals for services not covered by WellCare of Kentucky. In this section, we describe our approach to adhering to the contract

requirements of Section 30.2 Direct Access Services; the contract requirements of Section 30.3 Second Opinions, including routine network evaluation to enlist in-network or out-of-network providers with the qualifications and expertise to meet an Enrollee's need for a second opinion; and the contract requirements of Section 30.6 Referrals for Services Not Covered by Contractor, including processes and procedures to refer Enrollees to services covered by Medicaid fee-for-service (FFS) providers and programs, such as non-emergency medical transportation (NEMT).

As is the intent of our coordination for carved-out services and our suite of VASs, our goal is to provide Enrollees with access to services for their whole-person service needs and to make sure they feel comfortable with the providers providing those services and know how to access or ask for assistance with accessing services covered by FFS programs and providers.

We educate Enrollees about accessing direct access services with the Welcome Call, one-on-one interactions with their Care Coordinator, the Enrollee Handbook, Enrollee portal, Enrollee newsletter, the MyWellCare smartphone app, and when they call the help line. We assist Enrollees with information about provider office locations, languages spoken, gender preferences, and contact information. We support access to medical appointments by assisting with appointment scheduling and referrals to non-emergency transportation (NEMT) to the desired provider, as well as connecting Enrollees to local social resources, such as childcare.

WellCare of Kentucky maintains an open network and our Enrollees can see any in-network provider. We ensure direct access and do not restrict the choice of a qualified provider by an Enrollee for the following services within our network:

- Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists, and opticians
- Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontist
- Voluntary family planning in accordance with federal and state laws and judicial opinion
- Maternity care for Enrollees under 18 years of age
- Immunizations to Enrollees under 21 years of age
- Sexually transmitted disease screening, evaluation, and treatment
- Tuberculosis screening, evaluation, and treatment
- Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020
- Chiropractic services
- Specialists as appropriate for an Enrollee’s condition and identified needs for Enrollees with special health care needs requiring a course of treatment or regular care monitoring
- Women’s health specialists

Second Opinions. Enrollees have a right to obtain a second opinion in or out of WellCare of Kentucky’s Provider network and to receive information on obtaining second opinions related to surgical procedures and to complex and/or chronic conditions. We inform Enrollees, in writing, at the time of Enrollment, of an Enrollee’s right to request a second opinion. At an Enrollee's request, we provide for a second opinion related to surgical procedures and the diagnosis and treatment of complex or chronic conditions within our network or arrange for an

Enrollee to obtain a second opinion outside the network without cost. Often, when seeking medical advice or treatment for conditions ranging from mild to a potentially life-changing event, it can be daunting or confusing for an Enrollee to receive a new diagnosis. In these situations, we recognize that our Enrollees and their families only want to find the best possible medical opinions and treatment options available. As such, all Enrollees may request a second opinion when there is a question or dispute with either the Primary Care Provider, or a decision made related to the necessity of surgical procedures or the diagnosis and treatment of complex or chronic conditions. It is perfectly acceptable for a member of the healthcare team, parents, guardians, or a social worker to make the request on behalf of an Enrollee.

Our Enrollee Services representatives assist Enrollees with identifying a second opinion provider and with scheduling the appointment. Subject to an Enrollee's consent, the representative contacts the Primary Care Provider. In addition, we use all Enrollee touchpoints as an opportunity to discuss with and educate Enrollees regarding their concerns, including how to request a second opinion.

We handle requests for second opinions using the following methods:

- *In-Network Providers.* Enrollees receive a second opinion at no cost by a qualified healthcare professional within our existing provider network. WellCare of Kentucky has in place a robust provider network throughout the Commonwealth, which includes pediatricians and specialty care providers capable of assisting with second opinions, while also working with our staff to coordinate services with the Primary Care Provider.
- *Out-of-Network Providers.* If there is not an in-network participating provider with the expertise required for the medical condition available, then a non-participating provider provides the second opinion at no cost to the Enrollee. Enrollees may elect to have a second opinion provided by an out-of-network provider located in the same geographical service area. On a case-by-case basis, we negotiate a single case agreement with out-of-network providers to avoid balance billing and ensure these providers meet Medicaid requirements.

It is the responsibility of the Primary Care Provider to coordinate tests ordered for a second opinion with participating providers and to develop a treatment plan for the Enrollee after review of the second medical opinion. We educate Primary Care Providers about second opinion processes and their responsibilities during provider orientation and in the Provider Manual.

Referrals for Non-Covered Services. We acknowledge that certain Medicaid services are excluded from the Kentucky Medicaid Managed Care benefits package, but continue to be covered through the traditional FFS Medicaid Program. Our customer service and field-based staff receives annual training and have reference documents available to them to assist Enrollees and coordinate with DMS' providers in the delivery of these services to our Enrollees.

When an Enrollee needs to receive a Medicaid service outside the scope of our covered services, we refer the Enrollee to a qualified healthcare provider in the Medicaid FFS program and/or to needed services covered by the FFS Medicaid Program—as directed by DMS. We have written policies and procedures for the referral of Enrollees for non-covered FFS Program services, including transition to a qualified healthcare provider and assistance with obtaining a

new Primary Care Provider and for accessing FFS services, such as NEMT. When referring Enrollees to needed services not covered by WellCare of Kentucky, we track the referrals and services being provided by a FFS provider or program in the Enrollee's record in CareCentral, making sure an Enrollee's person-centered care plan accurately reflects the services and this information is available to the entire MDT. Our of our Care Managers, Care Coordinators, integrated care team, Enrollee Services representatives, and the CCHL staff complete training on MCO-covered and FFS Program covered benefits and services and know how to refer, connect and coordinate Enrollee care and services to FFS providers when necessary—including engagement and coordination with carved-out FFS service providers, local community partners, and programs run by DMS and other state agencies. The Community Connections program tracks Enrollee services provided in the community through our local partnerships to address SDOH and other needs. Our local Care Coordinators maintain knowledge of services outside the scope of WellCare of Kentucky and proactively discuss referral options for our Enrollees' person-centered needs.

c. Describe the Vendor's proposed approach to the following:

i. Interfacing with the Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

WellCare of Kentucky has routinely worked alongside DMS and DHBDID in the form of ongoing meetings to collaborate on the leading behavioral health issues facing the Commonwealth and our Enrollees. With the establishment of the new collaborative workgroups, Lori Gordon, the future SKY Executive Director, or her designee will meet no less than quarterly to discuss State Mental Health Authority and Single State (substance abuse) Agency (SSA) protocols, rules, and regulations. As part of this process, CareCentral enables us to make the Enrollee's person-centered care plan available to the MDT and state agency staff when working together on transitions of care and other Enrollee-facing activities.

Historically, WellCare of Kentucky has been viewed as a leader in the field of integration and behavioral health care. Leveraging our experience as one of the only MCO's in the Commonwealth to provide in-house behavioral health services, we have always responded to requests by DMS, DBHDID, and other state agencies for recommendations and guidance with the expertise of our integrated care team. This input includes our lessons learned through trial and error, pilot program ideas and results, and evolving best practices within the industry that we regularly apply throughout our Care Coordination program.

Topics for Discussion. Through this collaborative process, we will speak to the topics of SMI and SED; other priority populations; Targeted Case Management (TCM); Community Associate and Peer Support provider certification training and processes; satisfaction survey requirements; priority training topics (e.g., trauma-informed care, suicide prevention, co-occurring disorder, evidence-based practices); the Behavioral Health Services Hotline; and behavioral health crisis services, as specified by DMS.

As requested by DMS, WellCare of Kentucky and our behavioral health team will coordinate the following processes:

Enrollee Education Process. Specific to individuals with SMI and children and youth with SED, we will provide DMS and DBHDID with our proposed education materials and protocols. In addition to education provided by the Enrollee's Care Coordinator, we typically address SMI and SED topics using education materials such as the Enrollee newsletter, Enrollee portal, and Enrollee Handbook. DMS approves our Enrollee Handbook and all other educational materials, as required under the current contract. In addition, we regularly identify Enrollees experiencing or at-risk of SMI or SED through the HRA, the Enrollee Services Call Center, the NAL, CCHL, and our REACH (Unable to Contact) program for hard-to-reach Enrollees. Each of these channels triggers an actionable engagement by an assigned Care Coordinator, who educates and guides the Enrollee's whole-person care experience when receiving treatment for their comprehensive needs. In addition, our provider engagement team works closely with our provider network to educate them on the importance of identifying and referring Enrollees with SMI or SED to WellCare of Kentucky for enrollment in Care Coordination and a qualified behavioral health specialist. Our provider education tools include PCP-behavioral health toolkits, which contain evidence-based screening tools and CPGs that assist them in the support process for specific SMI and SED issues, **Figure C.20-6**, and integration with support for physical health needs.

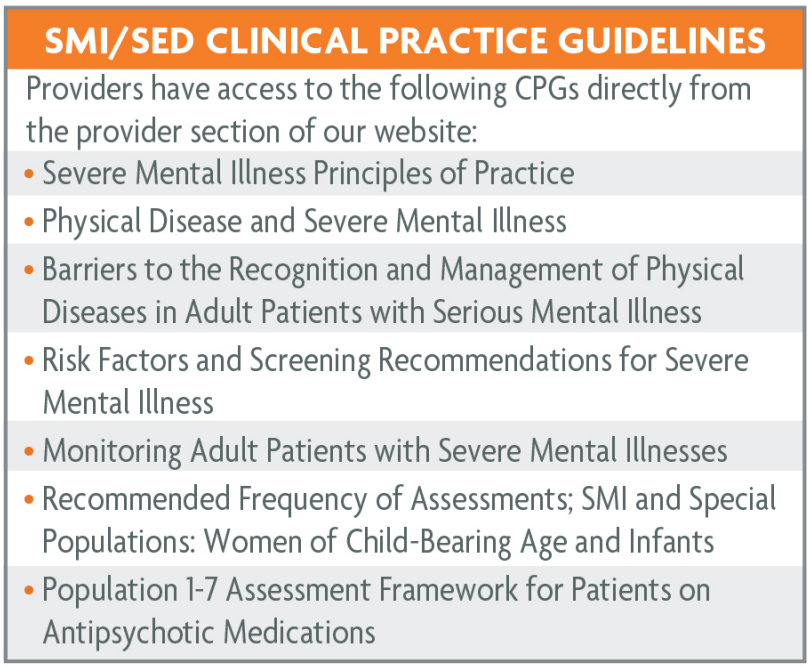

Figure C.20-6 SMI/SED Clinical Practice Guidelines

To encourage referrals and immediate action, we educate providers on implementing the Screening, Brief, Intervention, and Referral to Treatment (SBIRT) model, helping providers rapidly assess the severity of a behavioral health condition, engage in feedback, and identify and refer the Enrollee to an appropriate local treatment provider. Once the Enrollee is identified, WellCare of Kentucky sends them a welcome packet, which includes the Enrollee Handbook that addresses accessing benefits and services for behavioral health and crisis situations.

Integrating Behavioral Health Services Hotline. We recognize that DMS is seeking to streamline the disjointed mobile crisis support system in the Commonwealth. In addition to financial contributions, we would propose working with the MCOs to develop a single, accessible hotline capable of routing all Enrollees to the appropriate MCO Behavioral Health Services Hotline. This would eliminate the confusion sometimes caused by multiple numbers, and simplify the system

down to a single, easily identifiable number to support Enrollees behavioral health needs and crises. In the meantime, we educate Enrollees on how to access our Behavioral Health Services Hotline, which supports emergency and crisis situations by trained personnel, 24 hours a day, seven days a week, 365 days a year, toll-free throughout the Commonwealth. Adhering to the contract requirements, WellCare of Kentucky will continue to implement our approved processes along with DMS, DHBDID, and the CMHCs for our integrated service lines that route Enrollees to the appropriate hotline based on their immediate needs, as seen in **Figure C.20-7**.

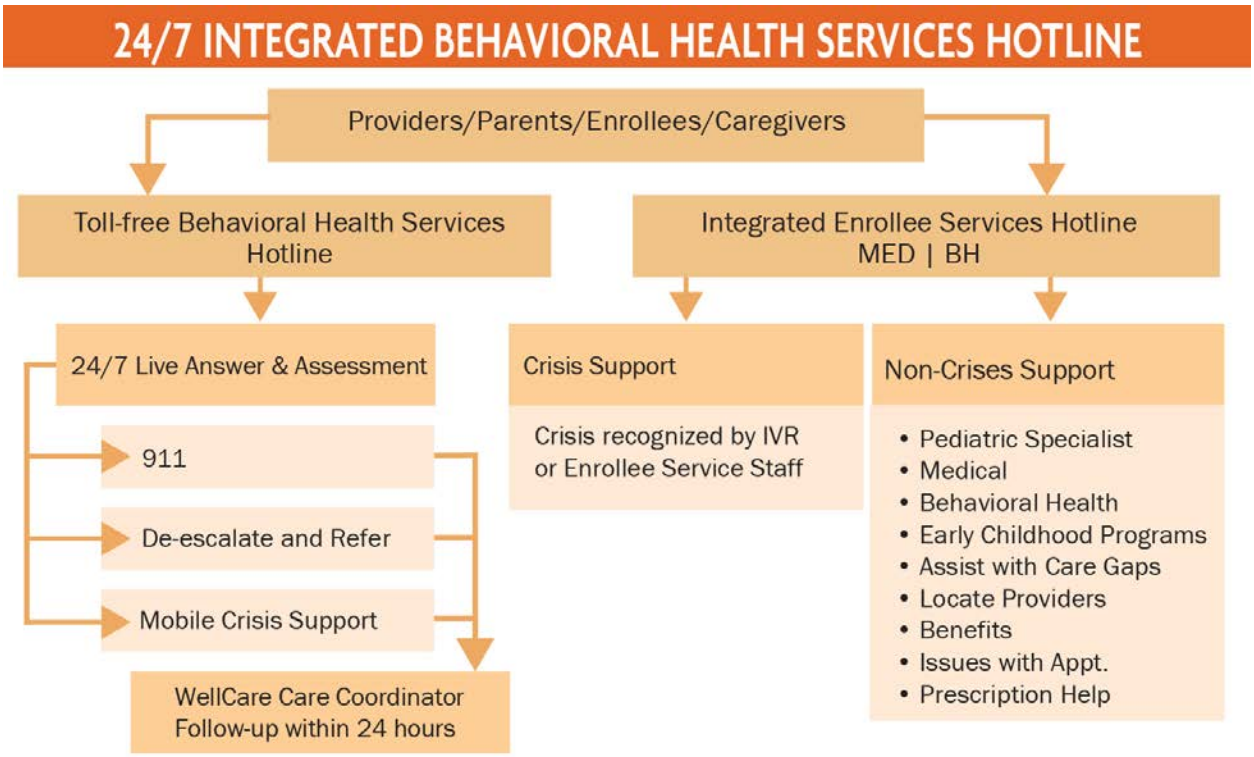

Figure C.20-7 Behavioral Health Services Hotline Routing Procedures

Our dedicated Behavioral Health Services Hotline staff are licensed professionals, including LMHCs, licensed clinical social workers (LCSW), as well as registered nurses and developmental and intellectual disabilities (DID) professionals with advanced behavioral health training. They intervene, de-escalate, and support Enrollees in emergent situations. In 2018, the national hotline supporting WellCare health plans nationwide received over 10,000 Enrollee calls, with nearly 1,000 coming from the Commonwealth.

In addition to our dedicated Behavioral Health Services Hotline team, we train each member of our Enrollee Services staff to respond to the unique physical, behavioral, pharmacy, and SDOH needs of our Enrollees for their whole-person care experience, including assessing the need for a crisis response. We provide our Enrollees, DMS, DHBDID, providers, FHQCs, and CMHCs with information regarding the hotline and how to access it. This open communication process ensures that our Enrollees learn about our hotline resources through multiple channels and feel comfortable reaching out for support when necessary.

Collaborative Agreements. As we have successfully championed for over eight years, WellCare of Kentucky will continue to work with DMS on establishing collaborative agreements with state-operated or state-contracted psychiatric hospitals, as well as with other Department facilities for individuals with co-occurring behavioral health and DID. We have described this process more in-depth in the response to the following question.

ii. Coordinating with the Department to establish collaborative agreements with state operated or state contracted psychiatric hospitals and other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. Describe potential challenges and methods to address such challenges.

WellCare of Kentucky continues to coordinate with DMS to establish collaborative agreements with state-operated or state-contracted psychiatric hospitals and other Department facilities that support individuals with co-occurring behavioral health and DID. Since 2011, we have participated in collaborative transition of care meetings for our Enrollees to assist with the development of the transition plan as they prepare to return to their home or community setting. Our goal is to work with the CMHCs to ensure our Enrollees have the opportunity, resources, and support to live independently in their communities.

We participate in transition planning and ongoing Care Coordination for these Enrollees, many of whom have SMI and are transitioning from a licensed Personal Care Home (PCH), psychiatric hospital, or other institutional settings to integrated, community-based housing. Adhering to the contract requirements, we participate in and have attained full compliance with all IPRO Medicaid compliance audits through our participation and contribution to the transition of care process.

The following describes our processes:

- *Regional Transition Committee Meetings for State Hospitals.* Our Care Coordinators attend monthly Regional Transition Meetings held at the state hospitals across the Commonwealth. Coordinated with DHBDID and community mental health providers, we review the list of identified WellCare of Kentucky Enrollees, current treatment issues, barriers to receiving treatment services, and the transition plans to move Enrollees to community-based housing. In addition, we participate in bi-monthly Interim Settlement Agreement (ISA) meetings.
- *Continuity of Care Meetings.* Our Care Coordinators attend the quarterly Continuity of Care meetings to identify and review Enrollees with rapid re-admissions, and identify all Enrollees with DID diagnoses. Facilitated by DHBDID, these meetings take place at the state hospitals and include the ombudsman, MCOs, and CMHC staff to ensure every individual is being supported by CMHC resources upon discharge.
- *Enrollees Living in PCHs.* We assign a Care Coordinator to each of the state facilities to engage Enrollees and their caregivers whenever an individual is identified who would like to transition to community-based housing. CMHCs are required to perform outreach visits to the PCH and determine if an Enrollee prefers to live independently in the community with supports from the CMHC. Our Care Coordinators communicate with each of the CMHCs

across the Commonwealth through email on a bi-weekly schedule to identify Enrollees transitioning from the PCH to independent living.

- *Care Coordination Enrollment.* If we identify an Enrollee for transition within the next 30 days, we automatically enroll them in Care Coordination and collaborate with the appropriate CMHC staff and Enrollee. We collaborate with CMHC staff on a weekly basis to review the Enrollee's status and obtain a copy of the Person-Centered Recovery Plan developed by the CMHC provider.
- *Comprehensive Assessment.* Within 14 days of the transition from the psychiatric hospital or PCH into community-based housing, we meet with the Enrollee and perform a comprehensive assessment to ensure their physical, behavioral, pharmacy, and SDOH needs are met.
- *Ongoing Support.* Based on the results of the assessment, we may enroll the Enrollee into the Care Coordination program for ongoing support. We also attend regular meetings with the CMHC to discuss the Enrollee's status. During this time, we complete a PHQ9 and CAGE assessment along with the SF-12. We incorporate the Enrollee's Person-Centered Recovery Plan into their WellCare of Kentucky care plan documented in CareCentral.
- *Enrollees with DID.* Enrollees with DID admitted to state hospitals are identified in Continuity of Care meetings and by CMHC care managers. During this meeting, all Enrollees that require outreach are discussed, and a transition plan is developed. All Enrollees with DID receive the same dedicated Care Coordination support we provide all individuals under our care.

As Enrollees with co-occurring behavioral health and DID conditions require specific supports and resources to maintain well-being and live independently, our integrated Care Coordination team strives to engage Enrollees in face-to-face visits to better understand their needs and personal goals. By meeting with them in their environment, we can assess their needs and identify resources that will help improve their quality of life and ability to live independently. The following includes examples of our support for Enrollees with DID:

- Referrals to the Commission of Children with Disabilities, Brain Injury Services, and resources for Enrollees with vision or hearing impairments.
- Grant funding to local agencies to help address specific DID needs, facilitated by ongoing communication between our Care Coordinators and the agencies.
- Partnering with the Office of Vocational Rehabilitations to facilitate Enrollee assessments and referrals to local agencies that assist with employment opportunities and connections, such as the Opportunity for Work and Learning (OWL).
- Connecting children to the Kids SpOt Center for the evaluation and assessment of disabilities, and coordinating services for occupational, physical, and speech therapy.
- Referrals to the Human Development Institute (HDI) Center for Assistive Technology (CATS) to obtain DID-related equipment such as talking boards or text, telephone, and typewriting (TTY) devices that help Enrollees maintain independence in the home. HDI CATS is the regional Assistive Technology Regional Center (ATRC) serving Lexington and the surrounding region.

CHALLENGES AND METHODS TO ADDRESS SUCH CHALLENGES

One of the major challenges of the discharge and transition planning process that our team experienced is the communication between our Care Coordinators and the CMHCs supporting our Enrollees. From discharge to the transition to a PMH, we need to know where our Enrollees are located so we can provide assistance and ensure they experience a comfortable, seamless transition. To address this challenge, we developed a new communication process with the CMHC liaisons, which includes weekly or bi-weekly email communication that helps us identify whether or not any new WellCare of Kentucky Enrollees are transitioning. This high-touch communication helps us stay informed in between the Regional Transition Committee meetings.

Helping Enrollee with Autistic Disorder Obtain Community Living Waiver (SCL)

The state guardian for a 25-year-old Enrollee with autistic disorder requested assistance from the assigned WellCare of Kentucky care coordinator. Sadly, the Enrollee's biological family was deceased, forcing the Enrollee's entry into adult guardianship. Previously, the Enrollee had been sheltered at home and never received any behavioral health services prior to this time. The guardian recommended that the Enrollee receive psychiatric testing. To coordinate, we collaborated with the Pennyroyal CMHC and the Enrollee's PCH to engage in psychological testing. Based on the results, the guardian was able to apply for a Support for Community Living (SCL) waiver, which provides Medicaid-paid services to adults or children with intellectual or developmental disabilities. These supports include updates to an individual's home or vehicle to ensure personal safety; personal assistance with tasks such as bathing, dressing, grooming, housework, laundry, and meal planning; positive behavior supports to identify and reduce behaviors that interfere with activities of daily living (ADL) and social interaction; and residential support services that help individuals live as independently as possible.

iii. Complying with the Mental Health Parity and Addiction Equity Act.

We fully support parity for mental health and addiction to help our Enrollees live a better and healthier life. Our integrated model of care with one integrated care team covering all care needs, including physical, behavioral, pharmacy, and unmet social needs, focuses on the delivery of whole person care. With behavioral health care available as an essential and covered benefit, we improve health outcomes by reaching additional people with prevention, wellness promotion, and early intervention and treatment of mental health and substance use disorders (SUD). WellCare of Kentucky and our providers comply with the contract requirements in 30.9 Mental Health Parity and the Mental Health Parity Addiction Equity Act (MHPAEA) of 2008 and 42 C.F.R 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by WellCare of Kentucky and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. As evidence of our ability to comply with mental health parity requirements and regulations, refer to **Attachment C.20.c.iii WellCare Parity Submission Form - KY – Final,**

provided electronically. WellCare submitted our CMS Toolkit Parity document to DMS in August 2017. DMS had some questions, which were addressed. We continue to update our submissions as required by CMS and as benefit plan designs may change by the Commonwealth – remaining in compliance with mental health parity per CMS guidelines.

We continually support compliance with mental health parity by:

- Making sure our utilization grids comply with mental health parity
- Providing ongoing expert consultation and recommendations regarding compliance with MHPAEA as specified in the benefit plan
- Verifying medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits
- Ensuring the criteria for medical necessity determinations for mental health or SUD benefits are available to Enrollees, potential Enrollees, and network providers by making our level of care and coverage determination guidelines available online
- Ensuring plan benefits include a clear description of the behavioral levels of care and covered services
- Maintaining a clear and easily accessible process for filing appeals and complaints, which complies with regulatory requirements
- Offering robust provider network and monitoring the availability of providers
- Providing a clear reason to Enrollees and providers for any denial of reimbursement or payment with respect to mental health or SUD benefits

From how we authorize services to how we monitor and evaluate services, our utilization management program complies with federal laws and regulations on mental health parity, including MHPAEA. We do not require referral for routine outpatient behavioral health services. We ensure Enrollees have access to a mental health or substance dependence assessment without requiring prior authorization. Specialty services like psychological testing require authorization, which similar to authorization for medical specialty providers. To ensure ongoing compliance with parity requirements, we established and maintain a cross-functional task force with executive leadership support that audits, monitors compliance, and collaborates to ensure behavioral health and substance use disorder services remain in parity compliance with physical health services. The task force conducts a thorough review of the impact of MHPAEA to all key functions covering our benefits, clinical management processes, and network contracting.

In 2017, WellCare developed a template analysis document, using the Centers for Medicare & Medicaid Services (CMS) Parity Compliance Toolkit, published in January 2017 as a guide. The document is the basis for assessing our compliance with the MHPAEA. Within it, there are five sections, each addressing a specific parity component: Benefit Classification; Analysis of Financial Requirements, Quantitative Treatment Limitations (FRL), and Aggregate Lifetime and Annual Dollar Limits; Non-Quantitative Treatment Limits (NQTL); and a Compliance Monitoring Plan. Our internal audits have shown we are consistently within parity along each domain.

d. Describe initiatives the Contractor will implement to identify trends in provider-preventable conditions and to educate providers who are identified as possibly needing support in better addressing those conditions.

Under the leadership of our CEO, Bill Jones, WellCare of Kentucky follows CMS guidelines for provider-preventable conditions (PPC) and has processes in place through our provider and clinical teams, along with our Medical Director, Dr. Howard Shaps, and the vice president of health services, to educate providers who require enhanced support and guidance for addressing certain conditions. PPCs include health care-acquired conditions (HHAC), other provider-preventable conditions (OPPC) and "Never Events," which refer to significant preventable medical errors that our Enrollees should never experience.

In our experience, the most effective strategy for reducing PPC involves extensive training of hospital staff, education, and safety-oriented process design. We require all providers to report PPCs associated with claims for payment or Enrollee treatment for which payment would otherwise be made. WellCare of Kentucky will report all identified PPCs in a form and frequency as specified by DMS.

The following describes our processes to identify PPCs, deny payments when appropriate, and educate our providers to prevent PPCs from occurring:

Defining a Provider Preventable Condition. In accordance with Section 2702 of the Patient Protection and Affordable Care Act of 2010, we follow the required non-payment policies for PPCs, including HCACs. We consider a PPC to be any condition in a healthcare setting resulting in a negative consequence, such as an infection, a preventable surgical complication, or poor glycemic management. We consider an unexpected death or serious disability resulting from a surgical or invasive procedure or any event deemed preventable using medical literature review by a qualified professional to be a Never Event. Never Event errors include surgical or other invasive procedures resulting in a different procedure altogether; the correct procedure but on the wrong body part; or the correct procedure on the wrong patient, to name a few.

PPC Coding. The first step in ensuring non-payment for a PPC is to identify those conditions that fall into the PPC category. We identify codes using our core processing system that matches the conditions for which there will be no payment made to the provider. The codes automatically deny PPC events pending additional clinical information by system adjudication and configuration set-up parameters in the claims system.

Identification of PPC and Quality Improvement Review. Our utilization management nurses and Care Coordinators working directly with Enrollees and local providers complete training on quality concerns, which includes PPCs, HHACs, and Never Events. When a WellCare of Kentucky team member, quality staff member, or family member identifies a potential PPC, they refer the quality of care issue (QOC) to the quality improvement (QI) team for further investigation.

We define a QOC issue as a break in the standard care process that may or has led to a negative Enrollee health outcome. Additional QOC issues include delays or omissions of care, medication issues, patient safety events that cause Enrollee harm (e.g., faulty equipment, infection,

restraint-related falls), and post-operative complications causing an increased length of stay or readmission.

Example of how identifying PPC events and then educating providers reduced PPC events in Kentucky. Our WellCare of Kentucky quality team received multiple QOC concerns from both our utilization management and Care Coordination teams regarding post-operative infections from a single hospital located in Eastern Kentucky. As part of our internal process, our Medical Director, Dr. Howard Shaps, reviewed each case and decided to "track and trend" the facility in question to identify future cases. Over the subsequent months, the quality team received additional cases for a total of 15 reported concerns. Upon further review, we identified a trend that showed the majority of cases occurred following sterile surgery, such as a laminectomy.

During the review of these cases, Dr. Shaps discovered avoidable post-operative complications, such as spinal abscesses experienced by our Enrollees. Due to concerns for Enrollee safety, a team of WellCare of Kentucky quality specialists and Dr. Shaps conducted a visit to the facility to discuss their findings and educate the provider team on methods to mitigate future risk to our Enrollees. Since the intervention, we have seen a significant decrease in these cases.

Denial of Payment. We train and educate our providers, provider representatives, finance staff, utilization management nurses, and quality team on the meaning and identification of all PPC conditions that would cause a denial of payment. While we do everything in our power to ensure a safe healthcare experience for our Enrollees to avoid PPCs, we ensure no payments are made when these rare but unfortunate events do occur. In adherence with Section 30.8 "Provider Preventable Diseases," WellCare of Kentucky will not pay a provider for a PPC that meets the defined criteria, which includes the following

- Identified in DMS' Medicaid plan
- Has been found by DMS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines
- Has a negative consequence for the Enrollee
- Is auditable
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

As stated, our claims payment system is configured to deny payment for any service falling in a PPC category consistent with federal regulations. We are acutely aware of the seriousness of patient safety and adverse events and have policies, procedures, and systems in place to avoid paying for these events. In addition, whenever a potential PPC is identified but not specifically auto-denied, a referral is sent to the QI team for further investigation. All QOC concerns are used in quality committee discussion and for the credentialing and re-credentialing process for our providers.

Provider Manual and Contract. Our provider contracts reinforce the definition of a PPC and our process for automatic denial of payment whenever a PPC occurs. The Provider Manual describes our process, which prevents providers from billing, attempting to collect from or

accept any payment from WellCare of Kentucky for non-covered procedures. We remain committed to removing unnecessary, ineffective care while promoting the importance of strict patient safety measures and processes at all times. In addition, we adhered to the CMS requirement regarding a present on admission (POA) field to document the presence of anything that could become confused with a PPC. For example, if an Enrollee enters the hospital with a urinary tract infection (UTI), the POA field is used to capture the diagnosis at the time of admission so that upon discharge the hospital is not held responsible for the UTI. We ensure that providers understand the POA requirement and the need to complete that field for each WellCare of Kentucky Enrollee admitted with a condition that applies.

C.20 Covered Services

- Attachment C.20.c.iii WellCare Parity Submission Form - KY – Final (Provided Electronically)

21. Pharmacy Benefits

C.21. PHARMACY BENEFITS

a. Describe the Contractor's proposed approach to administration of pharmacy benefits and related pharmacy services, including the following in its response:

i. If using a Pharmacy Benefit Manager (PBM), provide a copy of the Subcontract, approach to integration with other services, as well as assuring transparency in pricing and reporting.

ii. Methods to ensure access to covered drugs and adherence to the preferred drug list.

iii. Responsibilities and composition of the P&T Committee.

iv. Proposed DUR Program, including approaches to collaborate with the Department on pharmacy initiatives.

v. Proposed Maximum Allowable Cost (MAC) program.

vi. Approach to operation of a pharmacy call center.

b. Describe the Contractor's pharmacy claims payment administration, including an overview of the Point of Sale (POS) system and processes for complying with dispensing fee requirements.

c. Describe the Contractor's processes and procedures to provide timely, accurate and complete data to support the Department's rebate claiming process and ensure the Department maintains current rebates levels

d. Describe the Contractor's processes and procedures to provide data and support Department-based efforts and initiatives for 340B transactions.

e. Describe the Contractor's pharmacy Prior Authorization process, including the following as part of the response:

i. Transparency in communicating the conditions for coverage to providers.

ii. Required credentials for staff reviewing, approving and denying prior authorization requests.

iii. Use of pharmacy and/or medical claims history to adjudicate prior authorization requests.

C.21. PHARMACY BENEFITS

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 31 Pharmacy Benefits of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. As such, all covered outpatient drugs, over-the-counter drugs, and compounded prescription services are provided for our Enrollees as defined by the Preferred Drug List (PDL) in conjunction with standards provided for by 42 U.S.C. § 1396r-8, as applied to Medicaid managed care in accordance with 42 C.F.R. § 438.3(s) and 438.210(a).

a. Describe the Contractor's proposed approach to administration of pharmacy benefits and related pharmacy services, including the following in its response:

As an experienced leader in the Commonwealth, and a fiscally responsible partner to DMS since 2011, WellCare of Kentucky's pharmacy program is led by our Pharmacy Director, Thea Rogers, PharmD, and Pharmacy Manager, Ayonna Tolbert, PharmD. Together, Dr. Rogers and Dr. Tolbert have worked alongside DMS and our managed care organization (MCO) counterparts to identify critical issues and develop new programs and initiatives to meet the needs of our Enrollee population across the Commonwealth. Our pharmacy program plays a significant role in maintaining the health of our Enrollees by helping manage their conditions and improve their quality of life. We leverage the deep experience of our parent organization, WellCare Health Plans, Inc. (WellCare), providing pharmacy benefits and integrated clinical services in 12 state Medicaid programs through a hybrid model in which we maintain responsibility for clinical decision-making on behalf of Enrollees and providers, instead of outsourcing this critical function to a Pharmacy Benefits Manager (PBM). WellCare is on track to administer approximately 240 million claims annually, see **Figure C.21-1**.

Over 60 Million Kentucky Claims Paid Since 2012	
Year	**Rx Count**
2012	3,253,533
2013	5,045,311
2014	8,130,368
2015	9,776,462
2016	10,523,387
2017	10,474,490
2018	10,469,280
2019	10,224,485
Total	**67,897,316**

Figure C.21-1
Pharmacy Claims

Through ongoing collaboration with our partners, prescribers, and network pharmacies across the Commonwealth, Dr. Rogers and Dr. Tolbert, along with our provider engagement team, ensure that our Enrollees receive the highest standard of local support, guidance, and reliable access to all their medications. As pharmacy management continues to play an ever-increasing role in health status through integration with physical and behavioral health services, we incorporate pharmacy into our overall clinical approach and share Enrollee pharmacy data through CareCentral, our Care Coordination platform, with pharmacists, nurses, and other clinicians. Our suite of clinical components includes programs for polypharmacy, management of antipsychotic medications for children, medication adherence and reconciliation, medication therapy management, and our One Provider-One Pharmacy program currently **helping over 2,800 Kentuckians with results from 2018 that include a 27% drop in opioid utilization, a 47% increase in Medication-Assisted Therapy (MAT), a 25% increase in maintenance medications, and a 33% decrease in Emergency Department utilization to date.**

The following section describes our proposed approach to the administration of pharmacy benefits and related pharmacy services.

i. If using a Pharmacy Benefit Manager (PBM), provide a copy of the Subcontract, approach to integration with other services, as well as assuring transparency in pricing and reporting.

WellCare of Kentucky uses a hybrid pharmacy management model that enables our team to perform the majority of critical functions and processes in-house while providing integrated support and oversight of the services performed by our PBM vendor—CVS Caremark. Our

expansive network includes more than 1,400 contracted pharmacies, with more than 1,100 located across the Commonwealth and approximately 300 out of state.

Unlike many of our competitors, **we do not outsource quality initiatives, clinical programs, prior authorizations, formulary development and maintenance, or call center management to the PBM partner.** This hybrid model promotes administrative efficiency by providing our pharmacy team with control and management of coverage determinations, redeterminations, formulary management, Pharmacy & Therapeutic (P&T) Committee responsibilities, quality measures, Drug Utilization Review (DUR), and Enrollee and provider calls. Refer to **Attachment C.21.a.i Pharmacy Benefit Manager Subcontract Copy**, provided electronically, for review.

The following components of this model allow us to maintain a strong partnership with the PBM while consistently monitoring the services they provide.

Approach to Integration. To support shared responsibilities, our delegation oversight and auditing functions diligently monitor and review PBM responsibilities, such as the development and management of the pharmacy network and the processing of claims. It is the policy of WellCare of Kentucky to conduct an annual audit of its PBM, to monitor performance and ensure that contracted services are performed in compliance with our policies and regulations from the Centers for Medicare and Medicaid Services (CMS). We also conduct weekly auditing and validation of the PBM's invoices to ensure that invoice charges accurately correspond to actual Enrollee utilization, and review PBM management reports to measure performance. Working together, we run disruption analysis reports when implementing PDL updates or adhering to new state requirements, as well as prior authorization transition reports for Enrollees transferring from the Fee-for-Service (FFS) program or another MCO.

In Kentucky, we shall submit monthly reports of capitation payments made to the PBM. Working closely with Dr. Rogers and Dr. Tolbert, WellCare Health Plan's Vice President of Pharmacy Benefit Relations, Robert Champagne, oversees the internal and external PBM operations for all PBM-related activities to ensure that state contract requirements are being met and that our pharmacy network is successful in their submission of claims.

Transparency in Pricing and Reporting. We consider transparency the most critical element of our integration with a PBM partner. Our contract requires the PBM to follow a strict pass-through pricing model in regards to the pharmacy network (including rebates and network discounts)—spread pricing is never allowed nor considered an acceptable practice. We provide full disclosure of all payments to and from the PBM. As a MCO leader in the Commonwealth since 2011, we have always followed a pass-through pricing model by paying the PBM a direct single source of revenue in the form of a flat administrative fee. As a result, there is no difference between the PBM to pharmacy payments and the MCO to PBM payments made for pharmacy claims. We report this process and the results to DMS through encounter submissions. In addition, as our relationship with the independent, local pharmacies in Kentucky remains a critical

A Fiscally Responsible Partner

WellCare of Kentucky has never condoned or practiced a spread pricing model during our time in the Commonwealth. Other MCOs in the state continue to see increased revenues related to spread pricing while we report a clear 0% spread.

cornerstone of our whole-person approach to pharmacy services and support, we remain committed to maintaining strict oversight of the PBM and to our responsibility to meet the contract requirements. As such, we adhere to DMS' requirement that no additional or indirect remuneration fees or any membership fees will be imposed on a pharmacy as a condition of claims payment or network inclusion. In addition, no additional retrospective remuneration models including Generic Effective Rates (GERs) shall be permitted.

Reporting. WellCare complies with all pharmacy benefit reporting requirements and ad-hoc requests for reports and data determined by DMS and applicable statutory or regulatory authorities. In partnership with the PBM, WellCare of Kentucky provides monthly reports to DMS that include our payments to pharmacies in the Commonwealth versus the amount paid to the PBM in administrative fees as part of the SB5 requirements.

At DMS' request, we provide both summary and detailed reports, such as claim level details, PDL compliance, coverage determination turnaround times (TAT), and appeals. In addition, we provide comprehensive formulary management and coverage determination reports on a monthly basis, as well as quarterly pharmacy utilization trends for top drugs at operations meetings with DMS.

For all reporting activities required of the services provided by the PBM, we maintain full responsibility for the reporting measures and compliance with the requirements of the contract. Per the requirements, annual reports will be delivered no later than August 15th of each contracting year, which includes reports and information required through KRS 205.647 and all additional requests made by DMS.

ii. Methods to ensure access to covered drugs and adherence to the preferred drug list.

Decreasing Costs through Generics
The generic equivalent prescribing rate increased from 77.5% in 2012 to 91.25% as of April 2019.

WellCare of Kentucky has developed and maintained an approved preferred drug list (PDL) for the Kentucky Medicaid program since 2011, ensuring access to all covered drugs for our Enrollees and adherence to the PDL. Nationally, our experienced P&T Committee manages the PDL for WellCare's 13 health plans across the country. The Kentucky PDL is tailored to the needs and requirements of the local population and DMS, and was developed and continues to be maintained and updated on an ongoing basis through input provided by local prescribers, continuous research of new medications, regulatory requirements, and product utilization. Our pharmacy benefits model ensures access to all medically necessary outpatient drugs consistent with Section 1927 of the Social Security Act (SSA). Adhering to the contract requirements in Section 32.12 Covered Drugs, our PDL will continue to not be more restrictive than FFS coverage of outpatient drugs. The following processes describe how we provide access to covered drugs for our Enrollees and maintain adherence to the PDL.

ENSURING ACCESS TO COVERED DRUGS

In accordance with 42 C.F.R 438.10 (h), we regularly engage our Enrollees to help them understand their pharmacy benefits and to provide medication-related clinical services that promote appropriate medication use and adherence. Our multiple engagement methods and

communication channels include Welcome calls by our trained pharmacy support team, the Enrollee WellCare of Kentucky ID card, Enrollee Handbook, inbound and outbound Enrollee calls, the WellCare of Kentucky website, face-to-face care management, the MyWellCare mobile smartphone application, Enrollee Services Call Center support, and quarterly newsletters. The following processes describe additional support for helping our Enrollees access covered drugs through open communication.

Face-to-Face Engagement. In our eight years' of experience in Kentucky, we know that face-to-face engagement at the local level with our network pharmacies and providers can have a significant impact on the quality of support experienced by our Enrollees. Through ongoing education and training, we employ local pharmacists to meet with providers to supply them with the necessary knowledge and tools to help them educate Enrollees about their pharmacy benefits, options, and access. Leading this community-based effort, Dr. Rogers and Dr. Tolbert perform in-person visits to our local prescribers, pharmacies, and independent pharmacies to educate them on accessing the PDL, the appropriate use of medications, and the prior authorization process.

MCO Training at the Pharmacy

In 2018, our Pharmacy Director, Thea Rogers, PharmD, and Pharmacy Manager, Ayonna Tolbert, PharmD, conducted a total of 547 provider meetings engaging over 1,300 providers in the Commonwealth to provide education and one-on-one training.

PDL Disruption Analysis. Before a major update to the PDL occurs, we run a disruption analysis report that identifies all Enrollees likely to be impacted by changes to the list or prior authorizations (PA) or step therapies. This is a critical step that ensures our team alerts the Enrollee and facilitates the appropriate adjustments with the prescriber prior to the Enrollee's next medication refill to proactively prevent gaps in medication therapy, reduce the prescriber burden for unnecessary PAs, and ensure continuous adherence to the PDL.

Provider Education Program. Supporting the efforts of Dr. Rogers, our provider engagement team engages local prescribers through education in the convenience of their own offices. Training includes using the provider portal to help streamline the Enrollee’s experience and accessing information to help inform the Enrollee of the details of their pharmacy benefit. We also provide guidance on pharmacy use, cost trending, Enrollee care gaps related to medication prescribing, and adherence. Tailored prescribing reports help our providers modify their prescribing behaviors and make adjustments to better promote evidence-based drug therapies and best practices. During these sessions, we deliver evidence on the comparative efficacy, safety, and cost-effectiveness of commonly used therapies in medical practices.

Community Support. Understanding that the people of Kentucky prefer personable interaction and service from their preferred, local pharmacists, we inform Enrollees that they always have a choice of pharmacy providers. Our Care Managers, Enrollee Services Call Center, and Pharmacy Help Desk are always available to assist Enrollees with any questions or concerns they may have regarding their pharmacy benefit. For Enrollees requiring assistance getting to their local pharmacy, our community engagement team can assist them with obtaining transportation to and from the pharmacy at a time convenient to their schedule.

ENSURING ACCESS TO THE PDL

Our methods to ensure adherence to the PDL begin with our pharmacy leadership team of Dr. Rogers and Dr. Tolbert, who have established strong relationships with their colleagues at DMS to coordinate state-required benefits, necessary clinical services, and local policies. Following their leadership, and through engagement with the P&T, WellCare of Kentucky uses the following methods to ensure adherence to the PDL under the contract requirements and provide access to covered outpatient drugs and biological products:

1. Review electronic format of preferred vs. non-preferred designations by National Drug Codes (NDCs), Generic Product Identifiers (GPIs) or therapeutic class
2. Document requirements and coverage criteria by program, such as PA criteria, step-therapy guidelines, quantity level limits, age limits
3. Forward to the PBM for programming
4. Perform test claims to ensure the PDL is properly programmed prior to go-live

Testing Accuracy. We have established and proven processes to continuously receive, load, and test PDL changes that respond to changing drug introductions, generic conversions, and pricing changes. On an ongoing basis, we use the PDL test files to ensure processing accuracy for the daily pharmacy PDL interface files with the NDCs and utilization management (UM) criteria provided by our formulary team. **In 2018, WellCare generated more than 170,000 test claims to validate the accuracy of the uploaded files across their national health plans.**

Developing New Prior Authorization Criteria. When new drugs come to market, new safety concerns are reported, or new guidelines are established we collaborate with our P&T Committee, led by Dr. Cynthia Miller (Senior Pharmacy Medical Director at WellCare Health Plans) to develop PA criteria with the goal of protecting the health and safety of our Enrollees and to prevent inappropriate medication usage. For example, we update our PA criteria based on annual reviews of industry standard guidelines, such as the American Association for the Study of Liver Diseases (AASLD) for Hepatitis C, as well as the American Academy of Pediatrics (AAP) guidelines and the Center for Disease Control's (CDCs) respiratory syncytial virus (RSV) surveillance data for the drug, Synagis.

Establish and Maintain PA Requirements. In collaboration with our contracted practitioners, our DUR and P&T Committees establish and maintain all PA requirements. The committees structure our PA rules to ensure alignment to standards of care, enable the delivery of care by providers, support Enrollee navigation through the healthcare delivery system, and prevent risk of over-utilization of services. We use a variety of data sources to evaluate our PA rules and determine where to add, remove, or change PA requirements. These include state and federal requirements; national publications and peer-reviewed journals; nationally recognized treatment guidelines; quality performance measures; requirements for emerging technologies and medication; utilization and claims data; and approval and adverse determination data.

Developing Prior Authorization Criteria

Our DUR Committee reviews the practices and policies of formulary management activities for clinical appropriateness, such as PAs, step therapies, quantity limitations, generic substitutions,

and other drug utilization activities that affect medication access. In cases where a drug poses potential efficacy, toxicity, or over or under-utilization challenges, the DUR Committee establishes criteria to promote appropriate use. Preliminary drug use criteria are developed at the time that a drug is proposed for consideration to the PDL. We review all criteria and submit revisions based on recommendations on an annual basis.

WellCare does not require PA for drugs exempted by state or federal laws and regulations. We establish utilization management edits for drugs that tend to have a high degree of clinical variability and efficacy. We develop and review PA protocols at least annually and provide criteria to meet for the drug authorization—such as specific diagnoses, lab values, trial and failure of alternative drugs, and allergic reaction to preferred product. Our PA is necessary to verify clinical appropriateness; ensure drug safety; prevent fraud and diversion; detect Enrollees receiving duplicate or unnecessary medication therapies from multiple prescribers; detect and prevent substance abuse; and allow coverage for medications not listed on the PDL.

The PA process is available for requests that fall outside established UM parameters, including the following areas:

- *Step Therapy.* We implement step therapy when there are several different drugs available on the PDL for treating a particular medical condition. This method encourages the use of therapeutically equivalent, lower-cost alternatives (first-line therapy) before moving to more expensive alternatives. Providers seeking to prescribe outside of the step therapy guidelines may request an exception through the PA process. We do not implement step therapy (or generic first) for drugs excluded by DMS, including drugs in the following classes: HIV/AIDS, hemophilia, multiple sclerosis, cancer, and end-stage renal disease (ESRD).
- *Quantity Limits.* We implement quantity limits to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring quantities supplied are consistent with FDA-approved clinical dosing guidelines. We use quantity limits to prevent billing errors. Providers seeking to prescribe a higher quantity may request an exception through the PA process (e.g., changes to opioid limits).
- *Generic Utilization.* Generic medications are a critical component to cost containment of the pharmacy benefit. We promote generic utilization in accordance with Medicaid policy. Coverage of a brand-name drug may be excluded when an A-rated generic substitute is available and the brand-name drug is not on the PDL. Providers seeking to prescribe the brand-name drug when a generic is available may request an exception through the PA process. In 2019, the generic equivalent prescribing rate increased from 77.5% in 2012 to 91.26%.
- *Age Limits.* Some medications have an age limit associated with them. We impose PA requirements for providers seeking to prescribe a drug falling outside of the age limit. For example, we send antipsychotic medications for children under ten for further clinical review to ensure appropriateness.

We use point-of-sale step therapy edits in place of required PAs for products where we only need to verify historical utilization of a first line drug or a diagnosis. One example is the newest diabetic agent, which is second-line behind metformin per the ADA guidelines; when the

Enrollee's claims history shows metformin was tried, the second-line agent pays at the point of service.

iii. Responsibilities and composition of the P&T Committee.

WellCare's P&T Committee serves to improve the quality of care provided to our Enrollees by promoting appropriate prescribing and drug selection through establishing standard of care practices and managing the cost of pharmaceutical care. Adhering to contract section 31.7 Pharmacy and Therapeutics Committee, WellCare of Kentucky uses a P&T Committee in accordance with KAR Title 907. The P&T will meet in Kentucky periodically throughout the calendar year as necessary and make recommendations for changes to the PDL or drug formulary. As an advisory committee to a public body, we acknowledge that the P&T Committee is subject to Kentucky's Open Meetings Law in KRS 61.800 to 61.840. Through our contract with DMS, we will provide notice of the time, date, and location of all P&T meetings.

RESPONSIBILITIES OF THE P&T COMMITTEE

Meeting at least quarterly, the P&T makes recommendations for changes to the PDL and is responsible for the activities described in **Table C.21-1**.

Table C.21-1 P&T Committee Responsibilities

P&T Responsibilities	Description
PDL Development and Drug Selection Determination	Serving as the official organizational liaison between the medical staff and the pharmacy program, the P&T Committee develops its preferred drug list (PDL) recommendations and determines drug selection by considering the drug's efficacy, safety, side effects and cost-effectiveness profile.
Review and Approval of Medications	All matters pertaining to the use of medications are reviewed and approved through the P&T Committee—an advisory, educational, and quality improvement council.
Ongoing Review and Maintenance of the PDL	The P&T Committee is responsible for the initial and all subsequent reviews of the PDL including reviewing each major therapeutic class annually and as new pharmaceutical information becomes available.
Establish and Maintain PA Requirements	The P&T Committee collaborates with the DUR Committee to establish and maintain prior authorization requirements. We structure our PA rules to ensure alignment to standards of care, enable the appropriate delivery system, and prevent risk of over-utilization of services.
Advisory Role	The committee recommends the adoption of, or assists in the formulation of, broad professional policies regarding evaluation, selection, and therapeutic use of drugs by the physicians in our provider network. Decisions on which drugs to include in

P&T Responsibilities	Description
	formularies are made by the P&T Committee.
Educational Programs	The committee recommends or assists in the formulation of programs designed to meet the needs of the physician and pharmacy providers of the network regarding complete current knowledge on matters related to drug use.
Quality Improvements	Our Pharmacy Quality Oversight Committee (PQOC) assists in the design of quality improvement programs to detect potential drug therapy problems. The PQOC committee reports directly to the P&T Committee.

In addition, we host a quarterly local P&T Forum, an event open to the public that creates a space for prescribers, Enrollees, and pharmaceutical manufacturers to discuss clinical topics and related drug categories with specific consideration given to the impact of these on our Kentucky Enrollees.

COMPOSITION OF THE P&T COMMITTEE

The composition of the P&T Committee, in **Figure C.21-2**, adheres to the contract requirements and includes a Kentucky licensed physician and a Kentucky licensed pharmacist currently providing services to Kentucky Medicaid recipients. Led by Dr. Cynthia Miller, a Senior Pharmacy Medical Director at WellCare Health Plans, Inc., the P&T also includes key staff members from WellCare's Pharmacy, Formulary, and Rebate team. Dr. Rogers and Dr. Tolbert provide their input and recommendations to ensure that all decisions made by the P&T Committee are appropriate for our Enrollees in the Commonwealth.

Figure C.21-2 P&T Structure

Leveraging the expertise of specialists spanning across WellCare's national health plans, the composition of the P&T committee includes 23 voting members from five different states. This diversity provides our pharmacy program with valuable insight that we leverage to tailor our services for the Commonwealth. The physicians and pharmacists comprising the committee specialize in various fields, including geriatrics, pediatrics, emergency medicine, osteopathy, surgery, nephrology, internal medicine, genetics, gastroenterology, pediatric endocrinology, psychiatry, behavioral health, and oncology. Annually, **the P&T Committee reviews 89 drug classes for our Medicaid programs leveraging the expertise and participation of over 30 WellCare licensed pharmacists** who provide recommendations to voting committee members.

Additional components of our program serving under the leadership and oversight of the P&T Committee include the following:

Pharmacy Quality Oversight Committee (PQOC). The PQOC serves to improve the quality of care pertaining to pharmacy services through the oversight of all WellCare pharmacy-related quality processes and initiatives. These quality initiatives may include drug safety initiatives, clinical improvement interventions, appropriate prescribing and drug selection, establishing and adopting standards of care practices regarding medications, and Enrollee satisfaction. The purpose of PQOC is to improve the quality of care of pharmaceutical services.

Drug Utilization Review (DUR) Committee. The DUR Committee is a pharmacy review committee established by the P&T Committee. The purpose of the committee is to ensure that we conduct appropriate concurrent and retrospective drug utilization reviews, such as ensuring that drug therapy meets current standards of care, preventing medication-related issues, evaluating the effectiveness of drug therapy, controlling drug costs, and identifying areas of practice that require further education of network practitioners.

iv. Proposed DUR Program, including approaches to collaborate with the Department on pharmacy initiatives.

Our drug utilization review (DUR) program provides Enrollees with the best quality prescription drug benefit at the lowest possible cost while ensuring appropriate access to medically necessary drugs. Under the direction of the DUR Committee, our pharmacy program features a comprehensive, prospective, concurrent, and retrospective review of the Enrollee's pharmacy data to ensure that appropriate medication decision-making results in positive health outcomes. To supplement the DUR Program, we provide extensive medication-related clinical services and programs to promote medication use and adherence.

Our PBM implements WellCare's prospective DUR tools at the point of sale for over 60,000 contracted pharmacies nationwide by using the National Council for Prescription Drug Program (NCPDP).

Prospective DUR. Our PBM's claims system provides a central electronic repository for capturing, storing, and updating prospective DUR data. The claims processing system assesses each active drug regimen for our Enrollees in terms of therapeutic duplication, drug to drug interactions, drug to age contraindications, drug to gender limitations, drug to pregnancy contraindications, drug-to-disease contraindications, over and under-utilization, and other clinically appropriate evaluations.

Concurrent DUR. Our PBM maintains a profile of each Enrollee's medication history. Through real-time claims screening and application of our DUR criteria, the PBM system identifies potential adverse drug events (ADEs) for every prescription adjudicated. The system returns an alert, when appropriate, based on the severity level through the online claims adjudication system. We engage our network pharmacies to evaluate the alerts and potential ADEs for each prescription adjudicated. When we identify a potential conflict, we deliver one of the following interventional messages:

- *Messaging:* Alerts to network pharmacy during prescription processing to inform the pharmacist of a potential drug conflict.
- *Soft Messaging:* Alerts to the network pharmacy that may be overridden at the POS. Pharmacists are required to review the potential medication conflict, take action, and enter standard NCPDP conflict, intervention, and outcome codes for prescription adjudication.
- *Hard Messaging:* Alerts that do not allow an override at the POS. The pharmacist must contact us with supporting information to receive an override for the claim to process.

Retrospective DUR. We execute our retrospective drug utilization reviews (rDURs) with routine examination of claims data and other records through computerized drug claims processing and information retrieval systems to assess the clinical quality of prescribing and dispensing of medications. Our rDURs identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacies, and Enrollees associated with specific drugs or groups of drugs.

DUR Reporting Requirements. WellCare of Kentucky will continue to provide a detailed description of the DUR program to DMS on an annual basis to assist in compliance with and timely submission of the CMS Annual DUR Report. We will provide all data necessary for appropriate CMS Annual DUR Report submission, including our portion of the annual report template from CMS.

INTEGRATED CLINICAL PHARMACY PROGRAMS

Led by the clinical pharmacy team, our medication-related clinical services promote medication use and adherence through programs designed from our national, multi-year experience and delivered in collaboration with local resources. WellCare Health Plan's Vice President of Pharmacy Clinical Programs, Angel Ballew (MTMP), is an active member of the FDA Advisory Board for Medication Adherence and represents WellCare's membership within the Pharmacy Quality Alliance (PQA), which includes over 240 organizations helping to advance the quality of medication adherence, safety, and use. Dr. Rogers and Dr. Tolbert work closely with Dr. Ballew to implement the programs described in **Table C.21-2** in the Commonwealth.

Table C.21-2 WellCare Clinical Pharmacy Programs

Clinical Program	Program Description
Enrollee Engagement	WellCare of Kentucky performs ongoing Enrollee outreach to promote medication use and adherence, ensuring Enrollees understand the importance of taking their medications as directed through texting reminders, outreach, calls, and mailings. Through ongoing adherence reporting, we identify at-risk Enrollees and enroll them in our Healthy Living Program (see below) for additional and comprehensive support. For those Enrollees identified with quality needs (e.g., statin use in persons with diabetes (SUPD), corticosteroid inhalers, anti-depression compliance), we enroll them in the associated quality outreach program to ensure ongoing adherence to their prescribed medications. Our multi-disciplinary (MDT) care management team conducts

Clinical Program	Program Description
	ongoing reviews with pharmacists regarding Enrollee medication regimens whenever utilization patterns cross a specific medication adherence threshold.
Medication Synchronization	Our medication synchronization process reduces unnecessary pharmacy visits, relieves transportation burdens, and promotes medication adherence by providing Enrollees the ability to synchronize the fill date for multiple prescriptions. This functionality prevents Enrollees from having to make multiple trips to the pharmacy each month and is particularly beneficial for Enrollees taking maintenance medications.
Polypharmacy Interventions	We have two programs within our DUR activities focused on polypharmacy or therapeutic duplication. Our point of sale (POS) program, which is managed by the PBM, has an alert that checks for two or more medications from the same therapeutic class. When this occurs, a message is provided to the pharmacist filling the claim. We review these alerts quarterly to identify any global trends. In addition, we have a behavioral health polypharmacy program. Monthly, we identify any Enrollee who may have more than one antipsychotic medication or any elderly Enrollee with dementia who has one or more antipsychotic medications. Once identified, we send a letter alerting the provider and request a formal review of the individual's medication profile. We perform a follow-up review of the Enrollee's medication profile during the next three months to determine whether a change has occurred. A letter was considered a success if the Enrollee no longer met criteria for the same measure in the three-month follow-up. **In 2018, successful outcomes were achieved for 60% of Enrollees targeted through the program.**
Managing Antipsychotic Medications for Children	Our Pediatric Antipsychotic Utilization program identifies potential drug therapy issues, including excessive dose and multiple medication therapies for children ten and under in the Medicaid population. When drug therapy issues are identified, recommendations are suggested to the provider via outreach. The program goal is to identify antipsychotic use in Enrollees less than ten years old as well as identify potential drug therapy problems. Communication is directed at the provider level to inform prescriber for Enrollees with potential therapeutic opportunities. **In 2019, WellCare of Kentucky performed targeted medication reviews for 616 Medicaid Enrollees under the age of 10.**
Healthy Living Program (Medication Management Therapy)	For our high-risk Enrollees, The Healthy Living Program includes MTM activities that proactively ensure medication use and adherence. The program includes the following components: • Physician alerts through faxes and pharmacist phone calls specific to Enrollees with gaps in care related to one of six designated chronic conditions to ensure Enrollee use and adherence • Targeted provider outreach and education regarding overuse and inappropriate us of antipsychotic medications

Clinical Program	Program Description
	• Interventions implemented by clinical pharmacists for Enrollees that use more than 10 prescriptions per month to address drug therapy issues related to medication use, duplication of therapy, safety, effectiveness, and compliance Clinical pharmacists and concurrent review specialists work with hospitalized Enrollees to reconcile their medications as a part of our comprehensive discharge planning process
Provider Engagement	Our provider relations team trains providers with face-to-face pharmacy educational sessions at their offices to discuss medication adherence best practices, the Healthy Living Program, and Enrollee outreach efforts. **In 2018, Dr. Rogers and Dr. Tolbert conducted a total of 547 provider meetings with 1330 provider contacts** either in person, telephonically, or through the Independent Practice Association (IPA) management to address PDL issues, respond to questions, and to provide feedback on individual prescribing practices to quality outcomes. We perform education efforts for network pharmacies to discuss medication topics, including use and adherence. In addition, we facilitate Enrollee use and adherence to medications using provider interventions, including deploying clerical support in physician offices, fax reminders, pharmacist calls to physician practices, HEDIS and adherence profiles on the provider portal, and Enrollee heat maps and lists that identify specific regions in the community where medication adherence needs to be addressed.
EQuIPP (Electronic Quality Improvement Platform for Plans and Pharmacies)	Pharmacy Quality Solutions (PQS) administers EQuIPP, a pharmacy benchmark system that provides performance data associated with quality measures to health plans and community pharmacy organizations. EQuIPP allows community pharmacist providers to identify non-adherent Enrollee opportunities, collaborate with provider practices to close care gaps, and improve medication adherence. Currently, the EQuIPP network includes 95% of all pharmacies nationwide, with 90% of these pharmacies used by WellCare Medicaid Enrollees. **In Kentucky, 95% of pharmacies participate in the EQuIPP network.** WellCare is the first health plan to launch the HEDIS measures, Antidepressant Medication Management (AMM), Medication Management for People with Asthma (MMA) and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA), within the EQuIPP platform in an effort to engage pharmacies with medication-related quality measures. Additionally, WellCare is the first health plan to launch the HEDIS measure, Statin Therapy for Patients with Cardiovascular Disease (SPC), and the PQA measure, Concurrent Use of Opioids and Benzodiazepines (COB), within EQuIPP for their Medicaid population. **In comparison to the national benchmark, WellCare of Kentucky pharmacies on the EQuIPP platform performed better in improving medication adherence for diabetes in the Medicaid population.**

Clinical Program	Program Description
PBM Pharmacy Advisor Support (PAS) Program: Medication Adherence and Care Gaps	Our PBM supports WellCare of Kentucky Enrollees through their Pharmacy Advisor Support (PAS) program, which promotes medication adherence and closing care gaps based on clinical quality measures. The PBM sends tailored messages via fax to our providers regarding key points in the therapy process for Enrollees with chronic conditions, such as diabetes, asthma, high blood pressure, depression, etc. Messages target Enrollees not adhering to their medication regimen (late-to-fill) or provide clinical considerations and recommendations that will help close a care gap, such as adding a statin for Enrollees on anti-diabetic medication. **Through these outreach efforts, the PAS program sent more than 16,500 messages for adherence to asthma medication, more than 7,000 messages for care gaps related to asthma, more than 23,500 messages for adherence to diabetes medication, and more than 1,500 messages for gaps in care related to diabetes.**
One Provider-One Pharmacy Program	As part of WellCare's new, national ACT for Opioids Program, we identify Enrollees with relevant behavior patterns by analyzing high numbers of controlled substance claims; multiple prescribers of controlled substances; prescriptions filled at multiple pharmacies; excessive utilization; Emergency Department utilization; and the geographic distribution of controlled substance prescribers and pharmacies. Once we identify an at-risk Enrollee, we enroll them in the One Provider-One Pharmacy program, where they are "locked-in" to one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines. **In 2018, the WellCare of Kentucky program enrolled over 2,800 Enrollees into Care Coordination. This resulted in a 27% drop in opioid utilization, a 47% increase in Medication-Assisted Therapy (MAT), a 25% increase in maintenance medications, and a 33% decrease in Emergency Department utilization.**
Medication Reconciliation	Our WellCare of Kentucky pharmacists contact Enrollees post-discharge telephonically or through support of their local integrated Care Coordinator. Our pharmacists work with the Enrollee's PCP as they perform medication reconciliation to ensure appropriate medication adherence and eliminate dangerous or unnecessary prescriptions. We also connect the Enrollee with our WellCare of Kentucky discharge planners and Care Coordination team. When necessary, our Care Coordinators call a Pharm.D. to support the process.

Collaborative Initiatives with DMS

As part of our DUR activities, WellCare of Kentucky will continue to work collaboratively with DMS on related pharmacy initiatives, such as the universal policy implementations, the pharmacy lock-in program, buprenorphine provider programs, and other initiatives. Through our partnership with DMS since 2011, Dr. Rogers and her pharmacy team have collaborated on many initiatives with DMS and other MCOs that have led to the identification and resolution of common issues and priorities for the Kentucky Medicaid Pharmacy Program.

In our experience, the current Pharmacy Director Workgroup has been one of the most successful ongoing collaborations between DMS and the MCOs in the Commonwealth. Our Pharmacy Director, Dr. Rogers, has participated in these ongoing monthly meetings and seen firsthand the importance of working collectively to identify common issues and develop collaborative solutions that benefit the Medicaid Enrollees throughout the Commonwealth. With the focus on helping the people of Kentucky receive better care and access resources that improve their quality of life, we have learned that regular contact with our peers sustains the ongoing critical discussion that helps us identify serious issues and develop solutions based on the input and expertise of every committed stakeholder involved in the process.

The following examples describe the successes of this collaboration experienced by Dr. Rogers, DMS, and our MCO peers:

- *Uniform Prior Authorization Criteria.* The workgroup collaborated on developing uniform prior authorization criteria for buprenorphine and Hepatitis C products to streamline the process and approach for managing these particular therapies. The project began when Dr. Rogers communicated with the state Medical Director, who had concerns about Enrollees access to these medications. We identified a region of the Commonwealth that had little to no access to specialists required for prescribing based on our Hepatitis C criteria. With further investigation and community outreach, we later found that there were some local providers who received additional education and training to obtain the necessary certifications, this information was not readily available using the standard NPI credential search. Dr. Rogers worked with the Medical Director and our prior authorization review team to develop a solution that would facilitate access to these medications for our Enrollees. As a result, prescribers now provide attestation for their training and receive prior authorization approval for prescribing these medications.
- *Pharmacy Management Dashboard.* The workgroup collaborated on the development of a pharmacy management dashboard that contains a set of consistent metrics used to compare trends across the pharmacy program.
- *Streamlined Policy Communications.* Understanding that it can sometimes be difficult for local pharmacists to understand and begin implementing new policies, the workgroup met to develop a standardized communication approach to educate Kentucky pharmacists about the new cost share requirements. This issue was brought to our attention by a WellCare of Kentucky Enrollee who needed their medication but did not have the ability to meet the costs of the associated co-payment. As a result, the communication letter that we used to address this issue with our pharmacy network was brought to DMS and approved for use by

all MCOs regarding filling medications for Medicaid beneficiaries at or below the Federal Poverty Level (FPL).

Most recently, we have contacted DMS to begin working on an issue regarding cost outliers. Certain cost outliers identified through pharmacy reporting may be impacting pharmacy cost trends for the FFS program and the MCOs in the Commonwealth. The discussion includes evaluating less costly alternative medications to use instead of expensive pharmacy products that may be contributing to wasteful spending practices for the Medicaid benefit.

v. Proposed Maximum Allowable Cost (MAC) program.

Adhering to the requirements of the contract and Kentucky Senate Bill 5 (SB5), WellCare of Kentucky will establish and maintain a generic drug Maximum Allowable Cost (MAC) program to promote generic utilization and cost containment. The program will comply with all maximum allowable cost laws and administrative regulations promulgated by DMS or by state or federal law.

Our PBM uses an analytical process to establish a MAC at a product level for generics and multi-source brand products. The analytical process involves a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by CMS, the National Average Drug Acquisition Cost (NADAC), and retail pharmacies. MAC prices are subject to change, which can occur at least on a weekly basis, and are based on marketplace trends and dynamics, and price fluctuations. For any MAC price change greater than five percent or drug new to the MAC list, the PBM will submit the price change request to DMS for approval in accordance with SB5 as outlined in KRS 205.647.

The MAC price appeal process shall meet the following requirements:

- A 60 day limitation on provider's right to appeal following the initial claim
- PBM will investigate and resolve the appeal within ten (10) days
- If the appeal is denied, the PBM shall provide the reason for the denial and identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the MAC
- If an appeal is granted, the provisions of 304.17A-162(2) shall apply. Ky. Rev. Stat. Ann. § 304.17A-162.

Providers may appeal the MAC price paid by the PBM at a product level. Submission of a paid claim by the provider is required for this process and they must notify the PBM within the period required by applicable Law, and provide all of the following information: date of fill, prescription number, Enrollee name, pharmacy NCPDP/NABP number, chain/affiliation code, phone number, email address, and RXBIN. Chain and Pharmacy Services Administration Organization (PSAO) pharmacies will submit MAC paid claim appeals through their respective chain or PSAO headquarters, which will then submit appropriate data to the PBM. Independent pharmacies (those that are not affiliated with a PSAO for contracting purposes) will submit MAC paid claim appeals using the Caremark Pharmacy Portal.

Provider may access the PBM pharmacy portal to obtain current MAC prices and upcoming MAC prices based on their price update schedule.

WellCare's PBM oversight team routinely reviews claims data and meets with the PBM to ensure the MAC program complies with SB5 requirements.

vi. Approach to operation of a pharmacy call center.

WellCare operates a toll-free pharmacy call center and provides support through live agents, 24-hours a day, seven days a week to respond to inquiries from pharmacies and providers regarding Enrollee Medicaid prescription drug benefits. The pharmacy call center responds to inquiries concerning claims processing, benefit coverage, claims submission, claims payment, exceptions and prior authorizations, and medication appeals. A quality assurance team monitors calls, and scores agents on accuracy, compliance, and completeness of assistance. We welcome DMS to monitor the call center through a review of statistical reports, telephone calls, or onsite visits. Our system tracks each call and retains information collected by the supporting agent, which is retrievable based on Enrollee information. In addition, we provide a pharmacy call center quality assurance program subject to DMS' approval, with monitoring results made available to DMS on a monthly basis, see **Figure C.21-3**.

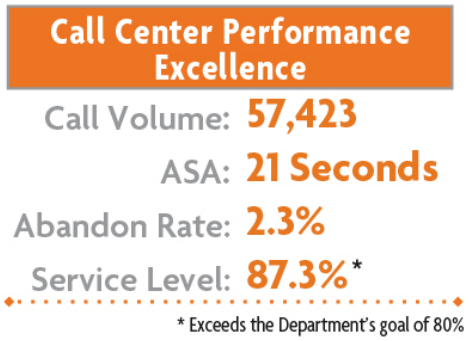

Figure C.21-3 Call Center Performance

Table C.21-3 describes the components of the call center that ensure a high level of service for all inquiries, questions, and assistance.

Table C.21-3 Pharmacy Call Center

Component	Description
Hours of Operation	WellCare's pharmacy call center provides support 24 hours a day, seven days a week. Our regular business hours are from 8 am to 9 pm Eastern Time, Monday through Friday. WellCare and our PBM collaborated to establish after-hours call practices to ensure that Enrollees and providers receive access to accurate information and necessary medications. Calls received outside of regular business hours (including weekends and holidays) are handled by WellCare's PBM. These calls are actively routed by time-of-day routing to the PBM outside of regular business hours.
Agent Support	Our call center agents are trained to expertly handle and support providers for the following topics: cost exceeds maximum rejections; Zyvox authorizations; questions related to narcotic medications (including reason for denial of coverage); determination requests, reversal of prescription claims; backdating of approved coverage determinations for LTC pharmacies; and emergency overrides and approval for up to a seven day supply. For complex calls or inquires that require escalation to our internal pharmacy team at WellCare, agents are instructed to route calls to our

Component	Description
	pharmacy technicians who are capable of providing support and resolution for the topics listed above, as well as injectable questions; lost or stolen medications; calls regarding medication appeals; and requests to speak directly to a Medical Director.
Call Center Reporting	The pharmacy team runs monthly data reports as requested by CMS or DMS. Reports include the following information: the total number of calls received; total number of abandoned calls; the average hold time to reach an associate; the number of calls answered in less than 30 seconds; and the average call handling time. Our call center managers and leadership team leverage these reports to track the performance and quality level of our pharmacy support and determine actions, remediation, or changes in allocation that need to be performed.
Call Center Forecasting	Each month, we perform a model forecasting of the expected call volume for the next month using historical data to forecast how many calls WellCare could receive. Once the forecast is calculated, it is forwarded to the manager of the Pharmacy Call Center for review. The manager, determines if the forecast is accurate based on any anticipated call center or pharmacy department activities (such as outbound notification campaigns). Once adjustments are made, the forecast is approved.
Agent Training	Our pharmacy team provides the following types of training for all pharmacy associates and call center agents in a live classroom setting or online training. • *New Hire Training (3 weeks)*. Consists of learning how to navigate and use the WellCare systems, details of quality assurance guidelines, and roles and responsibilities. Upon completion, agents understand how to use the pharmacy systems and resources to answer questions and concerns from callers. • *Update Sessions.* In-depth training for changes and updates provided by WellCare to ensure that processes are clearly communicated. • *Team Meetings*. Monthly team meetings held by the Call Center and internal expert pharmacy technicians covering areas of opportunity identified by our dedicated quality staff members and department managers. Team meetings help reinforce processes and enhance the associates' knowledge of concepts and processes. • *Train the Trainer Sessions*. An industry standard method of training used to train the vendor call center trainers. The pharmacy trainer meets with the trainers from the vendors to review any training materials and present new material. After the Train the Trainer session is completed, the vendor trainers individually train associates at the vendor sites. All new hire and ongoing training requires call center agents to complete an assessment and pass the assessment with a score of 90% or higher.

Component	Description
	Agents who do not successfully complete the new hire assessment are given a supplemental quiz after further coaching and training provided by the trainer or supervisor.
Quality Assurance	WellCare is committed to providing callers with knowledgeable answers to all their questions and concerns. Our dedicated quality team monitors calls and provides constructive feedback and guidance for all call center agents. A dedicated quality specialist monitors calls and provides call feedback to management for further training. In addition, we leverage a monitoring tool that identifies tone and negative words automatically. Feedback is provided to associates through group calibrations and individual monitoring processes. Call agent supervisors coach our agents based on monitored calls through the following process: asking the agent for their personal feedback about a call; providing positive aspects of the call; areas for improvement; emphasizing the importance of immediate improvement; providing the team managers with an assessment of the quality of work; and developing an individual developmental action plan (IDP) based on performance.

b. Describe the Contractor's pharmacy claims payment administration, including an overview of the Point of Sale (POS) system and processes for complying with dispensing fee requirements.

WellCare of Kentucky's pharmacy claims payment administration, including the Point of Sale (POS) system and processes for complying with dispensing fee requirements, adheres to Section 31.8 Pharmacy Claims Payment Administration. All claims adjudicated as payable are for our eligible Enrollees, to enrolled providers, for approved services, and in accordance with the payment rules and other policies, regulations, and statutes of DMS. **Since the beginning of managed care in the Commonwealth, we have paid more than 67 million claims. Table C.21-4** illustrates our claims payment metrics in 2019, which show that our average days for claims paid of 9.8 meets and exceeds the contract requirement of 21 days.

Table C.21-4 Claims Payment Metrics

Month 2019	Total Number Claims Pad	Average Days Paid	Claims Processing Speed (within four seconds)	% System Availability
January	931,840	9.93	99.98%	99.97%
February	846,084	9.8	99.98%	100%
March	885,988	9.79	99.97%	100%
April	887,529	9.79	99.98%	100%

Month 2019	Total Number Claims Pad	Average Days Paid	Claims Processing Speed (within four seconds)	% System Availability
May	880,272	9.78	99.98%	100%
June	1,993,394	9.81	99.97	100%
July	838,578	9.68	99.97	100%
August	868,993	9.78	99.98	100%
September	841,968	9.79	99.98	100%
October	897,647	9.78	99.98	100%
November	832,861	9.78	99.97	100%
December	883,599	8.89	99.98	100%

Our claims processing system performs eligibility verification, claim adjudication, provider validation, duplicate claims edits, and concurrent DUR edits online, in real time. Additional edits include Enrollee cost share calculation, incorrect price, expiration date, and claim cost. The POS system maintains complete Enrollee history and updates plan and eligibility specifications in real time.

The following claims data can be used to screen claims for possible duplication:

- Enrollee identification number
- Date of fill
- National Drug Code (NDC) number/Generic Code Number (GCN)
- National Council for Prescription Drug Program (NCPDP)
- Refill code
- Prescription number

These system edits, applied at the point of service, automatically manage, monitor, and ensure compliance with program parameters before a prescription is dispensed. This comprehensive set of online electronic claims verification and authorization edits, combined with extensive pharmacy desk audit and field audit capabilities, provides a full-scale operational platform for all claims payment administrative processes.

The following describes additional components of our POS administration process:

POS System Requirements. WellCare of Kentucky ensures that our POS system satisfies the functional and informational requirements for claim submissions from local pharmacies 24 hours per day, seven days a week, and 365 days per year. The POS system has the ability to apply an Internal Control Number (ICN) to each claim and its support documentation to track claims, conduct research, perform reconciliations, and for audit purposes. All Enrollee

information is protected by the appropriate HIPAA safeguard, and the POS system is capable of adding, changing, or removing claim adjudication processing rules to accommodate state and federal required changes to the pharmacy program within 30 days.

Complying with Dispensing Fee Requirements. We will incorporate a standard process for reviewing dispensing fees as part of the daily claims review. The assigned WellCare PBM coordinator reviews for proper claim adjudication and escalates to the PBM if errors are identified.

Pharmacy Claims Payments. We process, adjudicate, and pay pharmacy claims, including voids and full or partial adjustments, using the online, real-time POS through the following methods:

- *NCPDP Format.* We use the specified current NCPDP format and provide updates to this format at no cost to DMS. A "clean claim" refers to a properly completed paper or electronic claim submitted in compliance with NCPDP standards and approved for payment.
- *Denied Claims.* We identify and deny claims that contain invalid provider numbers, including when the taxonomy or National Provider Identifier (NPI) or provider number is missing or invalid. WellCare of Kentucky advises the provider whenever a submitted claim has been denied and specify the reason for the denial.
- *Third-Party Liability.* We identify any liable third party and ensure Medicaid is the appropriate payer of last resort. We pay our providers in full satisfaction of the clean claim or give them a credit against any outstanding balance previously owed.
- *Claim Resubmission.* When a claim is resubmitted with additional information or documentation, it requires a new claim for the purposes of establishing the time frame for claims processing.

Claims Processing. We provide the ability to process claims on batch electronic media and paper claims submitted directly for process. Paper claims may include those submitted when an Enrollee has to visit an out-of-network pharmacy in an emergency. Paper claims can be submitted on the NCPDP Universal Claim Form (version D.0). Adhering to contract requirements, we will process and adjudicate paper claims within ten days of receipt; assign ICNs to all batch claim within 24 hours of receipt; maintain an electronic backup of batch claims; and adjudicate electronic claims through the same processing logic as the POS claims.

Significant Impact Issues. We will notify DMS in writing no later than one day from discovery of any POS processing or claims adjudication issues that is or has the potential to significantly impact processing time for claims submission, adjudication, accuracy, or continuity of Enrollee drug therapy. As stated in the contract requirements, we consider a "significant impact" to mean a threshold of 100 or more Enrollee claims. Following notification, we will provide the root cause and corresponding corrective measures to prevent future issues from occurring.

Claims Processing Numbers. We establish a unique Medicaid-specific Processor Identification (BIN) and Issuer Identification Number (IIN), Processor Control Number (PCN), and Group Number combination for POS pharmacy claims processing. This process helps distinguish claims from other lines of business. The BIN/IIN and PCN number appears on all Enrollee identification

cards along with the toll-free phone number for pharmacy provider assistance and Enrollee assistance.

c. *Describe the Contractor's processes and procedures to provide rebate claiming process and ensure the Department maintains current rebates levels.*

Our processes and procedures to provide timely, accurate, and complete data to support DMS' rebate claiming process and ensure DMS maintains current rebate levels incorporates both POS retail pharmacy claims and prescription medication claims (including physician-administered drugs). WellCare of Kentucky has been submitting encounter data—including NDC-level detail—to the Commonwealth since program implementation and supports their rebate process and ability to create invoices for the billing of pharmaceutical manufacturers participating in the CMS rebate program for rebates. **For the past twelve months, our PBM's encounter acceptance rate of 99.98% has enabled DMS to capture rebates and maintain current levels in a timely manner. As a result of this high encounter acceptance rate, we have submitted approximately $663 million in pharmacy encounters in 2019.**

Process and Procedures. We configure our pharmacy and medical claims systems to promote clean encounter submissions, thereby decreasing the number of rebate disputes we receive from the rebate vendors and ensuring DMS maintains current rebate levels. We develop comprehensive reporting in the manner requested by DMS and submit complete utilization files. We send all data files at the required frequency, including the required data elements, format, and layout. Datasets are generated for both the typical POS pharmacy claims, as well as outpatient drugs submitted as medical claims under HCPCS codes (such as "J-Codes"). We work with our providers when rebate disputes arise to correct the claim, engage in resubmission, and ensure the claim for rebate is reflected accurately back to the Commonwealth.

Dispute Resolution Process. If a rebate dispute should arise, Dr. Rogers will assist in the resolution process, and WellCare of Kentucky will provide detailed claim information requested by DMS to support resolution activities and provide support throughout the process. When a pharmaceutical manufacturer submits disputed claims to the Commonwealth or the vendor handling the rebate billing for the Commonwealth, Dr. Rogers should be notified of the dispute. Dr. Rogers will research the disputed claims and contact the providers to determine if they have submitted an incorrect NDC. If it is determined that the pharmacy provider or physician provider billed the incorrect NDC, Dr. Rogers will request that the provider resubmit the claims correctly or WellCare of Kentucky will provide supporting documentation regarding the validity and accuracy of the disputed claim.

Reporting Features. We produce comprehensive and timely drug utilization data for the purposes of rebate reporting necessary for DMS to bill manufacturers for rebates in accordance with section 1927 (b) (1) (A) of the SSA and any Kentucky supplemental rebate program within the designated 45-day time requirement at the end of each quarterly rebate period. We send files at the required frequency (typically quarterly), including the required data elements, and follow strict data format and layout. We generate data sets for the typical point of sale pharmacy claims and outpatient drugs submitted as medical claims under HCPCS codes, such as J-Codes. We similarly notify the Commonwealth of rebates paid directly to WellCare of

Kentucky in the required format (typically an aggregated amount). In adherence to the contract requirements, reporting includes diabetic testing supplies, insulin, and those drug products administered by network providers in an office or clinic. This includes the total number of units of each dosage form dispensed or administered, strength, date of service (date dispensed or administered), paid date (actual date claim was paid), and the NDC of the covered outpatient drug, and the amount paid.

Table C.21-5 illustrates our PBM's acceptance rate for encounters, which facilitates the sending of utilization data to DMS so they can capture rebates and maintain current levels.

Table C.21-5 Encounters Acceptance Rates (April 2018-2019)

Measure	Requirement	Submitted	Met Requirements	Accuracy Rate
Accuracy	Each file submitted meets internal accuracy requirement	494 files	494	100%
Accuracy	Files submitted in appropriate format required by DMS	494 files	494	100%
Accuracy	New encounters are not duplicate of another encounter in the system	10,867,296 encounters	10,867,296	100%
Completeness	Resubmission and attestation of full file rejections	No rejected files in time period requiring an attestation		
Timeliness	Submit encounter file within five days of scheduled submission dates	52 weeks	52	100%
Timeliness	Submit new encounters within 30 days of adjudication date	10,867,926 encounters	10,867,926	100%
Timeliness	Timely Resubmission of encounter errors within 60 days	766 encounters	766	100%

d. Describe the Contractor's processes and procedures to provide data and support Department-based efforts and initiatives for 340B transactions.

Our processes and procedures provide data and support Department-based efforts and initiatives for 340B transactions. In collaboration with the PBM, WellCare of Kentucky supports participating pharmacies and pharmacists enrolled as 340B providers with the U.S. Department of Health and Human Services (DHHS). Together, we maintain the systems capability and methodology to appropriately identify 340B claims in real time, prospectively, and retrospectively with the utilization of NCPDP fields designed specifically for this purpose.

Providers are required to submit the values detailed below to WellCare of Kentucky when submitting claims purchased through the 340B program, in accordance with Department requirements:

- Electronic submissions of 340B claims should include the applicable submission clarification code, ingredient cost, and dispensing fee as a single claim
- Pharmacies must identify 340B claims with "2.0" in the Submission Clarification Code in NCPDP field 420-DK

Table C.21-6 includes a payer field description indicating the value to be used to identify drugs acquired at 340B pricing. Providers may use these fields to indicate claims for which dispensed drugs were acquired at 340B pricing.

Table C.21-6 Payer Field Description

NCPDP Field #	NCPDP Field Name	Value	Segment Summary	Comments
420-DK	Submission Clarification Code	20 = 340B	RW	20 = Required when designating the product being billed was purchased pursuant to rights as a 340B/Disproportionate.
409-D9	Ingredient Cost Submitted	Actual Acquisition Cost + Dispensing Fee	RW	Required when submitting claims acquired through the 340B program. Pharmacies should submit their acquisition cost plus.
423-DN	Basis of Cost Determination	08 = 340B	RW	08 = Required when designating the 340B/Disproportionate Share Pricing/Public Health Service acquisition price.

The fields outlined in **Table C.21-7** will be sent to the Commonwealth on the encounter files to ensure the Commonwealth captures this data.

Table C.21-7 Encounter Record Layout

NCPDP Field Value	NCPDP Field Value Description	340B Claim Identifier
420-DK	Submission Clarification Code	20
CMS-1500 Field Number	CMS-1500 Field Value	CMS-1500 Field Description
24 D	Procedures, Services, or Supplies	CPT/HCPCS Modifier
837P Loop/data element	Electronic Claims Field Description	340B Claim Identifier

NCPDP Field Value	NCPDP Field Value Description	340B Claim Identifier
Loop 2400 SV101-3, SV101-4, SV101-5 and SV101-6	Modifier 1, Modifier 2, Modifier 3, Modifier 4	UD
UB-04 Field Number	Field Description	340B Claim Identifier
44	HCPCS/Rate/HIPPS Code	JG, TB, AY *
837I Loop/ data segment	Field Description	340B Claim Identifier
Loop 2400, SV202-2 (SV202-1=HC/HP)	HCPCS/Rate/HIPPS Code	JG, TB, AY *

*These modifiers are captured for Medicare claims and need to be submitted when present on crossover claims, where applicable.

Adhering to the contract requirements, WellCare of Kentucky will not reimburse a 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities. We will not assess any fee, charge-back, or other adjustment upon the 340B entity on the basis that they participate in the program set forth in 42 U.S.C. §256b.

e. Describe the Contractor's pharmacy Prior Authorization process, including the following as part of the response:

WellCare of Kentucky has an average prior authorization turnaround time (TAT) of under 8 hours of receipt.

Our prior authorization (PA) process ensures that Enrollees receive safe, appropriate, and cost-effective medications in a timely and efficient manner without disruption to their care. To facilitate this process, local prescribers have access to a seamless communication and PA experience with their WellCare of Kentucky counterparts and system navigation. Our PA process is compliant with Section 1927(d)(5) of the Social Security Act (SSA) and 42 C.F.R. § 438.3(s)(6) and with all Department requirements.

Across our national health plans, WellCare Health Plan Inc., is compliant with each of the service level agreements in place with our state Medicaid partners for required turnaround times (TAT), processing nearly 100 percent of PA requests within 24-hours when required. On average, we process pharmacy requests under 8 hours of receipt of the request—achieved by operating a clinical pharmacy program (open seven days a week) with WellCare facilities located in Arizona and Florida for business continuity and time zone issues. We date and time stamp all PA requests, ensuring resolution within a 24-hour timeframe—unless additional information is required from the prescriber, and status can be checked online in real time. In addition, we have added a new feature, electronic prior authorization (ePA), for which providers can use a web-based portal to initiate requests.

i. Transparency in communicating the conditions for coverage to providers.

To promote full transparency in communicating the conditions for coverage to providers, we update them to PA policy changes well ahead of implementation, ensuring that PA requests can be submitted in time to avoid disrupting medication regimens for our Enrollees. Our methods for communication include our provider newsletter as well as our formulary change notices and access to our PA criteria through our formulary search tool (**Figure C.21-4**.)

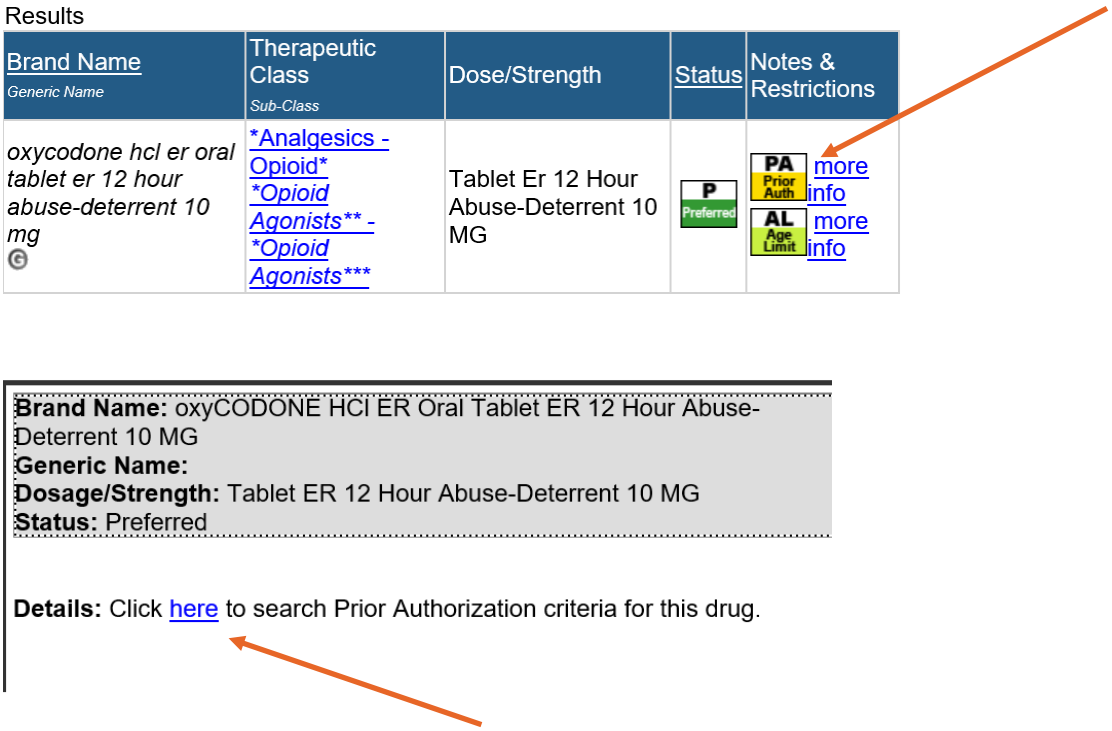

Figure C.21-4 Formulary Search Tool

In addition, electronic Prior Authorization (ePA) lets providers identify the need for prior authorization during the e-prescribing process and submit the prior authorization electronically before sending the prescription to the pharmacy. This significantly decreases the administrative burden and increases understanding of prior authorization requirements, which reduces delays to therapy.

When a manual request is necessary due to complexity, the prescriber may complete the authorization request online using the provider portal, attach any additional documentation, and click submit—on average, we respond to all PA requests within eight hours.

We send a fax to the provider informing them of the outcome of the PA. If there is a denial, we send a letter to the Enrollee. A PA request is only ever denied following a thorough review by a clinical pharmacist and signed off by a medical director. When this occurs, the system generates a DUR letter and automatically transmits it to the prescriber and the pharmacy. The DUR letter includes a clear description of the reason for the denial, preferred alternatives or additional details, and other information that the Enrollee and provider can use to understand the decision. A physician peer review shall be available upon a physician's request for any denial made at a pharmacist review level.

In addition, during provider outreach visits, our pharmacy team shares formulary updates and changes with the provider. Adhering to contract requirements, our process includes the ability for the Enrollee, or the prescriber on behalf of the Enrollee, to appeal a decision or submit a grievance for all PA decisions denied after the final escalated review. Our PA related appeals and grievances are in accordance with Section 24.2 Enrollee Grievance and Appeal Policies and Procedures and Section 27.10 Provider Grievances and Appeals of the contract.

Our multi-level approach enhances the prescriber experience and facilitates ease of use for requesting PA. The PA process uses POS automation and electronic PA (ePA) to streamline the decision-making process, reduce denials, and achieve faster turnaround times. Using the provider portal at the point-of-care, from the convenience of their preferred device (e.g., smartphone, tablet, laptop), providers can easily identify preferred and non-preferred drugs, PA requirements, and preferred drugs that can be substituted for non-preferred drugs. Our ePA platform is a simple to use, web-based portal, or embedded in an electronic health record (EHR), that we co-brand through our partnership with Surescripts.

Leveraging this functionality, we perform a real-time benefit check (RTBC). Prescribers can answer patient-specific questions while the Enrollee is in their office and have the prescription filled before arriving at the pharmacy. Our Pharmacy Help Desk is available seven days a week to address all PA-related questions and requests. The help desk works alongside the PBM team to support complex issues, providing after-hours support for 24/7 coverage. When other services are requested along with a medication (e.g., DME, home infusion, nursing supplies, etc.), our pharmacy team processes all requests within a single authorization, facilitating a seamless PA experience for the provider's office.

Lastly, our provider engagement team educates physicians on key pharmacy resources such as the PDL, PA processes, and our web-based drug search tool. We use this academic, detailed framework to conduct interactive education that provides unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions.

ii. Required credentials for staff reviewing, approving and denying prior authorization requests.

To support our PA program, we staff skilled, licensed pharmacy physicians who use nationally recognized and evidence-based criteria, industry-leading technology, well-documented policies and procedures, and strong clinical oversight. **Today, we staff 12 clinical pharmacists (PharmD), approximately 240 pharmacy technicians (CPhT), and a medical director (MD).**

While we do not require every pharmacy technician to have their CPhT, many of them have obtained that level of training and credentialing.

In addition, our dynamic queue management and workflow tools, including smart processing algorithms, ensure timely and accurate clinical decisions under the guidance of a licensed clinical pharmacist. A PA request is only denied after a thorough review by one of our clinical pharmacists and the Senior Medical Director of Pharmacy, Dr. Cynthia Miller.

iii. Use of pharmacy and/or medical claims history to adjudicate prior authorization requests.

Our policies and procedures were developed in adherence to NCQA standards. Our PA determinations, including those from escalated reviews, are communicated to the requesting provider within 24 hours from the initial request (including weekends) in compliance with the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act (SSA), and other federal regulations. The following information provides details of our PA processes:

Electronic Prior Authorization (ePA). Our ePA platform is a simple to use, web-based portal, or embedded in an electronic health record (EHR), that we co-brand through our partnership with Surescripts. With no software or applications to download or install, prescribers can easily access the ePA portal online and initiate requests using two methods:

- Initiate a PA using a code provided by the pharmacy through a fax notifying the provider that a PA is needed
- Initiate a PA at the time of prescribing by entering patient, plan, medication, and pharmacy details

From the portal, providers have access to the Enrollee list, where they can create and confirm new patients, fill in prescriptions, confirm prescriptions, and select the appropriate pharmacy. The prescriber then answers a series of questions supplied by WellCare of Kentucky that can lead to an approval, with an authorization placed within 10 minutes—eliminating the need for a paper or manual request. The ePA process incorporates an RTBC to inform the provider of the medications listed on the formulary and the associated utilization management criteria.

A worklist tool provides a centralized view of all tasks that require action for a provider's Enrollees. Available from the worklist, providers view PA information and details, which include the status of the PA response, authorization details, outcome information, Enrollee information, notes, and attachments. Providers have the ability to directly acknowledge an approved PA or electronically file an appeal. The portal saves the complete workflow history of the PA process, allowing providers to view whether or not question sets have been completed, responses have been acknowledged, or if a PA is awaiting a response. By default, the portal displays 30 days of cases but can be expanded to reflect a customized timeline.

Automated Processing. The PBM's pharmacy claims adjudication system enables authorization requests for automatic approval at the POS if certain conditions are met based on pharmacy and/or medical claims history. This system integrates with our historical claims database and our clinical management platform to access information regarding an Enrollee's medical conditions and prior claims history. If the available information (e.g., Enrollee diagnosis) sufficiently satisfies the formulary requirements and PA criteria, the claim processes in real-

time without the need for manual intervention by the prescriber. We also offer automatic batch processing when appropriate, such as during a disaster situation.

Manual Processing. When automated processing is not possible, PA requests are submitted to our Drug Evaluation Review unit and assigned to trained pharmacy technicians. Technicians evaluate each request according to FDA guidelines and clinical protocols approved by the P&T Committee. Our technicians use decision tools as well as pharmacy and medical history when reviewing coverage determination requests, such as for non-PDL drugs or requests outside of step therapy parameters or quantity limits. Authorization requests will be processed, and the prescriber notified of the approval or denial within 24 hours. In the event a prescription is awaiting PA, and the prescribing physician cannot be reached, we authorize a 72-hour emergency supply in adherence to the contract requirements so as not to jeopardize the health or safety of the Enrollee.

We document all PA-related activities and decisions in Compass, our online pharmacy case management system. The Compass system is our comprehensive pharmacy utilization management platform that provides our team with a comprehensive view of the Enrollee. The system includes automated processes, such as ePA, that promotes a more efficient, user experience with faster response times for our providers. The information documented and stored within the Compass system will continue to be made available for immediate review and DMS' request. For documentation purposes, we offer the designated Kentucky Medicaid universal PA form and WellCare's PA form to our providers, both accessible from WellCare of Kentucky's provider website.

C.21 Pharmacy Benefits

- Attachment C.21.a.i Pharmacy Benefit Manager Subcontract Copy (Provided Electronically)

22. Special Program Requirements

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C.22. SPECIAL PROGRAM REQUIREMENTS

Describe the Contractor's approach to meeting the Department's expectations and requirements outlined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." The approach should address the following:

a. **Approach to ensuring Enrollees and Providers are aware of special program services.**

b. **Description of medical necessity review process.**

c. **Outreach methods to engage Enrollees.**

d. **Approach to identify, enroll and encourage compliance with lock-in programs.**

e. **Approach to coordination, including referral and follow-up with other service providers, like Women, Infants, and Children (WIC), Head Start, First Steps, School-Based Services, DCBS and the Kentucky Transportation Cabinet Office of Transportation Delivery.**

C.22. SPECIAL PROGRAM REQUIREMENTS

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 32 Special Program Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Special program services and knowledge of these services empower and encourage Enrollees to take an active role in their own health and to make informed decisions about their health care. Special program services help to remove barriers to an Enrollee's care like transportation or help an Enrollee attain their health-related goal like going to the dentist. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and special program services promote access to comprehensive health care services to children under age 21. The EPSDT program emphasizes prevention, early detection of physical or mental conditions that can impede children's health and development, and medically necessary treatment to improve a child's health outcomes. By educating and outreaching to Enrollees and families or guardians about the availability of special program services and helping them to effectively use special program services, covered benefits, and other resources available through the Kentucky Medicaid program, WellCare of Kentucky supports DMS' focus on quality goals, closing care needs, and improving health outcomes.

Collaboration among providers, state agency staff, community-based organizations, and our own internal staff, including Enrollee Services staff, care coordination team, and community advocacy staff, ensures Enrollees experience the full benefit of special program services like EPSDT. Our dedicated Quality Improvement leadership team includes Medical Director, Dr. Howard Shaps and Quality Improvement Director, Laura Betten. They lead our efforts to optimize the health and wellbeing of children ages 0-21 through EPSDT program and improve pediatric health outcomes. They oversee quality staff who outreach to Enrollees who have care needs, including children who are overdue for their EPSDT screenings. They also maintain a knowledge base of HEDIS

requirements and implement clinical performance methods to continually improve WellCare of Kentucky's HEDIS performance.

In this section, we:

- Discuss our approach to conducting outreach and education for Enrollees, family/guardians, and providers to increase their awareness of Kentucky Medicaid special program services. Special program services include EPSDT; dental services; emergency care; urgent care and post stabilization care; maternity care; voluntary family planning; and nonemergency transportation services; pediatric Interface, excluding school-based services provided by school personnel; pediatric sexual abuse examination; and the lock-in program.
- Describe our medical review process to ensure Enrollees receive healthcare services that are medically necessary to treat, correct, or reduce illnesses and identified conditions. This sometimes includes authorizing medically necessary services that may not be covered benefits, as determined on a case-by-case basis to address whole-person needs to ensure Enrollee access to medically necessary diagnostic and treatment services.
- Provide an overview our approach to identify, enroll, and encourage Enrollee compliance with our lock-in program and engagement in care coordination services.
- Outline our collaborative approach to coordination with other service providers. This includes referral and follow-up activities with community-based services like Women, Infants, and Children (WIC), Head Start, First Steps, and School-Based Services. We collaborate with and refer Enrollees to state agencies like DCBS and the Kentucky Transportation Cabinet Office of Transportation Delivery. We follow up with state agency staff to make sure Enrollees are participating in and benefitting from special program services.

Evidence of our commitment to promoting Enrollee access to and engagement in care and services, including special program services, is WellCare of Kentucky's excellent quality measures for our comprehensive Quality Management program. **Our program leads the Commonwealth in 24 HEDIS measures for 2019, including all three Well-Child Visit measures and Annual Dental Visits. We have maintained a two-year commendable NCQA accreditation status, earning more NCQA 4 and above ratings than any other Kentucky plan across Enrollee satisfaction, prevention, and treatment measures.**

Describe the Contractor's approach to meeting the Department's expectations and requirements outlined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." The approach should address the following:

a. Approach to ensuring Enrollees and Providers are aware of special program services.

WellCare of Kentucky demonstrates Enrollees are our priority by putting our Enrollees first so they can get the care and services they need to stay healthy. We maintain a strong focus on early prevention and treatment. We help Enrollees and their families/guardians effectively use the resources available through special program services. We offer a wide range of educational materials and use numerous and innovative methods to inform Enrollees, families or guardians, and providers

about the availability of special program services. We consistently refer Enrollees to and coordinate with other providers that provide special program services.

EDUCATING ENROLLEES AND FAMILIES OR GUARDIANS ABOUT SPECIAL PROGRAM SERVICES

Enrollees and their families or guardians want to know what benefits and services are covered. We meet Enrollees where they are by offering a multi-modal communication and outreach approach that includes program service descriptions via easily understood written and online materials; verbal explanations from WellCare of Kentucky staff, providers, and community-based organizations; digital communications; face-to-face interactions; and home visits when appropriate. In all Commonwealth regions, Enrollees and community residents who participate in community events and activities can talk to our staff face-to-face and meet with our community partners to learn about improving health and wellness and the features and benefits of special program services.

Parents and guardians have both a responsibility and desire to ensure their children get needed health services, but many need education and support to understand and access EPSDT screening and other special program services like dental services and transportation. We coordinate access to other child-oriented special program services like pediatric sexual abuse examinations. In this case, WellCare of Kentucky staff informs parents that we have providers in our network who have the capacity to perform a forensic pediatric sexual abuse examination and upon receiving a request from DCBS, we coordinate this service. We have an established relationship with DCBS and our staff works closely and collaboratively with DCBS staff to coordinate services for our Enrollees.

METHODS TO EDUCATE ENROLLEES, FAMILIES, OR GUARDIANS ABOUT BENEFITS AND SERVICES

Our experience tells us that Enrollees and their families/guardians have different preferences in how they learn about covered benefits and services. We meet Enrollees where they are and use a variety of methods to continually educate Enrollees and families/guardians about special program services:

- *New Enrollee Welcome Call and Welcome Packet:* We offer a combination of automated and live new Enrollee Welcome Calls, which includes calls to action like asking Enrollees to confirm receipt of new Enrollee onboarding materials, including the Welcome Packet and ID card and reminding them to schedule primary care appointments. In addition to the Welcome letter and other informational items, our Welcome Packet includes information related to special program services, including but not limited to:
    - Message encouraging Enrollees to schedule well checkups
    - Information on the appropriate use of the Emergency Department
    - Healthy rewards program brochure, a program that rewards Enrollees who complete specific preventive health, EPSDT, wellness, and engagement milestones

      We include other tools in the initial welcome packet and in subsequent Enrollee communications. This includes prenatal care materials and important phone numbers, including 24-Hour Nurse Advice Line and our Community Connections Help Line (CCHL)

for assistance with social resource needs. We direct Enrollees to call our Enrollee Services toll-free line to obtain written materials, receive assistance with the Enrollee portal, or to receive assistance on any other matter like help finding a doctor or dentist. All material included in the Welcome Packet is also available on the Enrollee portal.

- *Welcome Video:* Our captioned, dynamic welcome video is a recent innovation to engage our Enrollees through a multi-media version of the written *Quick Start Guide,* included in the Welcome Packet. Enrollees and families/guardians access the video through a link on a new Enrollee welcome text (SMS) message. The four-minute video on WellCare Health Plans, Inc.'s (WellCare's) YouTube channel explains in English, with captioning in Spanish. It educates viewers about resources where an Enrollee can learn about benefits and services, including special services like EPSDT and dental services, the role of a Primary Care Provider with a prompt to schedule an appointment, the purpose of the 24-Hour Nurse Advice Line, and how to reach our CCHL for live assistance with social needs.
- *Enrollee Services Call Center:* WellCare of Kentucky Enrollees can reach our Enrollee Services call center staff at 1-877-389-9457. Enrollee Services representatives are often an Enrollee's first contact with us. When an Enrollee initiates an inbound call and it is their first contact, the Enrollee Services representative helps the Enrollee complete the onboarding process, including completing their initial health risk assessment. They help Enrollees understand benefits and services, and answer questions about how to access services; help Enrollees find a doctor or other providers and schedule appointments; and help Enrollees connect to other health care services like dental services or voluntary family planning services. Depending on an Enrollee's needs, an Enrollee Services representative may help an Enrollee connect to the Kentucky Transportation Cabinet, Office of Transportation Delivery for nonemergency transportation services or help a new mom connect to maternity care.
- *Public Website:* WellCare of Kentucky has a mobile-responsive public website. In 2019, the top three most visited sections of the Kentucky Medicaid website included the Welcome page, the Healthy Rewards Program page, and the Benefits page. Our Healthy Rewards Program provides gift card rewards for Enrollees completing wellness visits and preventive care.
- *Enrollee Portal:* Enrollees can access the portal from the internet or from mobile devices. It provides Enrollees a secure, personalized health care experience and 24/7 access to self-service functions. Within the portal, Enrollees can change Primary Care Providers or check on the status of service authorizations. Enrollee portal features banners, which we can use to call attention to special program services. Our Enrollee portal offers Enrollees and families/guardians the following information:
  - Enrollee-specific care needs and how to close those gaps
  - Electronic versions of Enrollee newsletters, which include articles about the availability of special services programs
  - Find-A-Provider search tool
  - Enrollee rights and responsibilities

- *Enrollee Handbook:* Our Kentucky *Enrollee Handbook* contains information to help Enrollees connect to the care and services they need. Enrollees and families can access the Enrollee Handbook on our secure Enrollee portal at wellcare.com/Kentucky. Through simple navigation and two clicks, Kentucky Enrollees can download the *Enrollee Handbook*, learn about preventive care, and find FAQs in the New Enrollee Quick Tips section. The Find-A-Provider resource is an intuitively designed query tool recently redesigned according to health literacy principles to help Enrollees find physicians using words, such as pediatrician or obstetrician. Enrollees filter and compare search results by languages, gender, accessibility considerations, specialty, and distance from a user-chosen location, such as home, work, or current location. The *Enrollee Handbook* highlights special services program descriptions, including but not limited to:
    - Covered Services, immunizations, pregnancy services, and hospital services
    - WellCare of Kentucky's extra benefits like our Healthy Rewards Program Enrollee incentive program and other value-added services, such as over-the-counter items - $10/month per household and free sports physical, maternity care special program services along with our population health management WellCare Baby Steps maternal and child health program
    - Emergency care, including 24-Hour Nurse Advice Line and out-of-area emergency care; urgent care; and post stabilization care services
    - Dental services
    - Non-Emergency Medical Transportation (NEMT)
    - EPSDT
    - Lock-In Program
- *Digital Engagement:* An effective means of Enrollee engagement, we direct our Enrollees to our digital platforms and demonstrate how to navigate managed care as a convenient way for Enrollees to obtain information or perform self-service functions. Through digital platforms, which comply with Federal Section 508 standards and web content accessibility guidelines, Enrollees learn about benefits and services, how to access care, learn about preventive care, how to self-enroll in our health and wellness programs, and how to order a new ID card. For Medicaid Enrollees with frequent address changes, mailed materials sometimes do not reach them but digital communication are often an effective means of communication. Engaging Enrollees through their mobile devices and helping them to take even small steps, such as downloading our mobile app, is a step toward empowering them to be active participants in their health and health care.
- *MyWellCare mobile app:* Our mobile app makes getting and staying healthier easy. WellCare actively uses our mobile app to communicate important information to our Enrollees and provides easy access to services. In 2018, as a result of **our proactive approach and updated functionality, WellCare of Kentucky experienced a YoY increase of 476% in downloads of the mobile app for Kentucky Medicaid Enrollees from 2017-2018. The top app features used in 2018 were Find A Provider, Messages, and ID card.**

  The MyWellCare mobile app is free and is compatible with Apple and Android devices. This digital engagement tool enables Enrollees to assume more responsibility for their health

through familiar tech capabilities and functions. Enrollees can call the Enrollee Services number on the back of their ID cards if they have questions about the mobile app or need assistance downloading it.

Using the app, Enrollees can view open care needs displayed together with their provider's phone number, which they can tap to call and schedule appointments. They can email their Mobile ID card to providers. We continually add functionalities to our digital applications to keep pace with our Enrollees' increasing utilization and feedback regarding their online experience. **Figure C.22-1** shows the MyWellCare mobile app features.

Figure C.22-1 Using the MyWellCare mobile app, users can use a smart phone or tablet to pull up their ID card, find a provider, and more.

We align monthly health messaging with general, non-PHI messages, or push notifications that mirror the inbound IVR route messaging and the public website.

- *Inbound caller IVR route messaging increase health and wellness awareness:* We create IVR route messaging that inbound callers hear as their calls transfer to our staff. Route messages rotate from month to month and focus on specific health and wellness topics. For example, in 2019:
  - **March:** Dental health for you or your child is important. Ask your customer advocate about your dental benefits. He or she can help set up a visit with your dentist. WellCare of Kentucky is your partner in preventive health!
  - **April:** April 22 to April 26 is Every Kid Healthy Week. Help your kids eat healthy and stay active all year long. Do you want to learn about nutrition and healthy habits? Ask your customer advocate to set up a visit for you and your doctor! WellCare of Kentucky is your partner in preventive health!
- *Outbound calls regarding Enrollee care needs:* WellCare of Kentucky quality staff, Field Outreach Coordinators, and Care Managers make outbound calls to Enrollees and families or guardians to close gaps in care, including overdue EPSDT screenings or immunizations. Our staff provides reinforcement and support, such as assistance with scheduling appointments for needed services like well-child visits, immunizations, or blood lead screening as well as for annual adolescent and dental screenings. As an example, our quality staff initiated an Enrollee outreach campaign from October 2017 to December 2017 to increase well-child and dental visits. **Quality staff called 10,573 Enrollees. Of those calls, we successfully reached 3,226 Enrollees and closed 681 additional care gaps.** This had an impact on the following quality measures: our Adolescent Well Care measure improved by 31.57%, our Well Child visit measure for children 3-6 years old improved by 25.96%, and the Annual Dental Visits measure improved by 11.59%. In addition, Adolescent Immunizations, Combo 2 improved by 5.67%.

- *Mailings in the form of annual/seasonal prevention written reminders and newsletters:* We send to Enrollees and families/guardians an EPSDT guide and birthday cards to remind Enrollees about the screenings and preventive services they should receive during the year. Birthday cards, as in **Figure C.22-2**, encourage Enrollees to reach out to their Primary Care Provider to schedule a check-up and receive screenings and/or preventive services. We send targeted reminders, e.g., reminding Enrollees that February is Oral Health Month to encourage Enrollees to use dental services. Enrollee newsletters (mailed and electronic on the Enrollee portal) contain benefit updates and details, highlight new services, communicate outreach events in specific communities, and present fitness and health education.

Figure C.22-2 Birthday Postcard

- *Outreaching and Educating Enrollees at Community Events:* We share a common goal with our community partners to improve the lives of the people in Kentucky communities. We engage with Enrollees in their own neighborhoods through our Community Connections Program and our comprehensive Enrollee and Community Education and Outreach Program. **In Kentucky in 2019, WellCare of Kentucky staff completed 1,409 community activities, reaching 37,509 community stakeholders.** Our Community Education and Outreach Program includes creative collaborations with various entities, including schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and more. WellCare of Kentucky staff continually seek new opportunities to partner with organizations that share our commitment to helping to build healthier communities. We leverage these partnerships to hold fun and informative health-related events; support women's health; and educate children and youth about how to develop healthy habits related to fitness and nutrition.

  Community events are activities where WellCare of Kentucky staff dedicate time to connect with community agencies or sponsor/host events for the community. Activities include attending interagency council meetings, specific health and social service-focused coalitions, as well as hosting community activities targeted at specific health or social issues. We have a strong commitment to participate in or sponsor local street fairs, health fairs, county fairs, Kentucky State Fair, festivals, and other scheduled and health-related events like community baby showers, which increase Enrollee compliance with and education about the EPSDT program. WellCare of Kentucky community relations team participates in community events that align with special program services and our Population Health Management program focus areas, including:

- Health Education -- Obesity: WellCare attended the YMCA Kids Day community event in Henderson County to promote healthy eating and living with kids. Asthma: Community health fairs in numerous counties across Kentucky
- Maternity Care -- Low Birth Weight and Pre-term Birth: Community baby shower events; Oh Baby Expectant Parent Fair; Parent Empowerment Workshop
- Transportation -- Mental health and substance use/misuse: Third Annual West KY Wellness Summit Community Mental Health and Breaking the Stigma! Mental health was the theme of the 2018 summit. WellCare partnered with the Chrysalis House for the past three years, filling transportation gaps that their women in recovery encounter through taxi vouchers, bus passes, and gas for Chrysalis House's on-site van.

- *Kentucky quality staff and care management staff:* Care coordination staff conduct educational activities that inform Enrollees about special program services and help them access those services. For high-risk Enrollees, they conduct a comprehensive needs assessment that identifies care needs. When identified, they educate the Enrollee about availability and importance of accessing these services, list referrals to special program services in the care plan, and coordinate access to the services. The Care Manager conducts ongoing monitoring and additional education, as needed, to support appropriate access.
- *Triggering events:* Certain events trigger engagement of Enrollees with over or under-utilization of services; Emergency Department over-utilization; discharge planning needs; behavioral health crisis intake; pregnancy; opioid or other controlled substance overdose, etc. Care Managers conduct in-person or telephonic outreach, education about appropriate utilization, assessment, and referrals to special program services, as necessary.
- *Providers and community partners assist us in educating Enrollees:* We educate providers, as described later in this section, to engage their assistance in educating Enrollees when a provider identifies a need for special program services. Our Community Connections team educates our community partners about special program services so that they can reinforce our efforts to increase Enrollee awareness of these services and the benefit of using them.
- *Creative efforts to target outreach and education efforts to Enrollees in harder-to-reach populations (e.g., Hispanic, African American, LGBT community, young adult, and veterans):* Partnering with faith-based and other community organizations, including food banks and homeless shelters, serving specific populations helps us connect with Enrollees in hard-to-reach or hard to engage populations. Individuals in the community trust these organizations. Developing customized outreach materials and resources helps us engage targeted populations in special program services. In Kentucky, our community engagement staff participate in a number of community events that target harder-to-reach populations. This includes events sponsored by Volunteers of America for veterans who may be homeless, resource fairs for grandparents raising grandchildren, and Healthy Start 502 Fathers baby shower for Jefferson County fathers in the African American community. See **Figure C.22-3** for an example of our communications materials from the Father's Baby Shower.

Our staff participated in the World Refugee Day Celebration in Bowling Green, celebrating diversity and cultures of newcomers who arrived through the Refugee Resettlement program. This event highlighted different cultures and provided educational opportunities for attendees to learn about helpful services and programs in the community, including healthcare services. Our staff sat on the committee for a Language Access Forum, an educational event for healthcare staff to learn how to communicate effectively with their patients who have limited English language proficiency. We attended the Americana World Festival hosted by the Americana Community Center of South Louisville and educated Enrollees about healthcare services. Our staff sat on a committee in Perry County for the LGBTQ ALLYance, founded at Hazard Community and Technical College to train organizations how to become a safe space for LGBTQ-identifying individuals, with the hope these individuals will feel safe seeking needed services

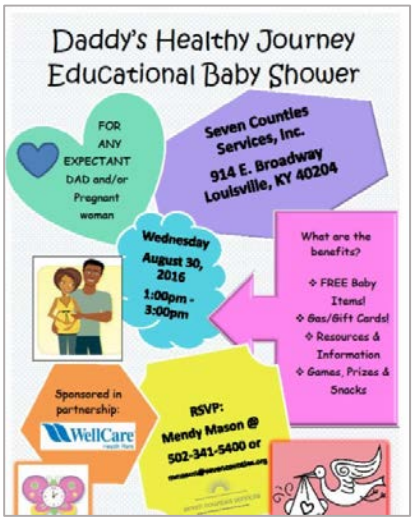


Figure C.22-3 Father's Baby Shower

Our multi-modal approach makes sure all of our Enrollees and/or their parents or guardians are aware of special program services and why these services are beneficial to achieving positive health outcomes. Our special program-specific approach complies with the Draft Contract and includes but is not limited to:

- *EPSDT:* We use a comprehensive approach to educating Enrollees and their families about EPSDT screening and special services, facilitating access and promoting the benefit of preventive services, the availability of screening and medically necessary services, the right to access these services, and how to access EPSDT-related services. We communicate, verbally and in writing, the Enrollee and family's right to appeal decisions related to EPSDT services. During touchpoints with parents and guardians, Kentucky of WellCare staff let them know we are available to assist with scheduling Primary Care Provider appointments, help them access NEMT services for transportation to and from appointments, and provide language assistance services, as needed. We also reward Enrollees with gift cards for completing screenings through our Healthy Rewards Incentive Program--even a small reward can incent change. **Kentucky's EQRO Annual Compliance Review – EPSDT in October 2018 revealed WellCare of Kentucky continued to be fully compliant in 2018 with all elements related to Enrollee education about the availability and benefit of EPSDT services and about how to obtain them. WellCare of Kentucky was also fully compliant with the requirement to inform Enrollees of their right to appeal decisions related to EPSDT decisions.**
- *Dental Services:* Poor oral health has an adverse impact on overall health and well-being of our Enrollees. We subcontract with Avesis Third Party Administrators, Inc. to provide dental services for eligible Kentucky Enrollees. We use various methods to educate and remind Enrollees about the availability dental benefits. We facilitate Enrollee use of these services

by helping them select a dentist and coordinating their preventive and primary care dental services for oral health conditions or illness.

- *Emergency Care, Urgent Care and Post Stabilization Care:* We inform Enrollees that they are entitled to timely emergent, urgent care, or non-emergent care appointments in our *Enrollee Handbook*. We let them know they do not need approval from a Primary Care Provider or from us to use these covered services. We help Enrollees understand when they should use emergency care, which is available to Enrollees 24-hours-a-day, 7 days a week, and when they should seek urgent care services for care for a condition that is not likely to cause death or lasting harm but for which treatment cannot wait for a normally scheduled appointment, i.e., within 48 hours of Enrollee request.
    - *Out-of-Network Emergency Care:* We let Enrollees know that we provide and/or arrange for the provision of emergency care, even when they need these services outside of our Network and that we cover payment for emergency services by a non-contracting provider.
- *Maternity Care:* Data shows us that increased use of prenatal care is associated with positive health outcomes. To maintain the health and well-being of our pregnant Enrollees, our goal is to ensure prompt initiation of a woman's' prenatal care or continuation of care without interruption for those who are pregnant when they enroll with us. We let new moms know that we will make every effort to help her continue access to the same prenatal care provider throughout her pregnancy and that maternity care includes her prenatal, delivery, and postpartum care as well as care for conditions that complicate pregnancies. We let Enrollees know that we cover all newborn Enrollee screening, as specified by the Commonwealth.
- *Voluntary Family Planning:* Family planning has a key role in the prevention of unintended pregnancy, including teen pregnancy. In addition, family planning information, education, and services reduce the incidence and impact of sexually transmitted diseases through screening and treatment. We make culturally sensitive information available and educate Enrollees about the value of planning pregnancies so that our Enrollees can make informed decisions about the use of birth control. We let Enrollees know that they do not need approval or a referral from a Primary Care Provider or from us to use family planning services and related preventive health services, which are available statewide, through qualified family planning providers, which may be local county health departments or contracted agencies. Our staff assists Enrollees with selecting a qualified family planning provider based on their choice and helps them with scheduling a timely appointment within RFP-specified allowable wait times for appointments.

  Our staff reassures Enrollees that family planning services are provided on a voluntary basis in a confidential manner in accordance with applicable federal and state laws and judicial opinions for Enrollees less than 18 years of age. We assure adolescents that family planning services are confidential and that any necessary follow-up care respects an Enrollee’s privacy, yet we cannot absolutely guarantee confidentiality.

- *Nonemergency Medical Transportation (NEMT):* Through the NEMT program, Kentucky Enrollees have safe and reliable transportation to Medicaid covered services. WellCare of Kentucky presents information in the *Enrollee Handbook* and provides educational materials and verbal explanations about the availability of these transportation services. We inform Enrollees how to access NEMT services, which are provided by the Kentucky Transportation Cabinet, Office of Transportation Delivery. When our Enrollee Services and care coordination staff refer Enrollees to NEMT services, they document these referrals in the Enrollee's centralized record. In addition, we inform Enrollees that NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services and that WellCare of Kentucky covers emergency-related transportation, including ambulance stretcher services.
- *Pediatric Interface Services:* Many Enrollees who are children rely on school-based services provided by school personnel and services provided under the Kentucky Health Access Nurturing Development Services (HANDS), which are excluded from our contract. However, we let Enrollees know that we cover other preventive and remedial care services. This coverage includes services provided by the Department of Public Health through public health departments in schools by a physician, physician's assistant, advanced registered nurse practitioner, registered nurse, or other appropriately supervised health care professional. We establish collaborative relationships with Kentucky health department staff and school personnel for our Enrollees who are receiving pediatric interface services.

  We inform the child's parents or guardian that in situations where their child's course of treatment is interrupted due to school breaks, after school hours, or during summer month that we cover all medically necessary covered services for eligible Enrollees. We also inform parents and guardians that we provide palliative hospice services in conjunction with curative services and medications for pediatric Enrollees diagnosed with life-threatening or terminal illnesses.

We offer Enrollees many opportunities to learn about and engage with special program services, which contributes to their satisfaction with their healthcare services. **Compared to other Kentucky Medicaid MCOs, we have the highest Enrollee satisfaction as measured by the CAHPS survey.**

EDUCATING PROVIDERS ABOUT SPECIAL PROGRAM SERVICES

Providers are our partners and have an important role in educating Enrollees about the availability of special program services. Our goal is to maximize collaboration between WellCare of Kentucky and providers to achieve optimal health outcomes for our Enrollees. Providers perform age-appropriate screenings for each EPSDT eligible Enrollee per the AAP/Bright Futures Periodicity schedule.

After executing a contract with a new provider, we send a Welcome Packet and an enrollment notice outlining their effective date, orientation information, and instructions on accessing the Provider Manual and how to login to our secure provider portal. Simultaneously, we assign a provider relations representative (PR rep) who schedules and completes provider orientation and other trainings with provider and office staff, including educating them about the covered

and value-added services we offer. We also educate them about special program services and the importance of the EPSDT program and closing care needs. **In an independent provider satisfaction survey in 2019, Kentucky Medicaid providers ranked WellCare of Kentucky with the highest overall satisfaction of all Medicaid MCOs in the Commonwealth. In that survey, the highest performing composite score of the over 40 questions we asked providers was WellCare Provider Relations Representative's ability to answer questions and resolve problems.**

WellCare of Kentucky requires Primary Care Providers to provide EPSDT services and monitors their EPSDT compliance. Further, we maintain an effective education/information program for providers involved in delivery of EPSDT services. We offer provider presentations on EPSDT health care needs and interventions, a provider tool kit, and conduct successful chart audits of documentation requirements. Our provider education and information program addresses current guidelines for components of EPSDT screening and special services and emerging health status issues that Primary Care Providers need to address as part of EPSDT services, such as early identification and treatment of autism.

Provider trainings include face-to-face interactions with our staff, provider orientations, newsletters, online learning modules, emails, faxes, letters, on-site training, summits, webinars, and more. We make sure providers are aware of special program services using the following approaches:

- **WellCare of Kentucky provider-facing staff educate providers:**
  - **Provider Representatives (PR Reps)** – Our PR reps conduct initial and ongoing provider training to ensure provider compliance with program standards and contractual obligations and to educate providers about special program services. The PR rep makes sure a provider's office can login to the secure provider web portal and can easily access the *Provider Manual*. Ongoing, PR reps provide Enrollee reports, reinforce the need for compliance with HEDIS measures, and discuss the value-based contracting. **In 2019, WellCare of Kentucky PR reps made over 6,600 visits to provider offices to educate providers and their staff.**

  - *Quality Practice Advisors (QPAs) –* Our QPAs are part of our quality team. They remind providers about the availability of special program services to address care needs. QPAs provide education regarding American Academy of Pediatrics guidelines/Periodicity Schedule. They work with providers to identify and close care needs related to preventive care visits, provide care gap reports, assist with EMR information through the pseudo-claims process, and provide educational material to remind office staff of the standards of care as outlined in HEDIS specifications (HEDIS Toolkits). **In 2018, WellCare of Kentucky QPAs made 4,748 Medicaid-related, 1,270 Medicare-related, 39 OB-related, and 80 behavioral health-related visits to provider offices to educate providers and advance the Commonwealth's quality measures. Continuing these goals in 2019, our WellCare of Kentucky QPAs exceeded 6,000 provider office visits.**
- *Initial provider orientation/provider onboarding promotes knowledge of special program services:* During orientation, PR reps use our Provider portal to navigate training documents.

This helps providers become aware of the various tools and resources available for everyday use. Primary topics discussed during initial orientation include:

- Managed Care Program and Services, including special program services
- Eligibility and Benefits
- Rights and Responsibilities
- Enrollee Care and Quality
- Authorizations
- WellCare's Compliance Program
- Billing, Payment, and Encounters
- Appeals and Grievances
- WellCare's Policies and Procedures
- Telemedicine Services
- Care Model
- Timely Access Requirements
- Continuity of Care and Transition of Care
- Enrollees with Special Health Care Needs
- Review of the Provider Manual
- Specialized Provider Education

For providers providing emergency medical services, we educate them that they have a minimum of 10 days to notify us of an Enrollee's screening and treatment for these services to be covered by WellCare of Kentucky.

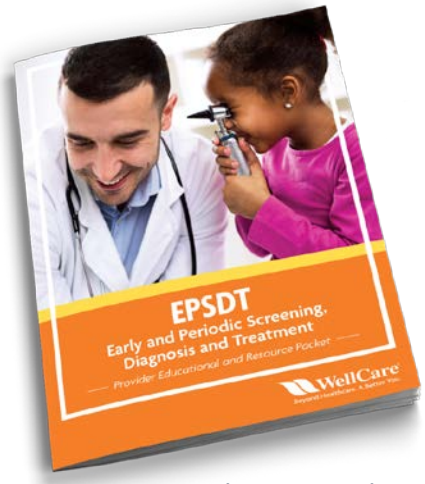


Figure C.22-4 Sample EPSDT Education

To promote EPSDT compliance, we educate providers on HEDIS Child Measures, including:

- Preventive screenings and treatment, as in **Figure C.22-4**
- Immunizations
- Follow-up visits
- Medication guidelines

Partnership

We train providers on and reinforce the importance of EPSDT documentation requirements and using correct coding guidelines to ensure accurate reporting of EPSDT. Provider-facing staff stress the importance of considering all aspects of a child's needs during EPSDT screening, including developmental and behavioral health screenings and substance use disorders. We reinforce that these screenings are essential to identify possible delays in a child's growth and development when steps to address deficits can be most effective.

- **Online training tools and resources available to providers via our 24/7 provider portal:** Our web-based, mobile-enabled provider portal offers 24/7 access to the public so participating and non-network providers can obtain program specific information, such as our *Provider Manual* and other information, within a few clicks. Our Section 508, HIPAA-compliant, and secure provider portal is a hub for physicians and their staff to learn about special program services. They can use tools, such as live chat and email, to process

transactions and to ask questions about special program services. WellCare's provider partners and provider focus groups across the country redefined the features and functions of the provider portal to align with their needs. This new functionality makes navigation more intuitive and enables access by smart phone, computer, or tablet.

- *Provider newsletter:* Kentucky providers can read about targeted topics, including special program services and preventive care requirements, in our quarterly provider newsletter, which is available on the provider portal.
- *Provider Manual:* We develop, maintain, and distribute a *Provider Manual* that offers information and education to providers about WellCare and Medicaid managed care special program services.
- *Other materials:* Various other provider communications include:
  - Quick Reference Guide (QRG) is an easy-to-use, how-to guide, which we update no less than twice yearly.
  - Bulletins provide ad hoc communications that educate providers about program changes and offer links and reminders.
  - Provider Tidbits are ad hoc communications about issues and resource links. PR Reps reinforce this content with providers.
  - Campaigns use multiple methods to disseminate information on specific topics like EPSDT, transportation, and dental services.
  - Email and chat offer secure conversations with WellCare associates via the provider portal. We send written information by email when upon provider request.
- *Ongoing provider education:* Training methods include group orientations, seminars and summits, one-on-one provider sessions, joint operating committee (JOC) meetings, webinars with PowerPoint presentations, phone calls, emails, and more.

b. Description of medical necessity review process.

WellCare of Kentucky is dedicated to quality care and transparency of our medical necessity review process. We continually seek new ways to improve Enrollee health and to better serve our Enrollees. We authorize medically needed special program services, especially for needs or conditions discovered during EPSDT screenings. We look at new treatments and new technologies to see if they will be helpful to Enrollees and families. We give evidence-based information and guidelines to our providers to help them make informed decisions about Enrollee care. On the current contract, our Utilization Management (UM) team responds to provider requests for a written or electronic copy of medical necessity review criteria. **WellCare of Kentucky is ranked first in Enrollee satisfaction, and we have an overall Enrollee voluntary choice rate of approximately 80%. This demonstrates we pay attention to our Enrollee's needs and care.**

WellCare of Kentucky has established and currently maintains a comprehensive UM program. Our UM program includes staff who follow systematic processes based on written policies and procedures to review services for medical necessity and clinical appropriateness of covered and non-covered services. Our Louisville, Kentucky-based Medical Director, Dr. Howard Shaps, MBA,

and his leadership team manages our clinical care operations and programs, including ensuring appropriate utilization and quality of care. Our Medical Director oversees treatment policies, protocols, quality improvement activities, population health management activities, and UM decisions, devoting sufficient time to ensuring timely medical decisions. WellCare of Kentucky's Medical Director is available for after-hours consultation, if needed.

UM staff makes determinations of medical necessity on a case-by-case basis, taking into consideration the particular needs of an individual and guided by information from an Enrollee's health provider(s) and evidence-based clinical standards of care. This applies to the EPSDT program where the determination of whether a service is medically necessary considers:

- All aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders
- Long-term needs, not just what is required to address the immediate situation
- Medical necessity decisions are individualized, therefore flat limits or hard limits based on a monetary cap are not consistent with EPSDT requirements

The benefit of our holistic approach is that UM staff can authorize medically necessary services that maintain an individual in the least restrictive setting possible. We recognize that additional services may be necessary to prevent further advancement of an Enrollee's condition (maintenance or control), to improve the quality of their health, or for corrective treatment. This includes treatment beyond medical necessity to help an Enrollee, including EPSDT-eligible children, reach their age-appropriate developmental level or to avoid institutionalization. Our goal is to ensure Kentucky Enrollees receive services for the treatment of illness, injury, disease, disability, or developmental condition and that these services are medically necessary to correct or ameliorate any identified conditions. This ensures we provide the right care to the right Enrollee at the right time in the right setting. For example, we may authorize a specially adapted car seat needed by a child because of a medical condition to avoid a transportation barrier to care.

Our holistic approach promotes collaboration between our care coordination and UM staff when working with a provider and the Enrollee, parent/guardian, and caregiver to ensure we support the Enrollee and the family. For example, in support of the Family First Preservation Services Act, today we work with providers to ensure families have access to services in their community and can assess unmet social needs, which often drive families into crisis and cause out-of-home placements. Care Managers and UM staff help to avoid an Enrollee's out-of-home placement in a foster care setting or residential treatment setting by authorizing services and supports that wraparound families or the Enrollee's relatives who provide temporary care during crisis. In addition, our Members Empowered to Succeed (METS) Program, which started in Kentucky as a pilot, assists Enrollees in stepping down from intensive services or obtaining more specialized services with extended authorizations for those services. Care Managers and UM staff reach out to providers proactively and work to create an authorization plan that identifies specific goals that demonstrate progress toward achieving treatment goals. The goal of the METS process is to use a collaborative approach to tailor authorizations and services to the person-centered needs of the Enrollee and their family/caregiver, while recruiting natural

and community supports as part of the care plan. METS has delivered meaningful results, including a 6% reduction in Emergency Department use. In Kentucky, our Care Managers with behavioral health expertise join weekly huddle calls to identify Enrollees who could benefit from field-based behavioral health or medical care coordination. Field-based staff collaborate with the METS program coordinators to address any identified barriers, including social needs like transportation or food.

The EPSDT special services program allows benefits not covered elsewhere in Medicaid. Medically necessary services can be preventive, diagnostic, treatment or rehabilitative. Examples include additional pairs of eyeglasses, additional dental cleanings, general anesthesia for dental treatment, or supplemental nutritional products. We identify and link Enrollees to providers who can deliver these services. Our UM program includes procedures for authorization and payment for such services. Enrollees have the right to appeal EPSDT special services denials.

Our UM staff conduct medical management activities that include prior authorization, concurrent review, discharge planning, retrospective review, and provider profiling. UM staff: 1) verify Enrollee eligibility; 2) conduct timely review of the medical necessity of a service; 3) determine the appropriateness of the service being authorized, including place of service to assure the Enrollee receives the right amount of care at the right time; 4) verify a service is covered; and 5) refer Enrollees to appropriate providers. On an ongoing basis, our staff monitors and evaluates the appropriateness of care and services for physical, behavioral health, and social services.

On the new contract, we will expand the description of medical necessity in our *Enrollee Handbook* to let Enrollees know that they can call Enrollee Services to request a written or electronic copy of our medical necessity criteria, as in **Figure C.22-5**.

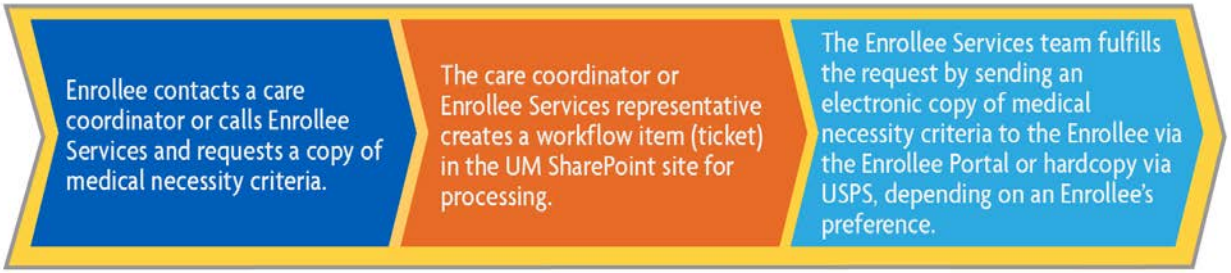


Figure C.22-5 Medical Necessity Criteria Requests

We developed CareCentral, our care management platform, to house all behavioral health and medical UM and authorizations into a single Enrollee view. Fully integrated with our single claims systems, CareCentral shows users an Enrollee's health record, medication history, health-related social resource needs, claims history, authorizations, and care plans. Authorized WellCare of Kentucky staff and providers have access to a complete picture of an Enrollee's needs across the entire spectrum of care when considering authorization decisions and utilization trends.

MEDICAL NECESSITY CRITERIA FOR UM DECISIONS

Our UM program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license in the Commonwealth of Kentucky and professional knowledge and/or clinical expertise in the related healthcare specialty actively participate in the discussion, adoption, application, and annual review and approval of all utilization decision-making criteria. UM staff uses numerous sources of information including but not limited to the following when making coverage determinations:

- InterQual Criteria (We also have the capability to use MCG or Milliman Care Guidelines based on a State's requirements or preference.)
- WellCare Clinical Coverage Guidelines
- Medical Necessity
- State Medicaid Contract
- Kentucky Clinical Coverage Policies
- State Provider Handbooks, as appropriate
- Local and Federal Statutes and Laws
- Medicaid and Medicare Guidelines
- Hayes Health Technology Assessment

The clinical reviewer and/or medical director involved in the UM process applies medical necessity criteria in context with an Enrollee’s unique circumstance, collaboration with providers, and the capacity of the local Provider delivery system. When medical necessity criteria do not address an Enrollee’s needs or unique circumstance, the medical director uses clinical judgment in making a determination.

WellCare of Kentucky complies with federal and state regulations for the medical necessity criteria we use. As required by the current Kentucky Medicaid contract, our UM staff uses InterQual as our primary medical/surgical criteria for medical necessity. On the new contract, we will continue to align with the Commonwealth's preference and use InterQual as our primary medical/surgical criteria for medical necessity. We use the American Society of Addiction Medicine (ASAM) for substance use. If InterQual does not cover a behavioral health service, we adopt the following standardized tools for medical necessity determinations:

- Adults: Level of Care Utilization System (LOCUS)
- Children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII)

With regard to medical necessity criteria not addressed for a service or for a specific population, we submit our proposed medical necessity criteria to DMS for review and approval by DMS subject to the guidelines specified in Section 4.4, Approval of Department. The Commonwealth permits use of CMS-recognized guidelines, national coverage determinations

(NCDs), and local coverage determinations (LCDs) when other criteria do not specifically address a provider request. We maintain written policies for applying the criteria based on an assessment of the local delivery system. At its discretion, DMS may require us to use of other criteria that it creates or identifies for services or populations not otherwise covered by the named criteria in the Draft Contract. Our UM staff uses medical necessity criteria that is based on established scientific evidence and is referenced in our documentation. Our UM staff incorporates local factors, such as Kentucky's demography, epidemiology, or provider network attributes.

We agree to implement Department-approved criteria within **90 days of receipt** of notice from DMS. Our medical necessity criteria is transparent and meets all relative documentation requirements as required by DMS, the Kentucky Department of Insurance, CMS, or other relevant regulatory agencies. Our Kentucky medical necessity criteria is available for review by DMS or the public by request and is available to providers The review criteria and guidelines are available to the Providers upon request and are posted on WellCare of Kentucky's provider portal.

UM staff who make service authorization decisions use written policies, procedures, and mechanisms to ensure consistent application of review criteria to process requests for initial and continuing authorization of services. Our written clinical criteria and protocols provide mechanisms to obtain all necessary information, including pertinent clinical information and consultation with the attending physician or other health care provider, as appropriate.

WellCare of Kentucky has a review body that includes representation by Kentucky licensed health care professionals who review medical necessity criteria at least annually. We attest on annual basis to the criteria used by our UM staff for medical necessity decisions. As an incumbent, we received DMS' approval for our current medical necessity criteria. On the new contract, we agree to submit our criteria to DMS for its review and approval to ensure compliance with new Contract requirements.

MEDICAL NECESSITY CRITERIA FOR UM DECISIONS RELATED TO DENTAL SERVICES

On the current contract, WellCare of Kentucky has medical necessity criteria specifically for dental services and uses it for the provision of dental services. WellCare of Kentucky's Dental Director Dr. Jerry Caudill is actively involved in all WellCare of Kentucky oral health programs and devotes adequate time to ensuring timely oral health decisions. Dr. Caudill makes sure our dental vendor's utilization review activities conform to our protocols, the Commonwealth's requirements and timeframes, and professional standards. Further, Dr. Caudill is available for after-hours consultation, if needed. On the new contract, we will submit our medical necessity criteria for dental services to DMS for its review and approval in accordance with Section 4.4 Approval of Department.

REQUIRED MEDICAL NECESSITY AND SERVICE AUTHORIZATION REVIEW TIMEFRAMES

WellCare of Kentucky makes prior authorization determinations in a timely and consistent manner so our Enrollees with comparable medical needs can and do receive comparable and consistent levels, amounts, and duration of services as supported by an individual's medical

condition, records, and previous affirmative coverage decisions. On the current contract, we track our adherence to medical necessity and service authorization timeline requirements. **Table C.22-1** shows evidence of WellCare of Kentucky's ability to comply with the Commonwealth's standard and expedited the medical necessity and service authorization timeline requirements 99 percent of the time during May 2019:

Table C.22-1 standard and expedited Timeline Adherence

Medicaid	Kentucky	Grand Total
Expedited		
Auth_Count	421	421
% TAT in Goal	99.0%	99.0%
AVG TAT Overall	0.41	0.41
TAT SLA	2	
Standard		
Auth_Count	11828	11828
% TAT In Goal	99.0%	99.0%
AVG TAT Overall	1.00	1.00
TAT SLA	2	

On the new contract, we agree to meet all Draft Contract-specified timelines for conducting medical necessity and service authorization reviews, including:

- *Standard Service Authorization:* We provide a service authorization decision as expeditiously as the Enrollee's health condition requires and within the Commonwealth-established timeframe, which is within **two business days of receiving the request**. WellCare faxes an authorization response to the provider fax number(s) included on the authorization request form. The Commonwealth may grant an extension for an additional 14 days if the Enrollee or his or her provider requests an extension, or if WellCare staff justifies in writing to DMS a need for additional information and specifies how the extension is in the Enrollee's best interest.
- *Expedited Service Authorization:* In the event the Provider indicates, or if we determine, that following the standard timeframe could seriously jeopardize an Enrollee's life or their health or ability to attain, maintain, or regain maximum function, we complete **an expedited authorization decision within 24 hours and then provide notice as expeditiously as the Enrollee's health condition requires**. We ask providers and train them how to request expedited decisions for prior authorization by telephone, not by fax or using our secure, online provider Portal. Providers can refer to WellCare's *Quick Reference Guide*, which providers can find on our website, for contact information for the UM Department via Provider Services. WellCare of Kentucky and providers will continue to consider a request

for authorization or preauthorization for treatment of an Enrollee with a diagnosis of substance use disorder (SUD) as an expedited authorization request. **In 2018, we had a total of 974 expedited authorization requests for all behavioral health levels of care. Of those, 337 Enrollees had a primary diagnosis of SUD.**

- *Post-Service (Retrospective) Review:* WellCare of Kentucky reviews post-service requests for authorization of inpatient admissions or outpatient services. **We complete retrospective review requests within 14 days.** If an Enrollee or the provider requests an extension or if we justify in writing to DMS a need for additional information and how the extension is in an Enrollee's best interest, retrospective review requests may extend up to an additional 14 days. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Enrollee's needs at the time of service. WellCare identifies quality issues, utilization issues, and the rationale behind any failure to follow WellCare's Prior Authorization/pre-certification guidelines.
- *Written Confirmation:* Upon an Enrollee or provider request, we provide written confirmation of our decision **within three business days** of providing notification of a decision if the initial decision was already not in writing. We provide written confirmations in accordance with Enrollee rights and responsibilities.

MEDICAL NECESSITY RELATED TO COURT-ORDERED PSYCHIATRIC SERVICES

WellCare of Kentucky does not deny, reduce, or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for Enrollees under the age of 21 or over the age of 65. We agree to present any modification or termination of services to the court with jurisdiction over the matter for determination. WellCare of Kentucky agrees to provide inpatient psychiatric services to Enrollees under the age of 21 and over the age of 65 for individuals who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.

MEDICAL NECESSITY RELATED TO ENROLLEES WITH SERIOUS MENTAL ILLNESS WHO ARE RESIDING IN INSTITUTIONS OR AT RISK OF INSTITUTIONALIZATION

We agree to provide services recommended in an Enrollee’s person-centered recovery plan and those services that meet medical necessity criteria for individuals with serious mental illness (SMI) and who are residing in institutions or those who are at risk of institutionalization. Our UM and care coordination staff participate in transition planning and continued care coordination for Enrollees with SMI who are transitioning from licensed personal care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing. A Care Manager conducts a comprehensive needs assessment (CNA) of medical and behavioral health needs to support an Enrollee’s successful transition to community-based housing within 14 days of the transition. To perform this assessment, our staff reviews the Enrollee’s Person-Centered Recovery Plan and level of care determination developed by the provider agency in tandem with our routine UM procedures.

c. Outreach methods to engage and empower Enrollees.

Our multimodal approach to Enrollee outreach provides many opportunities for Enrollees and their families to learn about and participate in special program services. Outreach activities engage and empower Enrollees and families by educating them and assisting them to connect with targeted services based on Enrollee need, while building healthy behaviors and improving health outcomes. As described in detail earlier in subsection a., we use the following outreach approaches to engage Enrollees and families:

- *New Enrollee onboarding materials,* including the Welcome Packet, ID card, and a message that encourages Enrollees/families to schedule well checkups.
- *Welcome video* that supports written onboarding materials.
- *Enrollee Services call center* with Enrollee Services Representatives who engage Enrollees and families by helping Enrollees complete their onboarding process and understand benefits and services. Enrollee Services Representatives also answer questions about how to access services, help Enrollees find a doctor or other provider and schedule an appointment, and help Enrollees connect to other services.
- *Digital engagement* is an effective means of Enrollee engagement. We direct our Enrollees to our digital platforms and demonstrate how to navigate managed care as a convenient way for Enrollees and their families to obtain information or perform self-service functions.
- *My WellCare mobile app.* This digital engagement tool enables Enrollees to assume more responsibility for their health through familiar tech smartphone and tablet capabilities and functions. Using the mobile app, Enrollees and families can:
  - Search for a provider by name, ZIP code, or location with our “Find a Provider” tool.
  - Find a hospital or urgent care facility with the “Quick Care” tool.
  - See preventive care an Enrollee may be missing in the “Wellness Services” section.
  - Use the “ID Card” tool to see their ID card. Show it to a provider on screen. Enrollees can even email or fax their ID card, as needed.
  - Get health-related messages like flu shot reminders.
- *Public website,* WellCare of Kentucky's mobile-responsive public website provides useful information to users.
- *Enrollee portal.* Enrollees can access the portal from the internet or from mobile devices. It provides Enrollees a secure, personalized health care experience and 24/7 access to self-service functions.
- *Enrollee Handbook.* Our Kentucky Enrollee Handbook contains information to help Enrollees connect to the care and services they need.
- *Direct-to-Enrollee household and targeted mailings.* We send annual/seasonal prevention written reminders and newsletters.
- *Outreach through collaboration with network providers.* We engage providers' assistance in educating Enrollees and families when a provider identifies a need for special program services.

- *Face-to-face outreach at community events.* Community events are activities where WellCare of Kentucky staff dedicate time to connect with community agencies or sponsor/host events for the community. Activities include attending interagency council meetings, specific health and social service-focused coalitions, as well as hosting community activities targeted at specific health or social issues. We have a strong commitment to participate in or sponsor local street fairs, health fairs, county fairs, Kentucky State Fair, festivals, and other scheduled and health-related events like community baby showers.
- *Outreach* through collaboration with faith-based and community organizations, such as food banks and homeless shelters.
- Telephonic and in-person outreach by WellCare staff. In Kentucky, all health care is local. Our local staff, including quality staff, Field Outreach Coordinators, and Care Managers, conducts multi-channel outreach activities to close gaps in care, including those related to EPSDT screenings and dental care. The key to empowering Enrollees is to engage them. We facilitate Enrollee engagement and participation in EPSDT screenings, special program services, and care coordination activities. We connect Enrollees to the special program services they need like EPSDT, NEMT, dental services, family planning services, Lock-In program, and more.

Care coordination and quality staff outreach to Enrollees to close care needs and connect Enrollees to special program services: To ensure Enrollees receive required EPSDT screenings and special services as well as provider-recommended treatment, WellCare of Kentucky established an effective and integrated care coordination function that includes field-based and telephonic outreach and a quality team that outreaches to Enrollees to close gaps in care. We maintain written policies and procedures for the provision of care, including dental services.

Care coordinators and Care Managers provide education and counseling to Enrollees and families/guardians regarding compliance with EPSDT visits and prescribed treatment and with the provider's treatment plan and referrals--and, sometimes this requires us to conduct a home visit to educate an Enrollee and family. Care Managers work with Enrollees and families/guardians to develop a plan for improving an Enrollee's oral health, a frequent care need for children and individuals with special health care needs or Enrollees located in residential treatment facilities. Care Managers outreach to Enrollees assigned to the Lock-In Program in advance of the lock-in to provide education and engage them in care coordination. Our care coordination staff makes referrals to family planning services and helps Enrollees coordinate timely appointments.

We provide Enrollees with support for transportation, appointment scheduling assistance, and connections to other supports, including services offered by the WIC program and other state and federal programs. Quality staff, Field Outreach Coordinators, Care Coordinators, and Care Managers follow up with Enrollees when they do not complete recommended screenings and treatment or follow-up with referrals, including EPSDT-related or social service referrals. Our staff works with Enrollees and families to identify and remove barriers to accessing care like transportation. We document all referrals in an Enrollee's CareCentral record.

Our integrated CareCentral care coordination system provides an integrated summary of Enrollee care needs: We maintain a single and centralized Enrollee record in CareCentral, our claims-fed care coordination system. Enrollee-facing staff document outreach efforts, information received from providers, assistance with scheduling appointments, assessment data, health history, all necessary diagnosis and treatment, receipt of EPSDT special services, and follow up. We track an Enrollee's referral compliance in their CareCentral record by means of claims submission and encounters as our tracking system for Enrollee acceptance or refusal of EPSDT services.

Our Community Connections team partners with community-based organizations, outreaches to Enrollees and non-Enrollees to educate the community about special program services, and educate them how to call our CCHL line to access social resources: Our Community Connections program links Enrollees and non-Enrollees to social services, such as food banks or meal delivery, housing assistance, financial assistance, transportation, education support, legal assistance, and employment services. We designed the Community Connections program to partner with community resources and help individuals navigate the local social support network to receive the care and services they need. A program priority is to identify local, community-based solutions to fill gaps in the network of social services. Care coordinators and Care Managers and other WellCare staff refer Enrollees and families, as needed or requested, to the CCHL team for assistance connecting to social services. We train care coordinators and Care Managers and give them the capability to access and search the Community Connections database of community-based organizations, which includes organizations like SNAP, WIC, and Head Start. They refer Enrollees and families/guardians to community-based resources and follow up to measure the impact of these services on our Enrollees' health outcomes as part of our closed-loop referral process. When we connect Enrollees to the social services they need, they are 5X more likely to schedule and go to their annual PCP visit, resulting in vital preventive care and screenings. **As validated by Robert Wood Johnson Foundation's Center for Public Health Systems and Services Research at University of Kentucky in 2015, there is $450 savings in healthcare costs per social service accessed.** This aligns with DMS' goal to help improve health outcomes for our Enrollees and lower the overall cost of health care.

d. Approach to identify, enroll and encourage compliance with lock-in programs.

As part of WellCare's new, national ACT for Opioids Program, we identify Enrollees with relevant behavior patterns by analyzing high numbers of controlled substance claims; multiple prescribers of controlled substances; prescriptions filled at multiple pharmacies; excessive utilization; Emergency Department utilization; and the geographic distribution of controlled substance prescribers and pharmacies. Once we identify an at-risk Enrollee, we enroll them in the One Provider-One Pharmacy Lock-In Program, where they are locked-in to one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines. We expanded our pharmacy Lock-In Program to address over-utilization of Emergency Department services.

Pharmacy Director Thea Rogers, Pharm.D., coordinates, manages, and oversees the provision of pharmacy services to Kentucky Enrollees. She provides clinical pharmacy direction for the

Kentucky managed care program, including, but not limited to medical economics, pharmacy, utilization, and quality management. After the success of the Kentucky Pilot Lock-In Program, WellCare implemented the Lock-In Program as best practice throughout the states where WellCare serves as an Medicaid MCO. WellCare manages our national Lock-In Program through our Tampa-based shared services department. Dr. Thea Rogers reviews complicated Enrollee cases and all appeal cases.

WellCare of Kentucky's Lock-In Program supports adult Enrollees (18 years old and older) who need help managing their health care needs. It limits overuse of medical and pharmacy benefits by making sure an Enrollee receives these benefits at an appropriate frequency and by ensuring care and services are medically necessary. Locking-in Enrollees to a specific provider and one pharmacy helps us closely monitor the services an Enrollee receives. **In 2019, 5,890 WellCare of Kentucky Enrollees were active participants in the Lock-In Program.**

The benefits of our Lock-In Program include:

- Protect an Enrollee's health and safety through tighter access to high-risk medications
- Facilitate effective utilization of services and improve quality of health care services for high-risk Enrollees through enhanced care coordination
- Decrease fraud, waste, and abuse of benefit resources
- Provide continuity of medical care
- Avoid duplication of service by providers
- Reduce inappropriate or unnecessary utilization of Medicaid medical and pharmacy benefits, including avoiding non-emergent care provided in an emergency setting
- Avoid excessive utilization of prescription medications obtained through multiple visits to physicians, specialists, and pharmacies
- Enhance quality of care by fostering stable relationships between Enrollee/physician and Enrollee/pharmacist

With the goal of reducing utilization of opioids and overdose-related deaths, in 2016 WellCare of Kentucky initiated our company's first pharmacy Lock-in Program. As a result, in 2017 in Kentucky we saw a 55% drop in opioid prescribing, a 35% reduction in cyclobenzaprine prescriptions (a common muscle relaxant), and a 30% reduction in benzodiazepine prescriptions. **In 2018, Kentucky's Lock-In Program achieved a 27% drop in opioid utilization, with a 47% increase in medication-assisted therapy (MAT) services, 25% increase in maintenance medications, and 33.3% reduction in Emergency Department visits.**

We piloted our initial lock-in program in Kentucky, achieving a sharp decrease in opioid utilization for Enrollees who were locked-in to one provider and one pharmacy. Positive results the first year of implementation included:

- Utilization of hydrocodone/acetaminophen and oxycodone/acetaminophen decreased by over 55% versus the baseline
- Benzodiazepine use decreased by over 30%

- Neurontin use decreased by over 30%
- Muscle relaxer use decreased

IDENTIFICATION OF AN ENROLLEE FOR THE LOCK-IN PROGRAM

WellCare of Kentucky uses retrospective claims review to identify Enrollees who are candidates for our Lock-In Program.

Lock-In Program Enrollment Criteria: We optimized our enrollment criteria to capture Enrollees at greatest risk for preventable outcomes from controlled substance/opioid abuse and misuse and those with unnecessarily fractured or duplicative pain management care. We identify Enrollees for the Lock-In Program through our 3+3+3+ED risk protocol. The criteria used for identification and enrollment of an Enrollee in the Lock-In Program during the retrospective review process includes Enrollees who:

- Excessive use of provider services
  - Fill prescriptions at least three or more pharmacies within 30 consecutive day period within a 180 lock-back
  - Use three or more physicians to obtain prescriptions
  - Use more than three controlled substances in a 30-day period
- Excessive use of Emergency Department services
  - Claims for six or more Emergency Department visits encompassing three or more unique Emergency Department facilities over a rolling 12-month timeframe
- Receive duplicative drug therapy from different physicians

Referrals: We review claims for Enrollees to determine candidacy for the Lock-In Program upon referral or reports of fraud, abuse, or misuse from providers, pharmacies, law enforcement agencies, or WellCare staff. This includes identifying Enrollees engaging in “doctor shopping” to get prescriptions from multiple doctors. Once we receive a referral, we review 12 months of pharmacy claims to determine the appropriateness of pharmacy utilization. The pharmacy team may recommend one of the following courses of action:

- Enroll Enrollee in a single pharmacy and Primary Care Provider Lock-In Program for 24 months.
- Send an intervention letter to the Enrollee.
- Send a warning letter to the Enrollee.
- Send a notification letter to the pharmacy.
- Enroll the Enrollee in WellCare’s Care Coordination program for education And reinforcement of safe and appropriate medication use and appropriate disposal of unused medications.
- Opioid misuse affects the whole family, therefore the Enrollee's Care Manager assesses caregiver burnout and coordinates resources for the Enrollee's family and/or caregiver.

- If medical justification is received, we take no action.

The pharmacy team logs all documentation related to Lock-In Program determinations. We maintain and update monthly a list of Enrollees enrolled in the Lock-In Program.

We use the Kentucky All Schedule Prescription Electronic Reporting (KASPER) tool: As part of the lock-in determination for Enrollees who appear to be over-utilizing controlled substances, our pharmacy lock-in team accesses the KASPER tool to investigate beyond retrospective claims review and include data on products for which the Enrollee may have paid cash.

Sound clinical judgement is essential: As needed, our pharmacy lock-in team uses sound clinical judgement to guide appropriate determinations related to over utilization and duplicative drug therapy.

Department approval: WellCare of Kentucky will continue to submit our Lock-In Program description to DMS for approval subject to Section 4.4, Approval of Department.

ENROLLMENT OF ENROLLEES IN THE KENTUCKY LOCK-IN PROGRAM

WellCare of Kentucky's Lock-In Program enrollment process includes the following features:

- *Written Notice via Automated Letter Generation:* Thirty days prior to lock-in, we send to Enrollees a letter of intent notification about their enrollment in the Lock-In Program. This letter explains the restriction that will be applied and how an Enrollee can request an appeal if they wish to contest the decision for enrollment into the program. All Enrollees have the right to appeal.
- *Lock-In Primary Care Provider/Pharmacy Selection:* Aligning with our one provider/one pharmacy approach, we lock the Enrollee to his or her Primary Care Provider on file in our XCelys claims and encounter system. In Kentucky, we select the designated lock-in pharmacy in accordance with the Geographic Access Requirements of the Kentucky contract. The designated Lock-In Program is geographically situated to give an Enrollee with limited mobility or transportation reasonable access to his or her providers. Thirty days prior to lock-in, in addition to sending a letter to the Enrollee, we send a letter to inform the Enrollee's provider and their pharmacy informing them of the Enrollee's lock-in status and their role.
- *Initial Care Coordination Outreach:* A Care Manager contacts the Enrollee prior to initiating pharmacy and prescriber edits. Initial Care Manager outreach includes: review of medical and pharmacy history; establish face-to-face or telephonic contact with the Enrollee; confirm accurate provider and medication list; explain the purpose of the Lock-In Program; notify pharmacy of any necessary updates; and conduct a comprehensive needs assessment to determine an Enrollee's whole-person needs. The Care Manager uses our substance use disorder (SUD) checklist, assists the Enrollee with other chronic conditions, and collaborates with medical and behavioral health staff, as needed.
- *Engage Enrollees in Support through Ongoing Care Coordination in Conjunction with Primary Care Providers:* For all Enrollees enrolled in the Lock-In Program, we refer them to WellCare’s case management team and connect them to a Care Manager to educate

Enrollees, coordinate their services, remove barriers to care, and monitor health outcomes. Care Managers help Enrollees identify the reasons for any over use of medical and pharmacy services. They help define person-centered goals and educate Enrollees about health-related social resources.

- *Enrollee Refusal to Participate:* Our care coordination team outreaches to all Enrollees assigned to the Lock-In Program. We advise the Enrollee that they are locked into one provider and one pharmacy but participation in care management services is optional. For Enrollees who refuse to participate in the care management program, we provide them with a phone number to reach us if they decide to participate later.
- *Lock-In Status Review:* For Enrollees enrolled in the Lock-In Program, while the Enrollee has lock-in status, he or she is restricted to one pharmacy and one Primary Care Provider to obtain prescriptions for a 24-month lock-in period. The pharmacy lock-in team reviews Enrollees enrolled in the Lock-In Program at least once during the 24-month lock-in period. If, after review of an Enrollee's drug-usage profile, we determine lock-in restriction and participation in the Lock-In Program is no longer appropriate, then we remove the restriction.

ENCOURAGE ENROLLEE COMPLIANCE WITH WELLCARE'S LOCK-IN PROGRAM

As part of our multidisciplinary approach to case management, the Enrollee's assigned Care Manager, Primary Care Provider, and pharmacist collaborate to oversee the healthcare needs of an Enrollee who is enrolled in the Lock-In Program. They make sure the Enrollee receives all medically necessary care for which the individual is eligible. The Care Manager keeps the Primary Care Provider and pharmacist informed about an Enrollee's whole health needs as well as the care and services the Enrollee is receiving, including social services. They educate the Enrollee about appropriate use of medical and pharmacy services.

Monitor and Follow Up: For Enrollees in the Lock-In Program, the Care Manager monitors his or her drug utilization as well as the Enrollee's current health status, their needs, and the services currently in place to address Enrollee-specific needs. Care Managers have access to and conduct a review an Enrollee's claims, including pharmacy and Emergency Department usage. The Care Manager measures and evaluates an Enrollee's progress toward his or her person-centered care plan goals, including education. They discuss major health issues and any barriers to attaining goals, including transportation or inability to access medications. The Care Manager assesses whether provider services and social services are being implemented in accordance with the care plan. The Care Manager follows up by adjusting care and services as needed to meet an Enrollee's needs and help them achieve Enrollee-defined care plan goals.

Lock-In Program Monitoring and Evaluation: At the corporate level, WellCare's Medical Economics team compiles detailed Lock-In Program data (e.g., number of Enrollees actively engaged in the Lock-In Program, pharmacy usage, non-emergent and Emergency Department usage, opioid use reduction, and cost savings) on a quarterly basis specific to WellCare's Medicaid line of business. They sort this data at the individual state Medicaid program level. After Quality Affordability Initiative staff reviews and validates the Lock-In Program data, the Medical Economics team approves the data for dissemination. The Medical Economics team

distributes quarterly Lock-In Program data to each of our state pharmacy directors. In Kentucky, Pharmacy Director Dr. Thea Rogers presents quarterly Lock-In Program data to the WellCare of Kentucky's leadership team.

Table C.22-2 presents positive outcomes for WellCare of Kentucky's Medicaid Lock-In Program, as of Q1 2019 for 1,112 actively engaged Enrollees during the six-month period from May 2018 - October 2018. **Opioid utilization reduced by 27.4%, representing a cost savings of $1.77 PMPM. Enrollee MAT use increased by 47.1% and use of maintenance medications increased by 25%. Providers who treat Enrollees who use opioids test them for HepC, accounting for a 7.4% increase in HepC prescription fills.** Overall, Lock-In Program pharmacy total costs increased by 54.9%, indicating a positive trend in Enrollees' appropriate use of MAT, HepC, maintenance medications, and other medications for diagnosed conditions. The data suggests improved Enrollee adherence to provider-recommended medication regimens, leading to improved health outcomes. Lock-In Program savings resulted from a reduction in opioid prescription fills and a reduction in emergent and non-emergent Emergency Department utilization.

Table C.22-2 Medicaid Lock-In Program Outcomes

Rx PMPM Breakout	Before	Enrollment	After	PMPM Change After vs Before	% Change After vs Before
Opioid Rx PMPM	$6.46	$4.58	$4.69	($1.77)	-27.4%
MAT Rx PMPM	$11.67	$20.26	$17.17	$5.50	47.1%
HEPC Rx PMPM	$16.59	$59.33	$17.81	$1.22	7.4%
Maintenance Rx PMPM	$188.98	$203.76	$236.27	$47.30	25.0%
Other Rx PMPM	$64.89	$131.75	$170.95	$106.07	163.5%
Total Rx PMPM	$288.58	$419.69	$446.89	$158.32	54.9%

In addition, our Lock-In Program data from the same time period shows:

- ***34.3% reduction** in non-emergent Emergency Department visits/1,000*
- ***31.7% reduction** in emergent Emergency Department visits/1,000*
- ***33.2% or $96.78 PMPM savings** in Emergency Department costs*

The following Enrollee story demonstrates how the Lock-In Program improved Enrollee outcomes by proactively prevented potential misuse and overutilization of controlled substances through education and care coordination.

Kentucky Enrollee Successful Experience with the Lock-In Program

In June 2018, our Enrollee, a 58-year-old male from Jackhorn, Kentucky, suffers from chronic pain and has diagnoses for disc degeneration, pulmonary hypertension, and chronic obstructive pulmonary disease (COPD). Retrospective claims review flagged him for review for the Lock-In Program due to meeting program criteria, which included receiving prescriptions fills for three unique controlled substances prescribed by three different providers within a 30-day period. He filled three controlled substance prescriptions at two different pharmacies during this period. This Enrollee's pharmacy utilization pattern put him at risk of poor health outcomes.

Thirty days prior to the Enrollee's enrollment in the Lock-In Program, WellCare sent a Lock-In Program notification to the Enrollee, his assigned pharmacy, and his Primary Care Provider on file. Concurrently, Lock-In Program staff referred this Enrollee to WellCare of Kentucky's care management staff for outreach to discuss the Lock-In Program and to facilitate the Enrollee's participation in care management to coordinate his care and remove any barriers to accessing the care and services he needs. A Care Manager called the Enrollee and explained the Lock-In Program. The Enrollee mentioned he changed Primary Care Providers. His current Primary Care Provider is not comfortable prescribing controlled substances and referred the Enrollee to a pain clinic for prescriptions for controlled substances. The Enrollee said he is currently taking prescribed medication for hypertension. The Enrollee agreed to participate in the care management program.

The Care Manager updated the Enrollee's centralized record in CareCentral. She documented the Enrollee's new Primary Care Provider and pain clinic physician's names and notified our pharmacy escalation team to update his Lock-In physician preferences so that the Enrollee would not experience an interruption in his medications. The adjustments were completed timely, and the Enrollee experienced a smooth transition to the Lock-In Program. The Enrollee stated he appreciated the Care Manager's personal touch in coordinating his services, handling issues, and educating him about the Lock-In Program. After almost a year in the Lock-In Program, this Enrollee has consistent and regular fills of his opioid medication from one provider and one pharmacy. We anticipate this Enrollee will successfully graduate from the Lock-In Program after 12 months.

WellCare of Kentucky delivers fully integrated, whole-person care through the coordination of physical health, behavioral health, social needs, and complex care models with the goals of improved health outcomes and more efficient and effective use of resources. Our Kentucky experience provides valuable insight into the utilization patterns and population health needs for Kentucky Medicaid Enrollees. This includes a wide range of individuals, such as moms and babies, adults with chronic conditions, adolescents and children with complex or comorbid needs, justice-involved individuals, and individuals with substance use disorders or serious mental illness.

e. Approach to coordination, including referral and follow-up with other service providers, like Women, Infants, and Children (WIC), Head Start, First Steps, School-Based Services, DCBS and the Kentucky Transportation Cabinet Office if Transportation Delivery.

APPROACH TO COORDINATION WITH OTHER SERVICE PROVIDERS

When providers and other entities involved with the health care delivery system work together for the benefit of the Enrollee and populations served. Coordinated care improves an Enrollee's experience with the system of care and his/her outcomes as well as reduces wasteful spending by avoiding duplication of care and services. Our approach to care coordination assures assistance with navigating multiple programs and community-based services, timely Enrollee assessment, development of a care plan that includes referrals to needed services and promotes optimal independence and Enrollee self-responsibility, and completion of monitoring and follow up activities. Care Managers identify and coordinate services and supports required to address an Enrollee's needs and goals, regardless of which program provides the benefit or service. **Coordination activities include referral and follow-up with other service providers like Women, Infants, and Children (WIC), Head Start, First Steps, School-Based Services, DCBS, the Kentucky Transportation Cabinet Office of Transportation Delivery, and more.** Care Managers educate Enrollees and families or guardians about the availability of special program services, including NEMT and family planning services. Enrollees who are not enrolled in our care coordination program can receive assistance with referrals to WIC, NEMT, and other social services by calling Enrollee Services or the CCHL. All referrals are documented in the Enrollee's centralized record. CCHL staff identify community-based resources to help Enrollees and work with them to develop an action plan that encompasses social needs to help them overcome health risks and improve outcomes.

Our care coordination platform, CareCentral, facilitates assessment, referral management, and interventions related to services provided by other providers and social resources provided by community-based organizations. This single, integrated clinical platform, fed through our single operating and claims system, is accessed by associates with diverse clinical and operational backgrounds and disciplines who all work for the same organization. Using CareCentral's Member Care Compass module, users have an integrated view of an Enrollee’s whole-person needs, including history and needs related to medical, behavioral health, medications, and social needs and referrals to special program services.

IDENTIFICATION OF ENROLLEES NEEDING SPECIAL PROGRAM AND SOCIAL RESOURCE SERVICES

Our approach to coordinating special program and social services begins with screening and identifying Enrollees who have these needs. We encourage all Enrollee-facing clinical and support staff, including MSRs, to routinely screen Enrollees for special program and social needs, including transportation, during interactions with Enrollees.

Predictive Modeling: We use predictive modeling to risk stratify Enrollees using multiple data sources and assign a risk score to each Enrollee. In an emerging feature of our ID/Strat tool, we include social service risk determined through our unique approach to cataloging and tracking

an Enrollee's utilization of social service resources. This utilization includes access to healthy food or non-benefited housing supports.

Health Risk Assessment (HRA) and Comprehensive Needs Assessment Tool: Like the HRA tool, our Comprehensive Needs Assessment tool includes questions that help Care Managers identify an Enrollee's whole person needs. It includes supplemental assessments that trigger when a social resource need is identified. They ask Enrollees if they are already receiving services from other programs like WIC, SNAP, Head Start, First Steps, or school-based services.

Referrals: Enrollee self-referrals and referrals from family, care coordinators, Care Managers, Primary Care Providers, other providers, CCHL staff, Commonwealth staff, WIC, school personnel, and social services staff or even a referral after a hospital discharge help us identify Enrollees with special program or social resource needs and/or those who may need care management. We educate community-based organizations on how to refer individuals to our CCHL.

Ongoing Identification: During interactions with Enrollees, clinical and non-clinical staff asks the Enrollee and family if they have any urgent or unmet social resource needs like food, shelter, transportation, or personal safety and promptly takes steps to address these needs. During a Care Manager's regular touchpoints with an Enrollee and during the Comprehensive Needs Assessment reassessment process, the Care Manager may identify a new social resource need, update an Enrollee's record, and make referrals.

COORDINATION, REFERRAL, AND FOLLOW UP WITH OTHER SERVICE PROVIDERS

WellCare of Kentucky begins the coordination process by establishing and maintaining collaborative relationships with other service providers like WIC, Head Start, First Steps, School-Based Services, DCBS, and the Kentucky Transportation Cabinet Office of Transportation Delivery, and the Kentucky community organizations that provide the social resources our Enrollees need, such as Low Income Home Energy Assistance Program (LIHEAP), HANDS program at local health departments, ARC Pregnancy Centers, and HEAR NOW. We train all of our Enrollee-facing staff, including Enrollee Services staff, Field Outreach Coordinators, Care Managers, and CCHL staff how to respond to Enrollee requests for help, e.g., food and transportation, available from WIC, Head Start, First Steps, School-Based Services, DCBS, and the Kentucky Transportation Cabinet Office of Transportation Delivery, and other Kentucky community organizations. We maintain contact information for these entities in our Community Connections database, for example, we include the phone number and address for WIC offices throughout all regions of the Commonwealth. Enrollee-facing staff document all Enrollee interactions and referrals in the Enrollee's record in CareCentral. This facilitates appropriate monitoring and follow up activities to make sure the services that other service providers deliver are meeting Enrollee needs and goals.

As part of our multidisciplinary approach to case management, their Care Manager convenes a multidisciplinary care team, which includes Primary Care Provider and may include representatives from other entities or state agencies, or community-based programs collaborate to oversee the healthcare needs of an Enrollee. With an Enrollee or

family/guardian's permission, we request state agency staff or other individuals engaged in an Enrollee's care, such as DCBS or school-based services personnel, participate on a multidisciplinary care team, engaging them in care planning and coordinating care in a manner that complements, yet does not duplicate, the Enrollee's care plan, services, and supports. They make sure the Enrollee receives all medically necessary care for which the individual is eligible. The Care Manager keeps the multidisciplinary care team informed about an Enrollee's whole health needs as well as the care and services the Enrollee is receiving, including social services. The Care Manager documents multidisciplinary care team recommendations and referrals in the Enrollee's record in CareCentral. Our staff follows up on Enrollee referrals, adjusts referrals as necessary to meet Enrollee needs, and measures an Enrollee's health outcomes related to social service referrals.

We have experience working with the following service providers and have learned best practices working with these entities and coordinating their services for Enrollees, including:

- *WIC:* Our Community Connections database includes contact information for WIC offices throughout Kentucky. When Enrollees call us for a referral to WIC or when it is listed on an Enrollee's care plan as an intervention, we can quickly provide the Enrollee and family with accurate information for local WIC offices. Our staff helps Enrollees complete applications for WIC services and SNAP (food stamp) benefits.
- *Head Start:* Every child deserves the right to arrive their first day of school ready to grow, learn, and succeed. We collaborate with families, early child and education provider, school staff, and community partners. Our staff coordinates referrals for our young Enrollees throughout Kentucky to participate in the Head Start program and follows up with a child's progress.
- *First Steps:* We routinely refer our medically complex children and foster care children to the First Steps program. WellCare worked with DCBS and foster parents to help set up these services. These services are appropriate for children less than 2.5 years old. After that point, we refer children to the Head Start program.
- *School-Based Services:* We frequently interact with school-based services. Some of our Enrollees receive behavioral health services through community mental health centers (CMHCs) embedded within a school. Often, our staff bridges the service components provided in the school with the other health-related and social services. We facilitate communication among families, therapists, and other providers.
- *DCBS:* We have many examples of our collaboration with DCBS. Today our regional teams of associates live and work in the regions and districts where DCBS offices are located. We assign a local WellCare of Kentucky foster care coordinator to each DCBS Service Region. This foster care coordinator meets with his or her assigned Service Region and county level offices to establish and maintain internal relationships with DCBS staff. For our medically complex individuals, we work hand in hand with DCBS and the Office of the Commission for Children with Special Health Care Needs to coordinate service delivery for children with complex needs. We work with DCBS and the Children’s Review Program and providers to coordinate discharge-planning efforts for children in acute level, subacute level, and

residential levels of care. We work with DCBS on the polypharmacy issues of children and youth. We work with DCBS and providers when an Enrollee needs additional services. DCBS staff outreaches to our staff to request assistance with locating specific service types. We then work with both DCBS, caregivers, and the identified provider to coordinate those services. **In 2018, our care coordinators held almost 1,000 care-planning meetings with DCBS and DJJ staff for our Enrollees in foster care.**

- *Kentucky Transportation Cabinet Office of Transportation Delivery:* We routinely refer Enrollees and families/guardians to Kentucky Transportation Cabinet Office of Transportation Delivery for NEMT transportation services. For Enrollees who have transportation needs that do not meet the criteria for coverage by the NEMT program, we coordinate transportation services offered by community-based organizations, as seen in the following Enrollee success story.

Care coordination and CCHL staff successfully refer Enrollees in western Kentucky counties to transportations services offered by Pennyrile Allied Services, Inc. (PACS).

Transportation Success Story - Pennyrile Allied Services, Inc.

WellCare established a partnership with PACS, a nonprofit community action agency, whose mission is to reduce and eliminate poverty. In 2015, community stakeholders identified transportation as the most urgent service gap for health in the region through a WellCare-led Community Impact Council held in Muhlenberg County. WellCare of Kentucky gave a $25,000 grant to support safe and reliable transportation options in the region. PACS' transportation voucher program has expanded to nine western Kentucky counties. Residents with limited incomes use vouchers for non-billable medical transportation to get to dental, vision, hearing, pharmacy, and behavioral health appointments. These vouchers give people regular, reliable access to healthcare to help them address their health concerns quickly, instead of delaying care until travel is convenient or affordable. By reducing health risks early, access to transportation can slow disease progression and help prevent future hospitalizations. From July 1, 2017 through March 31, 2019, 1,614 WellCare of Kentucky Enrollees received 36,969 total services from PACS, with 90% of referrals for transportation. Health outcomes for our Enrollees who used PACS services showed:

41% reduction in non-emergent Emergency Department visits for those with diabetes
41% reduction in inpatient admissions and 64% reduction in hospital days for those with asthma
41% reduction in visits related to acute lower respiratory infections

23. Behavioral Health Services

C.23. BEHAVIORAL HEALTH SERVICES

a. Provide a comprehensive description of the Contractor's proposed Behavioral Health Services, including the following:

i. Current or planned delegation to delegate all or part of the provision of Behavioral Health Services to another entity.

ii. Process for monitoring and evaluating compliance with access and care standards.

iii. Proposed innovations to develop and maintain network adequacy and access.

iv. Process for follow-up after hospitalization for Behavioral Health Services within the required timeframes.

v. Process for ensuring continuity of care upon discharge from a Psychiatric Hospital.

b. Describe the Contractor's approach to meeting the Department's requirements for operating seven (7) days a week, twenty-four (24) hours a day emergency and crisis hotline as defined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

c. Describe the Contractor's approach to coordination and collaboration between the Contractor, Behavioral Health Providers and the PCP as defined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

C.23. BEHAVIORAL HEALTH SERVICES

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 33.0 Behavioral Health Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

Since our program inception in 2011, WellCare of Kentucky has recognized the prevalence of behavioral health issues in the Commonwealth, particularly substance use disorder (SUD), and has championed the importance of having programs that engage and empower individuals in recovery and resiliency while enhancing and supporting the system that serves them. WellCare of Kentucky provides a comprehensive behavioral health program that serves the continuum of conditions and focuses on the issues most impacting Kentucky.

Our experience tells us that people with behavioral health conditions have a higher incidence of unmet medical needs and addiction to tobacco, alcohol, opioids, and other substances. Furthermore, people with behavioral health conditions are more likely to be homeless or housing insecure. Without attentive and coordinated discharge planning to transition from inpatient to outpatient, Enrollees with significant mental health conditions risk readmission for potentially preventable events, and may also have difficulty stabilizing or taking new medications if there is a delay in getting treatment from a new provider.

We provide a program that meets these challenges through:

- Integration to address both physical and behavioral conditions

- Coordinating elaborate partnerships with behavioral health and medical providers to create a high touch, integrated health system
- Supporting integrated care with social programs that improve Enrollees' outcomes and reduce medical costs
- Person-centered care management
- A provider network that supports the continuum of care for Kentucky's most prevalent disease states.
- Acknowledging and addressing the challenges of coordinating with state psychiatric hospitals, CMHCs, and SUD/treatment providers

Under the leadership of Behavioral Health Director, Dr. Marketa Wills and Senior Director of Behavioral Health, Lori Gordon, LCSW, MBA (who will be named Executive Administrator for the Kentucky SKY program), we have maintained the largest behavioral health network, which today includes more than 2,300 behavioral health professionals. Additionally, we have sustained a community presence across the Commonwealth that includes six regional offices to ensure our ability to maintain close contact with our Enrollees and local stakeholders, particularly community mental health centers (CMHCs). **This community presence has been a significant factor in our achieving status as the highest rated managed care organization (MCO) in the Commonwealth on the NCQA behavioral health metrics.**

Upon launching the program, we engaged with Kentucky's behavioral health community in an intentional process that continues today to ensure that Enrollees would have access to services and that key stakeholders would have relationships enabling collaboration and coverage. In 2012, WellCare of Kentucky was the only MCO to maintain a contract with Appalachian Regional Hospital (ARH) to continue serving Enrollees and providers in Region 8.
To ensure community voice in our behavioral health program, we developed the **Behavioral Health Clinical Advisory Council (BH-CAC),** which collaboratively monitors and improves WellCare of Kentucky's behavioral health program, helping us understand provider and Enrollee needs. It is comprised of 10-15 clinical leaders from multidisciplinary and diverse backgrounds in the Commonwealth, including inpatient and outpatient providers and advocates. This group represents diverse licensures, expertise, geographies, and populations. The BH-CAC has had quarterly meetings for eight years and continues to do so, guiding WellCare in all areas of the behavioral health program. The expansion of behavioral health services in 2013 is an example of the work of the Council. Through discussions with the advisory council and twice monthly meetings with CMHCs, we recognized, along with DMS', the need to expand the continuum of care within these vital provider organizations. WellCare of Kentucky expanded the services and developed a commensurate fee schedule for CMHCs to include a full range of services, adding many additional service codes such as intensive outpatient services and expanded in-home services well before they were covered benefits. After being the first to implement this program, we later helped roll it out across the Commonwealth. We continue to work with the CMHCs and the expanded behavioral health provider network to ensure access and improve quality, as we realize this is essential for the program to fulfill its mission.

WellCare of Kentucky has demonstrated its commitment to work collaboratively with DMS' and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to

ensure that quality Behavioral Health Services . We are committed to the integration of physical health, behavioral health, pharmacy, and social supports for Enrollees. It is the foundation of our care model and our integrated CareCentral clinical platform and permeates the entire company.

a. Provide a comprehensive description of the Contractor's Behavioral Health Services

WellCare of Kentucky recognizes that the best path to improved outcomes for individuals with behavioral health needs and substance use disorders is a holistic approach that helps them navigate the broad range of services available across the continuum of care. We recognize that Enrollees with chronic health conditions may also experience depression, anxiety and other disorders secondary to their health diagnoses which , may impede the patient's activation and adherence and treatment of medical conditions. In 2018, 28% of our Kentucky population had diagnoses for both a behavioral health and medical conditions. Given that prevalence, we integrate behavioral health into every part of our approach to care, including Enrollee engagement, broad access to care, clinical programs, and social programs including value-added benefits. In our design and operation of behavioral health services we incorporate the four core values defined by DMS' in Section 33.2 of the Draft Contract.

WellCare's model is results oriented, intensive, ongoing, and focused on Enrollee and provider satisfaction. Our behavioral health plan is overseen by our medical directors, Howard Shaps, MD, MBA (physical health), Dr. Marketa Wills (behavioral health), and Thea Rogers, Phar.D. (pharmacy) who are each deeply committed to supporting our program. The behavioral health team is diverse, comprised of representatives from population health solutions, provider relations, operations, and quality. This integrated team has demonstrated behavioral health program success. Our success in integration is the result of our proactive, multifaceted approach that includes the fundamental components of WellCare operations as well as Enrollee and provider- facing initiatives, described below**.**

ENROLLEE-FACING INITIATIVES

Individuals with mental health and substance use diagnoses require substantial support services for recovery and resilience. In 2018, 36.6% of our Kentucky Enrollees had a behavioral health diagnosis. Our primary goal is to identify and engage Enrollees in their own health using a variety of innovative approaches. Our comprehensive, integrated behavioral health program features a variety of activities and programs aimed at improving outcomes for Enrollees with behavioral health conditions. We engage Enrollees in the program through health coaching, face-to-face meetings, peer support, and value-added services to support healthy lifestyle changes. We also leverage technology and app-based approaches to Enrollee engagement.

Clinical Programs: WellCare of Kentucky is aligned with DMS' efforts to drastically improve outcomes for a variety of healthcare conditions and to empower individuals to improve their health and engage in their healthcare. Several of our national programs originated in Kentucky. We have developed comprehensive programs to address Opioid Misuse Prevention and Opioid Use Disorder Treatment, Adverse Childhood Experiences (ACEs), and Severe Mental Illness (SMI). Each of these programs include person-centered supports that focus on the whole

person, addressing physical health, behavioral health, pharmaceutical, functional, and social needs.

Care Coordination and Case Management Program: WellCare at Home is the centerpiece of our Care Management approach in which field-based care managers including more than twenty licensed behavioral health clinicians that engage Enrollees and their families in person at a time and place most convenient to the Enrollee. Bring able to see an Enrollee's challenges first-hand allows our care managers to better help address barriers to positive health outcomes. WellCare at Home remains one of our most successful programs. In an analysis of Enrollees enrolled in Complex Care Management receiving WellCare at Home interventions, in a one-year period, we saw their **ER use decline 21%, their inpatient admissions decline 27%, with corresponding increases in pharmacy spend of 16% and specialist visits of 27%.** This tells us that members are taking their prescribed medications and maintaining appointments with their physicians and therapist.

Identifying Enrollees: There is no wrong door for Enrollees to access our care management program. Referrals for care management identify Enrollees for the program. Every Enrollee-facing associate (e.g., care management, Enrollee Services, customer service, UM, discharge planning staff, and other Enrollee-facing staff) and Provider receives training to identify needs and make direct referrals to care management. Enrollees may self-refer or their family/legal representative may refer an Enrollee at any time. We can receive referrals from providers; the 24-hour Nurse Advice Line; BH Crisis Line; State staff; community partners; hospitalists; and other PHPs. In addition, WellCare has designed our stratification process with predictive analytics specific to the Medicaid population, which allows us to better identify emerging risks as well as behavioral health and substance use risks that are often masked in traditional cost-based stratification models. Our Opioid risk identification and stratification process, for example, can identify, after the first opioid prescription is written, who is at risk for misusing that drug. We assign Enrollees a Risk of Unsafe Use Score™, which identifies Enrollees at risk of unsafe use of prescription opioids and predicts the likelihood that an opioid user will be diagnosed with unsafe opioid use in the next one-year period. This allows us to intervene early with specially trained care managers to prevent Opioid misuse. Generally, our risk stratification methodology allows us to determine the risk of our overall population and identify Enrollee risk levels.

Care Needs Screening and Assessment: Once identified, our approach begins with an integrated screening and comprehensive health risk assessment, which identifies both medical and behavioral health conditions. The CareCentral assessment includes a dynamic, configurable comprehensive needs assessment. Care Managers can also use supplemental assessment for individuals with special health care needs. This assesses their immediate, current and past healthcare, mental health, and substance use history and needs; psychosocial, functional, and cognitive needs; social determinants of health, including employment and housing; ongoing conditions or needs that require treatment or care monitoring; current care being received; current medications; and their support network. The goal of the Enrollee Needs Assessment is to gain a whole-person understanding of the individual's goals, strengths, needs, preferences, abilities, functional needs, and physical and behavioral health status. Care managers, document

the findings from the assessments in the CareCentral system, which provides a 360-degree view and begins the integrated plan of care.

Care Planning: WellCare is committed to person-centered, integrated care planning process where the Enrollee voice is central to the process. Our care managers are trained to build relationships that elicits what is important to the Enrollee and family. Enrollees define the care team and the care plan goals. Our behavioral health care managers facilitate a collaborative multi-disciplinary team approach to develop an individualized plan of care. We develop enrollee-centered plans of care that include measurable goals, outcomes, interventions, supports, and services for the Enrollee's condition(s) and needs. Ongoing coordination with the PCP and behavioral health specialists is part of the care planning and monitoring processes. The care manager assesses the Enrollee for progress on the care plan goals and address any identified or potential obstacles to success. This can include issues such as limited transportation, lack of understanding of the condition, lack of motivation, as examples. The care manager guides and supports the Enrollee using motivational interviewing and teach-back techniques to empower them to realize their health improvement and recovery goals. . CareCentral empowers real-time collaboration among MDT members. Workflows extend beyond shared notes and secure text messages to incorporate multi-dimensional media, video-conferencing, shared dashboards and reports, and alerts. Care managers make personal contact with an Enrollee’s suggested MDT members to explain their responsibilities on the team and its importance to the Enrollee’s care. The care manager provides a copy of the care plan to MDT members and ensures they know how to access the Enrollee’s information via CareCentral’s secure Provider Portal.

Follow Up: Enrollee outreach frequency depends on their identified needs and risk level (Health Promotion and Wellness, Management of Chronic Conditions, or Complex Care Management). The care manager links Enrollees to necessary services and monitors their provision. This includes, for all risk levels, making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up. Through implementing the Enrollee's care plan, WellCare aims to enhance the Enrollee's health literacy to the greatest extent possible, and to help them become self-directed and compliant with their healthcare regimen. The care manager also:

- Facilitates Enrollee referrals to resources and follows up to determine whether Enrollees act on the referrals
- Monitors the Enrollees through implementation and interventions of the care plan, collaboration with MDT and the Enrollee ember or caregiver
- Monitors the Enrollee throughout the implementation of coordination activities and goal achievement, assesses progress against care plan goals, and makes necessary modifications
- Educates Enrollees on disease process/condition and promotes self-management.
- Provides Enrollees with nationally-recognized and approved educational material; coaches toward adherence to monitored treatment plans; develops and communicates Enrollee-specific self-management plans; and documents in the Medical Management Platform, during each contact with the Enrollee

- Understands Enrollee's care needs and circumstances may change; the care manager must continually evaluate the care plan to update and/or revise to accurately reflect the current Enrollee needs.
- Assisting Enrollees through Transitions of Care including, but not limited, to hospital to home and pediatric to adult care.

Enrollee Materials: As a fully integrated health plan, WellCare of Kentucky includes behavioral health specific information in all Enrollee materials and customer service scripts to educate Enrollees on the behavioral health benefit, the network, and how to access services. WellCare of Kentucky includes behavioral health specific information in all Enrollee materials and customer service scripts. Our Enrollee newsletter features behavioral health topics that focus on a specific part of the program. As an example, information on how to identify a behavioral health crisis, and how to access emergency behavioral health services, has been included as a way to address Kentucky's growing suicide rate.

Community Engagement: Community engagement partners work with social resource organizations to address social barriers at the individual Enrollee level while supporting the community through helping to secure the safety net infrastructure. The Community Engagement team in Kentucky is the largest across the company and has provided **6,446 community activities reaching 4,075,014 individuals or connections**. Our Community Engagement team engages Enrollees at our sponsored health fairs, back-to-school events, and other community events throughout the Commonwealth to educate them about their benefits, covered services, population health programs, and community resources. Often we learn at these events that Enrollees do not have a comprehensive understanding of the services they are entitled to, including access the Community Connections Help Line (CCHL), available health and wellness programs, or coordination support with non-covered services. The Community Connections Help Line includes peer support specialist that refer Enrollees (and non-Enrollees) to our community partners to address their social determinants of health.

Care Managment: Building a Skills Toolboxwith Community Support

In January of 2017, a Case Manager was connected with a 24-year-old member living in Louisville, KY. The member had been experiencing ongoing suicidal ideations, which resulted in rapid readmits every other day. At the time, the case manager shared that the member had a plan and means to execute, but kept reaching out. Our case manager treated every suicidal ideation as though it was the first, and worked with the member to build a "skills toolbox" so the member would have a viable solution for any issue that may arise. For example, if the member was concerned about how they were going to eat food that week, the case manager had a left St. Stephen's Food Pantry and Clothes Closet as a tool in the member's skill toolbox, and had showed the member how to use that tool. The member was taught how to utilize the tools available to them in the community, which resulted in the member taking the lead in their own health. In addition, our case manager worked with Bridgehaven and their staff to make sure that the staff was aware of the needs of the member and could assist in the total scope of care for this individual. For the member to have their full needs met, the care manager had to always consider "What is the next step or the next need? How can I assist the member with this next step?" The case manager's efforts went "Beyond Healthcare" to provide "A Better You" for this member, who previously relied on others to find solutions to their needs. Now, this member is aware of resources available to them in their community, and also knows how to utilize them when necessary.

Quality Program - Kentucky Behavioral Health, Enrollee Engagement, and Health Coach Team: A focused team of Quality Improvement coordinators, Health Coaches, a Patient Care Advocate (PCA) supervisor, and regionally located PCAs. Our current team includes:

- *Health Coaches that conduct continuous outreach* to Enrollees. Since beginning the program in February 2019, they have made more than 13,000 outreach calls to provide education on recommended critical behavioral health screenings and preventive services. In 2018, Deloitte Center for Health Solutions published a study indicating the top things Enrollees want to use smart phones for are recognizing depression or anxiety, and for health coaches.
- *Patient Care Advocate (PCA) team*, co-located in provider offices to help assist Enrollees in scheduling appointments and enrolling in care management through telephonic outreach and face-to-face engagement. If needs are identified the PCA may directly refer to the care management program.
- Kentucky-based **member outreach coordinators,** who use our Unable to Contact (UTC) program, REACH, to locate Enrollees for whom we have incorrect or missing contact information. We know when we can locate an Enrollee who was previously unable to contact, we increase quality and reduce medical costs by as much as 19.4%.
- *Telephonic Resources:* A live person answers WellCare of Kentucky's **Behavioral Health toll-free crisis services hotline** 24 hours per day, seven days per week, year round. With a person-centered approach, hotline associates provide crisis triaging to assess Enrollees' behavioral and physical health, pharmacy requirements, and social determinants of health needs, including their need for crisis services. Each crisis line associate are specifically trained to recognize critical issues; as well as, local community resources. To ensure each

crisis was managed, and to assess for any other needs, a local behavioral health care coordinator follows up within 24 hours (next business day) of a crisis line call, after the original reason for the call has been addressed. Our **24-hour Nurse Advice Line (NAL)** is staffed by highly qualified physicians, physician assistants, and nurses, who all know and understand how to educate Enrollees, how to find and select the right provider specialist for them, and how to quickly identify and take action for those in crisis; and direct those who are not in immediate distress to an appropriate level of care. They do so using sophisticated software that recognizes signs and signals of distress through word recognition.

- *Web-based Education and Resources:* WellCare offers an array of supportive and educational resources to address the healthcare needs of Enrollees, and their families. These include **mobile peer support** for substance use via MAP Health, our **Enrollee portal**, which provides access to education, highlights care gaps for Enrollees, helps them make appointments, and offers self-service tools and links to supports such as a pharmacy and provider search. We provide easy-to-understand **Krames health education materials** that support Enrollees in their self-care journey. Our health education programs, including Krames tools, are informed by our integrated clinical practice guidelines (CPGs) that cover both healthy individuals and those with acute and chronic conditions. Our **MyWellCare Mobile App** provides access for Enrollees, families, and caregivers to a digital library of mental health and substance use information, self-help tools, and our vignette series of People Like Me - stories of individuals with lived experience with mental health and substance use.

PROVIDER-FACING INITIATIVES

WellCare views our providers as key partners and stakeholders. We are committed to ensuring that providers have the resources and tools necessary to develop, implement, and successfully maintain our accreditation-based integrated provider models. We work with all providers, including Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Behavioral Health Services Organizations (BHSO), Multi-specialty Groups (MSG), Independent Practice Associations, and PCPs, to support Enrollees receiving integrated and holistic care.

In 2012, WellCare implemented an internal operational structure using a fully integrated behavioral and physical care model for all organizational functions. At that same time, we made it a priority to promote integration within our provider network. With expertise from across Kentucky and our national enterprise, our clinical leaders began discussions with our larger Community Mental Health Centers regarding models of integration.

These collaborative discussions led to the development of provider “Report Cards”, individualized reports for each provider, outlining the full complement of services their Enrollees with a serious mental illness received from WellCare (e.g., behavioral health, physical health, specialty care, hospital and where available, social services).

Using a data-driven approach, opportunities to improve health outcomes, divert avoidable ER and inpatient admissions and fully integrated care for our most vulnerable Enrollees were identified on a provider-by-provider basis. Following these discussions, WellCare asked providers to recommend key elements to promote integration in their practice. To support

these efforts, WellCare also introduced key providers to each other locally and facilitated professional collaborations regarding potential models.

Strong Collaboration with Behavioral Health Providers: In addition to the collaborative efforts described above, our Kentucky-based provider relations team facilitates monthly provider education sessions via WebEx, and regular in-person training to address any identified gaps. We also collaborate with providers through participation in clinical rounds with medical directors and other specialists. WellCare of Kentucky works with our community mental health program partners to expand suicide prevention efforts and increase awareness through our use of nationally recognized programs including **Mental Health First Aid (MHFA) and ZeroSuicide.** WellCare has committed to having every non-clinical, Enrollee facing associate trained in MHFA in 2019. We also support activities such as a "Train the Trainer" series whereby a cadre of community mental health programs, primary care offices, and community staff are trained to offer Mental Health First Aid seminars throughout the year in their communities and schools; and leadership seminars in ZeroSuicide practices for schools and community partners. WellCare will offer provider incentives for having member facing, non-clinical associates trained in MHFA. WellCare is engaging with ZeroSuicide, as one of the first insurers nationally, to conduct an organizational self-assessment and collaborate with ZeroSuicide on the results. The results of our organizational assessment will further advance and refine our integrated care practices.

We also support our network providers in establishing nationally accredited Behavioral Health Homes (BHH) in the mental health community. BHH standards recognize the importance of integration between medical and behavioral services and improve access to care to minimize the impact of adverse social determinants of health. They include clinical standards; infrastructure requirements; reimbursement policies to support integration; core performance measures using nationally recognized HEDIS® and other indicators; and financial incentives. Our model, including a provider readiness review tool, was informed by emerging practices nationally, evidence-based care guidelines, and actionable feedback from our Kentucky providers. We have worked with several CMHC providers to implement this model in Kentucky.

We continue to support these efforts with “Strategic Integration Sessions” to solicit provider input and to foster professional collaboration and implementation of a provider incentive for achieving accreditation as a BHH.

Our **provider portal** houses fully integrated information on best practices including behavioral health clinical practice guidelines for depression and anxiety behavioral health referrals, care gaps, the prior authorization look-up tool, Provider Relations Representative contacts, reference materials, and compliance resources. We distribute our **Behavioral Health Toolkit and quality scorecards** to providers and make them available online. The toolkit includes evidence-based screening tools for psychiatric conditions, depression, and suicidal ideation, among other key indicators—this includes information on psychiatric interventions as well as local, service area referral information to close potential gaps in care. The toolkit also outlines Behavioral Health HEDIS® measures that incorporate physical health screens, including those for diabetes and hypertension. Our **provider training** and **Provider Handbook** ensure that providers are familiar with contractual requirements, as specified in Section 33.7 of the Draft Contract.

WellCare of Kentucky also uses a **Gold Card Program** to reward behavioral health inpatient facilities based on their performance ensuring access to care. Facilities that meet minimum volume targets, with demonstrated quality performance as measured by their compliance with ambulatory follow up after hospitalization, and demonstrated efficient management of length of stay, earn Gold Card designation, so that they need only receive approval for an initial admission. Facilitating integration, our integrated platform, CareCentral, captures utilization, claims, assessments, care plans, goals, and diagnoses in a complete, 360-degree view of the Enrollee providers can access.

Our behavioral health provider engagement extends to the clinical authorization process. We make behavioral health outpatient services as readily available to Enrollees as possible by not requiring authorization for therapy services and auto-authorizing the first 220 units of support services (over 50 hours). After that, our clinical team reviews the medical record from our clinical provider to determine medical necessity. Additionally, based on feedback of our provider partners, WellCare of Kentucky implemented a 24/7 telephonic authorization process that includes outpatient services in 2017.

INTEGRATED COMPONENTS OF WELLCARE OPERATIONS

WellCare of Kentucky integrates behavioral health into every aspect of our approach to care. The primary elements that comprise our internal behavioral health operations include:

- *CareCentral*, our single system for managing behavioral health, pharmacy, utilization management, care management and claims that feeds the provider portal and provides a complete view of the Enrollee's health history, including care gaps. It also houses an integrated care plan addressing health needs and care gaps across the continuum, including social determinants of health.
- *Behavioral health expertise for collaboration in integrated departments:* Product, Regulatory, PR, Network, Health Services (UM and CM), Quality Improvement, and Pharmacy.
- *Integrated WellCare at Home teams that provide in-home care management services* include behavioral health clinicians and nurses; with pharmacy and Community Connections support.
- *Integrated interdisciplinary teams for individuals with complex needs* that provide a rich source of clinical expertise. These include physicians, RNs, LCSWs, Community Engagement Partners, Liaisons for Medically Complex Children, pharmacy, UM, and more.
- *Weekly Integration Rounds led by our medical directors* and including individuals in Kentucky that review complex cases using our holistic, whole-person approach – medical, behavioral and pharmacy.
- *Behavioral Health Operations Monthly Meetings* ensuring behavioral health initiatives are communicated and integrated across WellCare of Kentucky's functional organizational departments.
- *Comprehensive Cross-Training:* All staff, including ESRs, our physical health care management professionals, and the 24 licensed behavioral health professionals within our Kentucky-based integrated team, receives training to ensure that Enrollees with behavioral health needs are identified and referred to the appropriate level of care. We work with each

practice on quality improvements, educating providers on the VBP contract and tracking whole-person HEDIS quality measures, such as LDL Cholesterol (medical), Follow-up within seven days after Mental Health Hospitalization (BH), and Diabetes Screening for Enrollees using Anti-Psychotics (medical/BH). Training includes the use of integrated screening tools, clinical practice guidelines (CPG), care coordination and management, working with the MDT, participating in cross-training for physical and behavioral person-centered care, and caring for Enrollees with co-morbid conditions. Customer service representatives and other Enrollee facing associates are also trained on mental health first aid, and Kentucky specific resources. In addition, we train providers on identifying the social support needs of our Enrollees using reports that track social data and care needs and plugging the Enrollee into community resources through our Community Connections model and closed-loop referral system.

- *Members Empowered to Succeed (METS)*: In 2016, WellCare of Kentucky developed the METS program, which is now WellCare's national model. Based on SAMHSA's 10 Fundamental Components of Recovery, this integrated, holistic recovery-oriented program is for Enrollees in care for an extended period with high utilization associated with their services who might be able to graduate to self-care with other supports We assign targeted Enrollees a dedicated, specially trained METS care manager who develops a current clinical picture, including medication history, using information in CareCentral. After establishing a clear clinical profile, the care manager presents the Enrollee in a Treatment Team Review (TTR) meeting. The multidisciplinary TTR meeting identifies barriers, strengths, and other factors to develop the care manager's next steps to follow-up on the Enrollee's case and develop a tailored Roadmap to Recovery. Results for program participants include a 54.7% reduction in total visits, a 6.1% reduction in emergency department use, and an increase in pharmacy use – suggesting improved medication adherence. For these Enrollees, the **total cost for professional behavioral health visits dropped by 35.7%.** By ensuring Enrollees are in the right levels of outpatient care, we are able to free-up the system to manage new Enrollees or Enrollees immediately after crisis in the community.
- *Kentucky Behavioral Health Quality Initiatives:* Three teams of regionally located **Quality Practice Advisors (QPAs)** throughout the Commonwealth assist providers in closing care gaps such as medication adherence for depression and schizophrenia and educate them on HEDIS and Health Plan Review measures. They also emphasize the importance of completing appointment agendas, which allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment, and capturing all chronic conditions a patient has annually. QPAs also coordinate with care management and assist provider groups in practice transformation to develop coordination of care for patients. In addition, QPAs are responsible for EPSDT and Ambulatory Medical Record Review (AMRR) audits, reviewing results with providers directly and developing corrective action plans as needed. All of the QPAs are trained on how to discuss behavioral health care gaps with behavioral health providers. We also have four QPAs matched with regional CMHCs to support them in the BH P4Q program. In preparation for the new contract, we are implementing specialized QPAs to provide focused support to specialty providers, including Behavioral Health and OB/GYN. The Behavioral Health QPA will be the primary provider support for care coordination between medical and behavioral

as well as conduct visits with behavioral health providers for education on the Quality Program and performance. Our OB/GYN QPA focus on women's health care needs and will connect directly with providers to also educate about our Quality program and performance.

OPERATIONAL OVERSIGHT

As a fully integrated plan with medical, behavioral, pharmacy and social determinants, WellCare has a unique ability to provide operational oversight, respect, understand, and support providers as they evolve in their role as the Enrollee's health home or medical home, and become the primary source for care: medical, behavioral, pharmacy and social needs.

Provider Collaboration Models

Provider integration is one of WellCare's top priorities. We are committed to helping providers move to a more fully integrated healthcare system. WellCare's model, which is based upon the levels of collaboration and integration defined by the SAMHSA-HRSA Center for Integrated Health Solutions, places providers into one of three combined levels of collaboration:

- Coordinated (e.g., minimal or only basic collaboration, separate systems, and few shared cases);
- Co-Located (e.g., little sharing of systems, some meetings over shared cases, shared office space or located nearby); or
- Integrated (e.g., sharing most if not all practice space, consistent and frequent communication, operates as a complete and single Enrollee care team).

WellCare staff work with providers seeking to become Patient Centered Medical Homes, Behavioral Health Homes or in adopting integrated models of care. Over the last three years, WellCare's active collaboration with our community mental health providers has resulted in integrated behavioral health and primary care contracts for four centers: Adanta, Centerstone, Kentucky River, and River Valley.

To ensure our providers have support in delivering fully integrated care, we solicit input on barriers and work to address them. For example, we recently hosted a series of provider summits in three locations across the Commonwealth —Louisville, Lexington, and Bowling Green—to identify barriers to integrated care and seek provider recommendations on solutions. These strategy sessions directly affect how we approach integration internally.

Provider Contracting

WellCare of Kentucky has extensive experience working with our network providers to develop and implement Value-Based Payment programs. We believe that incenting providers to participate in our quality programs is an effective way to coordinate with them in improving Enrollee health outcomes. We offer provider incentives including our **Partnership for Quality (P4Q)** program that rewards providers for closing care gaps on key HEDIS performance measures and timely completion of appointment agendas; the **Behavioral Health (BH) P4Q program**, introduced in 2019 to align with DMS' goal of improving behavioral health-related outcomes among the people of Kentucky. 2019 care gap data shows that the CMHCs closed 7,039 care gaps **and more than $281,000 in bonus payments were paid out as a result of the**

new BH P4Q program. We will continue the BH P4Q program in 2020 with the CMHCs in Kentucky.

We have supported efforts to remove contract barriers for our integrated providers allowing behavioral health providers to bill for PCP services delivered through their programs. Our behavioral health and physical health providers are fully contracted and credentialed through a single process, and behavioral and medical health claims are processed and paid through the same operating system, which supports our single, holistic view of each Enrollee in real time.

In addition to our care coordination education activities, WellCare's internal interdisciplinary clinical team uses the following methods to help physical and behavioral health providers coordinate care:

- Assistance with discharge planning
- Data sharing strategies through portals, interconnectivity options or various reporting tools including care gap reports and behavioral health scorecards
- Integrated provider engagement team meetings
- Integrated technical assistance calls/webinars
- Integrated clinical case conferences
- Integrated provider advisory committees
- Weekly “Integrated Grand Rounds” on shared cases with complexity and integrated plans of care for more complex Enrollees
- Training and toolkits for both PCPs and behavioral health specialists to help them identify children and adolescents who would benefit from care coordination help them build strategies into their practice, such as internal rounds and consultation, to coordinate care
- Relationship building between our Care Coordinators, Provider Relations staff, Quality staff, Medical & Behavioral Health Medical Directors, Pharmacy Directors and the primary care and the behavioral health care providers.
- Connectivity to social safety net services, family caregiver support and other formal and informal supports through our proprietary Community Connections Model
- Integrated Independent Practice Association and Community Mental Health leadership meetings for Medical and Behavioral Health Directors
- Newsletters and personal physician correspondence

We are the glue between the providers that advocates for the Enrollee. We provide the qualitative Enrollee feedback on their experience through our Care Management outreach. We do not just rely on clinical data but from referrals from any provider or staff member. Our WellCare medical directors, both medical and behavioral Health, as well as our pharmacy team and other clinicians are readily available to consult with providers and help them connect their patients to behavioral health and medical services. In addition, providers have the ability to directly link their Enrollees to our case management services through a single fax number or email box.

i. Current or planned delegation to delegate all or part of the provision of Behavioral Health Services to another entity.

WellCare of Kentucky does not delegate or carve out the provision of behavioral health management as many MCOs do. Instead, we offer a fully insourced model of care that addresses the whole person. Our industry-leading, fully integrated approach is led collaboratively by Medical Director, Howard Shaps, MD, MBA and Behavioral Health Director Dr. Marketa Wills, MD, MBA (behavioral health). It brings together physical health, behavioral health, pharmaceutical, and social supports in a unified approach to caring for the whole person. In 2018, 28% of our Kentucky population had diagnoses for both a behavioral health and medical conditions. Since the outset, we have provided integrated care and we remain one of the only Medicaid plans to offer in-house integration.

ii. Process for monitoring and evaluating compliance with access and care standards.

Our process for monitoring and evaluating compliance with access and care standards meets Section 28.4 of the Draft Contract, including KRS 304. 17A-515, in Kentucky. Provider network monitoring to ensure Enrollees have access is an integral part of our overall approach to meeting care standards. **For 2018, we are ranked first in Enrollee satisfaction and earned the highest possible score of 5.0 on continued follow-up after ADHD diagnosis.**

WellCare of Kentucky recognizes that access to integrated, high quality health care services is crucial to Enrollee health, wellness, and satisfaction. Overall, we have the largest and most comprehensive provider network in the Commonwealth with over 34,500 providers and more than 2,300 Behavioral Health professionals.

Our provider network, quality, and care management teams are fully integrated. During collaborative meetings with other plans and DMS', Dr. Wills shares information with our network relating to updated clinical and department policies. This information flows through our network team and our ongoing provider education. These meetings also provide an avenue to address opportunities and challenges in the delivery of high quality behavioral health services. We use the material from these discussions to inform our network and care management teams, and incorporate significant changes into our provider education and care delivery.

NETWORK MONITORING

We recognize that ongoing monitoring and evaluation is imperative to maintain an adequate network that provides continuum of care to ensure Enrollees have access to care at the appropriate level, in accordance with Section 33.5 of the Draft Contract.

We monitor our network on an ongoing basis and engage in network development activities that expand our network beyond mere compliance with access requirement. Tools include a combination of GeoAccess reports, monthly out-of-network reports, network accessibility audits, open/closed panel reports, provider satisfaction surveys, Enrollee grievances, quality of care issues, utilization trends, HEDIS results, and more.

Over the past eight years, WellCare of Kentucky has built and maintained a network that exceeds DMS' standards for providing timely access to care for all of the Commonwealth's Medicaid Enrollees. Our network includes FQHCs, CMHCs, and BHSOs as the foundation of our network. Continual and consistent monitoring of our provider network is vital to our efforts, enabling us to identify and quickly remediate any gaps to ensure that standards are kept and access to care is maintained. Our comprehensive ongoing monitoring and development of our network providers allows us to maintain and exceed Enrollees' satisfaction, access to care, and comply with Department contract requirements for adequacy and access to care standards.

Assessing the adequacy of our provider network is a continuous process. Our Network Integrity Team performs monthly evaluations of the network using the tools and data sets described below to identify potential gaps and the need for expansion activities. Our ongoing activities allow us to identify opportunities as they arise to respond proactively with enhancement strategies. WellCare's Network Integrity Team is responsible for collecting and analyzing network data, through the methods described below. Our Network Management Team holds monthly Network Management and Development meetings (or more frequently, if needed), where we assess all provider types to identify if there are any issues, gaps in the network or other barriers to accessing care as well as any provider concerns that may impact their ongoing willingness to serve our Enrollees. While our leadership meets monthly to strategically address network compliance, our Kentucky-based staff, including PR Representatives, Service Managers, Enrollee Services and Enrollee Advocates, initiate action immediately to remove barriers to care for our Enrollees. We use the following tools, reports, and resources to monitor our network:

- *Monthly GeoAccess® Reports and Quest Cloud Analysis:* GeoAccess reports evaluate that time and distance standards are being adequately met at the provider level to meet the needs of Enrollees in each region. We run these reports using DMS-defined access standards. GeoAccess results are the key element reviewed during the quarterly Enrollee Access to Care committee meeting and an actionable plan results from the analysis.
- *ZIP Code Analysis for Enrollees without Access:* An analysis of Enrollees without access to specific specialties at the ZIP code level. The ZIP code analysis ensures that potential Enrollees in all applicable ZIP codes can be properly served.
- *Monthly Access Compliance Snapshot:* A drillable GeoAccess dashboard report of the provider network specialties by county. The report is run on a monthly basis using the current provider network and current Enrollee population. Each report is validated and analyzed for provider network trends and then distributed to our Network Management Team for action.
- *Quarterly Exception History Log (EHL):* Records provider network gaps, current patterns of care and narrative justification with steps to remedy each identified network deficiency. Provider network deficiencies are uploaded from the GeoAccess software into the EHL tool, where the Network Management Team writes a narrative describing the plan to fill each deficiency based upon the Network Management Team's research.
- *Out-of-Network Monitoring:* On a monthly basis, the Health Services and Network Teams' out-of-network reports are reviewed to identify any trends that indicate access issues

within the network. In such cases, this information is assigned to Provider Relations for remediation.

- *Enrollee and Provider Feedback:* We monitor Enrollee and provider complaints or grievances as one real time source of feedback on access. In addition, WellCare conducts annual surveys that include key questions about the quality and adequacy of our provider network. Our Quality Improvement Team reviews the results of the survey and shares the results with our Network Development and Provider Relations Teams to identify areas of opportunities for additional contracting and service improvements.
- *Closed Panel Reports:* Our Provider Relations Team review monthly closed panel reports to identify providers with recently closed panels. Provider Relations Representatives outreach to each provider in an attempt to have them re-open their panel. Closed panel percentages are reviewed by specialty to determine if additional providers are needed. Our Provider Relations Representatives also visit our provider groups to review and verify their details, including panel status. We also have a Provider Accuracy Audit in place that samples network data reporting for analyzing and reporting on the information reported to us, including panel status.
- *Out-of-Network Paid Claims:* The Network Development and Provider Relations teams monitor out-of-network paid claim reports to identify providers that are not currently contracted with WellCare. This information is shared with the Network Development Team to target recruitment activities.
- *Knowledgeable Associates:* Our PR Representatives and Community Connections Staff act as key resources for identifying gaps in the network. Our associates know their regions and are encouraged to immediately escalate to leadership any situation in which a provider is not available or does not exist to adequately meet an Enrollee's needs. As a result, we understand the provider landscape across each region of the Commonwealth, and we couple that with our understanding of the basic and specialized needs of our Medicaid Enrollees.
- *Quality Improvement Committee (QIC):* We hold quarterly QIC meetings attended by the following departments: Quality Improvement, Network Management, Regulatory, Health Services, Executive Leadership, Credentialing, Appeals and Grievances, Claims, Compliance, Community Connections, and Enrollee Services. During this meeting the Network Team reports on the state of the Network, including any gaps to be filled and other access and availability issues; provides information on barriers and action plans to address those barriers; and receives feedback from our internal partners on any network concerns. The Network Team uses this feedback to identify areas of opportunity within the management and execution of the Network and, when necessary, implements changes.

REMEDIATION OF ANY DEFICIENCIES

Our Network Management Team works quickly to address any deficiencies identified during the course of our network monitoring activities using a variety of methods:

- *Targeted Outreach:* We outreach to local providers to fill identified network gaps. Our field-based PR Representatives and Network Management staff personally contact non-

contracted providers to determine impediments to contracting and look across borders to recruit out-of-state providers in bordering states with natural referral patterns.

- *Working with Contracted Providers to Expand Access*: As described above, we use Quest Analytics tool to see if there is a Medicare provider of the provider type needed that is not listed on the Kentucky file. If located, we approach the practice by phone or in person to persuade them to see Medicaid patients. If necessary, we may offer an additional financial incentive, including value-based payment (VBP) contracts, to take on the additional population of Enrollees.
- *Offer Incentives:* When deficiencies are related to lack of access to a specific provider type in a specific area, we may initiate an investment opportunity by giving incentives such as VBP contracts to providers to expand into the area. We have also expanded our P4Q program to encompass behavioral health.
- *Single Case Agreements:* Our Network Contracting team fills individual gaps using a single case agreement with an out-of-network provider, seek an alternative delivery method for that service, and work with the Enrollee to find an appropriate alternative. This ensures seamless care for our Enrollees in places where there is a lack of any specific provider contract.
- *Existing Patterns of Care:* Our Network Integrity team closely reviews patterns of care to develop an understanding of provider referrals within each region and outreach to providers outside of those regions to support those patterns.
- *Leverage Provider Partnerships:* Our network development team and provider relations teams use individual relationships as well as provider advisory groups to encourage partner network providers to extend hours and to expand access.

The information and feedback we collect flows through our quality processes for improvement opportunities. Based on the nature of the opportunities presented, we assign actions for improvement to a department to lead those efforts. The progress of improvements are formally tracked through the Quality Department and reported back to all applicable committees and up to Executive Leadership.

PERFORMING DATA ANALYSIS

WellCare of Kentucky consistently invests in the enhancement of our formal Enterprise Information Management (EIM) Solution that supports all of our data needs, including application processing, regulatory reporting, and ad-hoc reporting. Specifically, this includes providing the data analytics and data informatics capabilities needed to drive performance improvement and quality management activities. This comprehensive EIM solution ensures that all data sources (e.g., HEDIS®, CAHPS, Claims, Appeals, Grievances, Rx data, Social, AMRR, Surveys) are captured and catalogued, integrated to enable robust reporting capabilities, and provide the analytic tools needed to identify care gaps and opportunities. Our local, Kentucky based analytic team focuses on trends, outliers and other analytics that inform our program development and improvement efforts.

PERFORMANCE IMPROVEMENT ACTIVITY

Combined with our affiliate health plans we possess broad and rich experience conducting performance improvement projects (PIPs). These achieve significant progress across clinical and

non-clinical areas through our adoption and integration of the Continuous Quality Improvement (CQI) Rapid Cycle Plan-Do-Study-Act (PDSA) methodology. Our PIP guidelines include: activities related to external quality review, mandatory activities, and the CMS guidelines as outlined in the most recent publication EQR Protocol 7 Implementation of PIPs. They also include:

- Specifications of clinical or health services delivery areas to be monitored including objective quality indicators
- A system to achieve improvement in quality
- Methods to evaluate effectiveness of the interventions
- A system to institute planning and initiation of activities for increasing or sustaining improvement

A WellCare PIP focused on managing the physical health of Enrollees with behavioral health conditions has improved our scores over the past three years for Body Mass Index Screening for People with Schizophrenia or Bipolar Disorder and Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD), exceeding the goal for 2017 with 95.62%.

In addition, our quality team reviews patient safety, critical events, and root cause analyses with our providers on a consistent basis. As an example, we have made more than 150 visits to the top 50 providers across the Commonwealth to discuss adherence to introduce the availability of our BH provider educational resource information packet (available on our website) including screening for co-occurring illness, and a discussion on how we can partner with them to improve Enrollee compliance with blood pressure, diabetes and cholesterol medications for all Enrollees including individuals with behavioral health conditions. Adherence to these medications is key to keeping people healthy and out of the hospital and it is a triple-weighted Star measure. We are now embarking on a similar program for psychotropic medication adherence, recognizing how critical a factor issue of non-adherence to these medications is in relapse.

Provider Resources to Support Improvement Efforts: We offer all providers an array of resources to help them improve Enrollee health outcomes. Through the Provider Portal, they can view all services received by an Enrollee, including physical and behavioral health utilization, laboratory, Medical Loss Ratio (MLR), claims, and quality performance. The portal also offers Heat Maps, which identify Enrollee care gaps by ZIP code drilled down to the provider group, physician, or Enrollee level. Our **UM scorecard** compares provider groups against WellCare key performance indicators including admission and readmission rates, MLR, pharmacy costs per Enrollee, generic dispensing rates and prescription PMPM, allowing providers to manage medical costs and address Enrollee care gaps. **Appointment Agendas** show Enrollee behavioral health care gaps and potentially missed diagnoses that providers can reference during patient visits. They offer providers and WellCare a comprehensive view of our Enrollees' health status to confirm they receive the right level of support for their condition. The **P4Q Portal** gives behavioral health providers a snapshot of the behavioral health care gaps tied to performance payments, so they can prioritize based on the measures that will result in the most improved Enrollee health outcomes. Our proprietary **AccuReports** system gives providers who have entered into a

VBP shared savings/shared risk arrangement with quality incentive payments to view data on readmissions, Enrollees incurring high costs, and pharmacy utilization via a secure site. Large practices participating in shared savings arrangements receive and use detailed claims data feeds to understand their performance and improvement opportunities. To ensure our providers have the most accurate and recent information, and to give them a direct line of communication with us Lori Gordon holds a monthly behavioral health provider call for each type of behavioral health provider. This is an opportunity for them to ask questions, learn about new clinical practice guidelines, and more. Additionally, our local WellCare of Kentucky portal expert conducts a weekly provider portal webinar.

iii. Innovations to develop and maintain network adequacy and access.

WellCare of Kentucky knows firsthand the challenges Enrollees face in accessing behavioral health care in the Commonwealth. We have focused on our relationship with CMHCs since the program launched, even when behavioral health benefits were not fully covered by the program. We also have 100% of the acute care hospitals in our network that were onboarded when we entered the Commonwealth as an MCO. Since 2011, we have continuously applied innovative solutions to developing and maintaining our behavioral health network adequacy and access. Bonnell Gustafson Irvin, MPA, Provider Network Director, and Candice Bowen, Senior Director of Network Management, lead WellCare of Kentucky in continuously developing our provider network. They meet with key stakeholders across the Commonwealth, helping us grow our traditional and supportive services network specific to behavioral health, and applying their unique knowledge of Kentucky's regional nuances to developing and maintaining network access through innovative solutions.

BUILDING CAPACITY OF EXISTING PROVIDERS

WellCare of Kentucky works to improve the Enrollee experience by building the capacity of our existing behavioral health provider network. Some examples of these efforts include:

- Telehealth to expand reach and improve access to care
- Value-based purchasing contracting and incentives to promote, track, and reward whole-person care integration activities, such as using PCP-BH integration toolkits, applying preventive measures and behavioral health screenings, facilitating access to care for physical and behavioral health conditions, managing chronic conditions (e.g., HbA1c control, medication adherence), and meeting HEDIS measures.
- Contracts with licensed independent social workers, clinical nurse specialists, and nurse practitioners who practice in remote locations
- Incentives for providers to participate in the adoption and use of health information technology and implementation of technological solutions to share health information through VBP and WellCare technology solutions.

TELEHEALTH

Telehealth services offer the benefit of expanding access to care for all Kentucky Medicaid Enrollees, including those who live in rural and underserved areas, have complex conditions or schedules that can make travel difficult, or simply prefer the convenience or privacy afforded by

telehealth access. Today WellCare has an established telehealth presence in the Commonwealth. **In 2018, we paid claims to providers for over 6,800 telehealth services for over 20 different types of services, including behavioral health.** We have also been active in the telehealth discussion in the Commonwealth, having participated in Kentucky Telehealth Board meetings for several years as well as the Telehealth Task Force resulting from SB 112, and having provided comments to DMS' regarding its telehealth regulation (907 KAR 3:170).

We support the Commonwealth's objective to increase the use of telehealth in conjunction with the passing of Senate Bill 112 that expands telehealth coverage and payment parity for telehealth services, and are fully prepared to work with DMS toward these goals. **WellCare is particularly excited to leverage telehealth capabilities as a component of substance use disorder (SUD) treatment.** A required component and best practice of SUD treatment for those receiving medication assisted treatment (MAT) is that individuals receive psychological counseling in addition to the medication. Many Enrollees who need SUD treatment are employed (part-time or full-time) or are parents who lack funds to pay for childcare. Some lack transportation or face transportation challenges, even with the non-emergency medical transportation benefit. This makes attending regular, in-person counseling sessions extraordinarily challenging. Our Community Connections program fills these gaps through community partnerships to eliminate barriers.

Bridging Access Gaps with Community Connections

Operation UNITE (Unlawful Narcotics Investigations, Treatment, and Education) was launched in 2003 by US Congressman, "Hal" Rogers, in response to a special report, "Prescription for Pain," which exposed the addiction and corruption associated with drug abuse in southern and eastern Kentucky. The organization hosts coalition meetings in its 32-county service region, which local Community Engagement Partners attend on a monthly or quarterly basis. In 2017, WellCare of Kentucky provided a grant for four youth Enrollees to attend their annual Operation UNITE camp. This is a free, weeklong leadership and adventure program for 200 middle school-age youth. Most of these youth are at high risk for drug use, have an immediate family that has been directly impacted by substance abuse, or are financially unable to afford a summer camp experience.

After providing this grant, we had the opportunity to learn more about their newest project, the Kentucky Help Statewide Call Center, through which individuals can speak to a specialist about available treatment services relevant to their needs. The Kentucky Help Statewide Call Center even links all individuals in Kentucky with available beds if needed. When Community Connection staff met with Debbie Trusty, the treatment director, she identified a barrier that some individuals who face in seeking treatment or assistance. She reported that many of the individuals who call are also seeking assistance with additional resources ranging from transportation to access treatment to fear that, as the family breadwinner, they could afford rent while in treatment. Limited access to these resources was keeping some from even taking the first step.

In response, WellCare of Kentucky collaborated with Operation UNITE to assist the Kentucky Help Statewide Call Center with funding to provide financial assistance for non-billable services including, transportation, housing, and childcare. Nancy Hale, CEO of Operation UNITE, wrote "As a community partner, WellCare is committed to implementing harm-reduction strategies aimed to education and enable citizens to mitigate – or, more important, to prevent – the impacts of substance abuse."

WellCare is aware that DMS' is expanded its SUD treatment scope. Included in this initiative was the creation of Behavioral Health Services Organization (BHSO) Tier II providers who provide outpatient SUD treatment including MAT. One component of this initiative is to enable narcotic treatment programs (NTPs) in Kentucky, which historically have used methadone as the MAT medication, to participate in Kentucky's Medicaid program and be paid for MAT. As part of the initiative, DMS will add methadone to the covered MAT medications.

WellCare intends to utilize the telehealth option for Enrollees receiving SUD treatment (particularly from BHSO Tier II providers) to enable them to receive counseling where most convenient for the Enrollee, including their home, job, or elsewhere. WellCare already covers psychotherapy via telehealth. In partnership with DMS' expanded SUD treatment initiative, WellCare plans to promote (to providers and Enrollees) the option to use telehealth for the counseling/psychotherapy component of SUD treatment.

The possible uses of telehealth are evolving. WellCare has a broad base of experience to draw upon in developing and launching telehealth initiatives. Through our national model for telehealth, we have made investments to educate enrollees on telehealth opportunities and

train providers on telehealth access and reimbursement policies. We will leverage that experience and work with DMS' and our network partners to examine opportunities to promote the expansion of telehealth under the new regulations through direct education of our provider and enrollee communities.

By partnering with a contracted telehealth vendor, WellCare augments its national telehealth coverage and leverages a coordinated system to deliver specific use cases like seven-day and 30-day follow-up after hospitalization visits. We also pay for services through multiple telehealth providers to ensure the broadest possible access to this important resource. Having all providers using the same platform enhances the coordination process and affords on-demand access capabilities, particularly for our physical healthcare needs. Providing this enhanced convenient access helps to avoid high cost, unnecessary emergency room and urgent care services.

WellCare also has experience in delivering telehealth services directly through our board-certified physicians. As a means of ensuring necessary consultations or treatment are delivered in a timely manner, some of our markets are using two-way, real-time virtual technology to deliver quality healthcare themselves. This third model serves as a safety net when needed.

WellCare of Kentucky will use the successful WellCare telehealth pilots in Georgia and South Carolina as models, and will provide funding to implement similar programs in Kentucky.

- Through the **Georgia pilot**, WellCare provided funding to implement a telehealth pilot program in collaboration with local organizations to open two school-based health centers. This helped school nurses connect students in rural areas with behavioral health providers through video conference. Launched in 2015, WellCare provided the funding to equip each school with telehealth systems that allow school nurses to connect students and faculty to healthcare providers at Appling HealthCare System via a video conference. This program was able to help children receive much-needed access to care in rural areas of the state, providing approximately 26,000 services (mainly focused on behavioral health) through 2017. We will use this experience to work with Kentucky schools to provide services to a broader range of students.
- The **South Carolina pilot** is the state's first direct-to-consumer telehealth program. It facilitates services to Enrollees at the setting of their choice, including at home. The Department of Health and Human Services stated, "This is the type of leadership from managed care that we are looking for, and WellCare is the first player to propose a collaboration like this." The pilot program focuses on helping Enrollees access outpatient care and MAT by identifying ED high-utilizers and individuals with serious health risks.

With Kentucky's telehealth expansion, we are very excited about employing what we have done in other markets in the Kentucky market as well as continually exploring new options. We fully embrace telehealth as an effective avenue to care for our Enrollees.

Other innovative technological solutions we will leverage in Kentucky include:

- *ID/Stratification:* Our population health solutions team, in collaboration with our medical economics and reporting and analytics teams and local medical directors, manages our proprietary risk stratification algorithm. With our improved CareCentral, our medical and

behavioral health management platform, **we continuously run this algorithm** against Enrollee data (i.e., claims) to enable timely, proactive outreach and care planning for Enrollees with high needs, or those at risk of future high needs. It uses inpatient, ED, and outpatient claims and encounter data, along with pharmacy claims, ICD-10 coding, health risk assessment responses,, readmission data, readmission risk scores, medical costs, medication adherence, SDOH referrals, and Decision Point Predictive Modeling software. Included in our algorithm are rules for co-morbid behavioral health and substance use disorders, co-morbid physical health conditions, co-morbid physical and behavioral health conditions, and other factors that may necessitate a higher level of care coordination/case management.

- *Biometric patient monitoring,* to watch for changes in Enrollee conditions such as diabetes, hypertension, and asthma. We know that in Kentucky, 14% of the Enrollees with SMI also have type 2 Diabetes, 41% have hypertension, and 12% have asthma.
- *JOOL Health Coach:* We are piloting a personal coaching smartphone application that encourages youth to check in with their peers and engage in healthcare services. It is tailored to specific populations and gives Enrollees with an SUD access to a transition-aged youth pathway. JOOL includes SUD assessments, resources, and referral information to help youth and their families learn about their SUD and the local community treatment options available. It provides Enrollees with an additional link to their provider.
- *MyStrength:* This evidence-based digital behavioral health platform provides interactive clinical programs to empower Enrollees to address depression, anxiety, stress, substance use, chronic pain, and more. It also supports physical (e.g., smoking cessation, diabetes) aspects of care, and includes CBT, mindfulness, motivational interviewing, mood trackers, and tools to measure effectiveness and improvement.

MyStrength has shown a 43% rapid symptom reduction within the first two weeks of engagement and a 70% cost reduction in total paid claims for Enrollees.

FUNDING TRANSPORTATION

From 2015-2019, Community Engagement Partners have facilitated 8 Community Impact Councils (CIC) in counties across the Commonwealth to bring community leaders together who have identified transportation as the most urgent social safety net gap within their county. Using WellCare's internal database, Community Connections has also seen transportation as a top referral in Kentucky and which organizations Enrollees were referred to for service. WellCare has collaborated with Bluegrass Community Action Partnership (BGCAP), LKLP Community Action Agency, Pennyrile Allied Community Services (PACS), and Rural Transit Enterprises Coordinated (RTEC) as local transportation providers who attended the CICs held in their communities.

As a result, WellCare has invested through grants to provide free transportation to individuals in 20 counties: Anderson, Boyle, Christian, Caldwell, Crittenden, Franklin, Garrard, Jessamine, Knox, Laurel, Lincoln, Livingston, Lyon, Mercer, Perry, Scott, Todd, Trigg, Whitley, and Woodford counties. Based on the individuals who participated in the locally facilitated Community Impact Councils, the transportation being provided includes non-billable medical

transportation; such as, trips to dental, vision, hearing, pharmacy and behavioral health appointments. It also includes transportation to education and employment opportunities, grocery stores, pharmacies, the local Farmers Market, and WIC appointments.

Enrollees who accessed Rural Transit Enterprises Coordinated (RTEC) and PACS often have a behavioral health diagnosis, as shown in **Table C.23-1**.

Table C.23-1 Transportation Connections by Diagnosis

	Pennyrile Allied Community Services (PACS)	Rural Transit Enterprises Coordinated (RTEC)
Depression	42.80%	61.80%
SMI	18%	12%
Bipolar Disorder	12.40%	21.3%
SUD	16.20%	34.20%
Other Mental Illness	53.40%	73.30%

LETTER OF SUPPORT FROM CHRYSALIS HOUSE

"Chrysalis House has had the opportunity to partner with WellCare of Kentucky on various projects that have improved our ability to provide services to the individuals served by both agencies. Funding for transportation is a consistent area of need for Chrysalis House; with 62 women, many of whom are either pregnant or have their infants living on site with them, some on MAT and most working, getting everyone to various medical appointments and other ancillary service providers can be challenging and expensive. WellCare has provided grants to assist with transportation, helping Chrysalis House meet the needs of the clients and the costs associated with those services. Chysalis House has also had the pleasure of partnering with WellCare in their pilot WellCare Works program designed to assist clients with locating resources for employment. This partnership compliments Chrysalis House's goal of assisting the clients achieve self-sufficiency in order to support themselves and their children. In addition, WellCare has come on-site to host baby showers for our pregnant women much in need of items to care for their infants, again, assisting Chrysalis House meet a critical need.

Chrysalis House feels extremely fortunate to have a partnership with WellCare and look forward to continuing to collaborate to serve the citizens of Kentucky in the future. We fully support WellCare of Kentucky's effort to be selected as a Medicaid Managed Care Organization under this initiative."

– LISA R. MINTON, EXECUTIVE DIRECTOR

INCREASING ACCESS THROUGH PROVIDER INCENTIVES

Another approach we use to maintain and develop access in Kentucky is to incent providers to offer evening and weekend hours. Our Quality **BH P4Q** program also offers rewards to providers for closing the following behavioral health-related care gaps for Medicaid Enrollees: Antidepressant Medication Management, Medication Adherence to Antipsychotics, Follow-Up after behavioral health inpatient hospitalization, cardiovascular monitoring for Enrollees with schizophrenia, diabetes monitoring for Enrollees with schizophrenia and diabetes, diabetes

screening for bipolar/schizophrenia and diabetes, and Metabolic monitoring for children on antipsychotics.

In Kentucky, we are piloting a P4Q program for 2019 with the 14 CMHCs and 5 behavioral health inpatient facilities. 28.8% of our Enrollees in Kentucky have a behavioral health diagnosis. The majority of these individuals are seen in CMHCs. 2019 data indicates 7,039 gaps closed for those seeking services at CMHCs and $281,000 paid out in bonuses. WellCare of Kentucky also uses a **Gold Card Program** to reward behavioral health inpatient facilities based on their performance ensuring access to care. Facilities that meet minimum volume targets, with demonstrated quality performance as measured by their compliance with ambulatory follow up after hospitalization, and demonstrated efficient management of LOS, earn Gold Card designation so that they receive approval for an initial management.

COMMUNITY PARAMEDICINE

Another innovative approach to enhancing the health and well-being of Enrollees and to improving health outcomes is Community Paramedicine. Community Paramedicine extends access to care by expanding the role of Emergency Medical Service (EMS) personnel to fill gaps in primary care availability and mitigate transportation barriers by providing home-based care. Community Paramedicine providers can provide a number of services including assessment services such as taking vital signs, medication compliance and blood pressure readings; prevention services such as immunizations and in-home fall prevention; and primary treatment such as wound care and medication administration, as well as referral to medical and social services. Among other benefits of community paramedicine, it helps alleviate transportation challenges that can have a significant impact on Enrollee access to all types of care. Our sister plan in Hawaii (Ohana) is piloting a community paramedicine program to increase access to basic health care services. WellCare of Kentucky will monitor the success of that pilot and whether it can be applied to further developing behavioral health access in Kentucky. With the recent passing of House Bill 106, WellCare is excited to support the expansion of Community Paramedicine programs that further extend access to care in underserved areas of Kentucky.

COMMUNITY INVESTMENTS TO INCREASE ACCESS

One thing that truly differentiates WellCare of Kentucky is our commitment to and involvement in the local community. We apply this to developing and maintaining access in the Commonwealth through community investments such as scholarships for nurses and doctors who study at the University of Kentucky and return to rural communities in Eastern Kentucky. We also provide, through our best in class Community Connections Model, community SDOH supports for transportation, homelessness, and food insecurity. WellCare of Kentucky is a recognized and successful contributor to community investments in the Commonwealth.

Between August of 2016 and January of 2019, 859 WellCare Enrollees received 14,743 services, or 17 services per person. On average individuals that accessed services, have 3.1 chronic conditions with 43.4% being

"WellCare understands the importance of meeting individuals where they are, and treats their members with a holistic approach."

– MELISSA COWLES, HOTEL INC STREET MEDICINE COORDINATOR

diagnosed with depression and 31% with SUD.

WellCare has been in partnership with **HOTEL INC** since 2013 addressing everyday issues faced by people in Kentucky living with homelessness. Their successful Street Medicine Program, launched in 2014, helps connect individuals who are homeless with medical professionals for preventive and additional care needs. Of the 425 individuals the program helped in its first year, they identified 66 WellCare Enrollees who had been classified as "unable to contact", and connected them with a behavioral health care manager.

FITT-ACUTE CRISIS INTERVENTION AND DIVERSION PROGRAM

WellCare of Kentucky is committed to developing mobile and in-home services for our Enrollees. To improve access to true mobile crisis treatment, we recently contracted with Lifecare to provide the FITT Program of virtual residential treatment for youth living with caregivers in a community setting. This program has been active in Tennessee for several years and has demonstrated outcomes that WellCare wanted to bring to the Commonwealth. This is an intensive in-home program collaborating with families to resolve crises, avoid out-of-home placement and provide skills for future crisis prevention. It also serves as a step down from inpatient or PRTF; and an alternative for youth at risk of hospitalization and PRTF. Just a few examples of what the FITT Program provides include:

- 24/7 in home mobile crisis services
- Door and window alarms
- Prescription lockboxes
- Respite for parents
- Access to a same-day prescriber
- 24 hour professional supervision in the child's home to monitor safety

iv. Process for follow-up after hospitalization for Behavioral Health Services within the required timeframes.

In Kentucky, we have prioritized follow-up after hospitalization for behavioral health services. We assign a care manager to each known Enrollee admission to a psychiatric bed to ensure they transition to post-discharge services. The care manager will leverage the complete member history and develop a discharge plan that considers risk stratification and available data to align the plan to that member's specific needs at that time. We know how important discharge transitions are and how challenging it is to significantly impact rate of follow-up for Enrollees. Our efforts to affect outcomes over time have made incremental improvements, and we continue to try various approaches to continue this upward trend. In spite of the challenges inherent in moving the needle on follow-up after hospitalization HEDIS measures, **we have achieved and maintained a ranking in Kentucky that is 2nd in the state out of five MCOs.**

In 2015, we implemented a performance improvement project (PIP) on this topic to improve follow-up through increased communication. We first identified facilities that had a combination of 10 or more mental health admissions with a readmission rate of 8% or higher. We then conducted targeted provider outreach, including mailing quarterly letters to hospital administrators documenting their facility's rate for the HEDIS® Specification for Follow-up after

Hospitalization for Mental Illness within seven days. Additionally, each hospital received reports comparing their facility's current rate with NCQA percentiles. A list of non-compliant Enrollees for the seven-day follow-up measure was included in each monthly mailing. In addition, the Behavioral Health Team for all high volume inpatient facilities conducted medical record audits. Interventions targeted to Enrollees included identification of those with discharges from a hospitalization for mental illness so the Behavioral Health Case Management team could conduct targeted outreach within one day of their discharge with ongoing analysis of barriers to discharge planning and access to care. Additional steps were taken including the development and distribution of a Clinical Practice Guideline (CPG) addressing discharge planning and care coordination at transitions and the implementation of process improvements for quicker notification to care managers of discharges from a hospitalization for mental illness. **The two hospitals with the highest overall improvement were The Ridge and NorthKey, increasing from below 25th to the 75th percentile.** Simultaneously, WellCare added the follow up after hospitalization measure to the Gold Card program, allowing facilities with higher rates to be relieved from the prior authorization process. currently, WellCare has 11 hospitals serving behavioral health Enrollees meeting Gold card standards of 50th percentile or greater for the FUH measure.

Our approach is to begin discharge planning for each Enrollee at admission, taking a special interest in behavioral health Enrollees as we look for new solutions to this key aspect of overall care. Through concurrent review, we maintain oversight and evaluation of Enrollees admitted to hospitals, psychiatric facilities, and rehabilitation centers. We begin the concurrent review process upon notification of an admission. This approach enables us to evaluate the admission, monitor the inpatient stay, provide comprehensive and timely discharge planning, and transition coordination to care coordinators for post-discharge care. Using CareCentral, our concurrent review nurses to complete a comprehensive review of the Enrollee's history, needs, and circumstances, which informs our concurrent review, discharge planning, and post-discharge activities. The care manager develops a discharge planning care plan that specifies the Enrollee's goals, problems, and interventions to help with successfully transitioning from the inpatient setting to home or an alternate lower level of care. The discharge planning care plan addresses any service needs, including medication reconciliation, medication adherence, appropriate outpatient care (e.g. therapy, physician visit, outpatient programs); and identifies housing and other SDOH factors. It also ensures the Enrollee has and includes a link to PCP and specific specialists to ensure seven-day follow-up. We have the second highest rating in the Commonwealth on the Mental and Behavioral Health measure of Follow up after hospitalization for mental illness.

In our Hawai'i market, we are launching an innovative program for the seven-day follow-up after hospitalization HEDIS measure. We are collaborating with a local medical center to ensure our Enrollees receive timely, virtual behavioral health care once they have been discharged from a behavioral health hospital stay. Prior to discharge, our WellCare ('Ohana Health Plan) community health worker meets with the Enrollee to provide education about the importance of follow-up care and how telehealth can offer convenient, quality care. During that visit, they schedule an appointment with a telehealth provider for a date post-discharge. The Enrollee receives an appointment reminder from both the telehealth platform and the community

health worker to increase the likelihood of their attending. At the end of the appointment, an appointment for the 30-day follow up may also be scheduled. Once the seven-day follow up appointment has occurred, our 'Ohana Health Plan rewards the Enrollee with a gift card. This is a new initiative launching as we write this proposal, so there are not yet outcomes to report. We will monitor those results and implement a similar initiative in Kentucky if it is successful in Hawaii.

Our Community Connections program, which we developed to support the integrated delivery of services in the Commonwealth in 2011, addresses Enrollees' SDOH needs. It includes a Community Connections Help Line (CCHL) staffed with peer coaches who provide information about community social service organizations, guide, and encourage individuals to access community resources, including transportation to help Enrollees attend follow-up appointments. In Kentucky, CCHL has referred 6,466 Enrollees to 18,955 services. These efforts are specifically designed to support improvements in follow up care post discharge.

Our most recent effort includes seven-day follow-up as a measure defined for VBC and P4Q arrangements for hospitals and behavioral health providers. We are also **piloting a Follow-up after Hospitalization FUH program** that leverages behavioral health care coordinators to ensure Enrollee compliance with their follow-up appointments. As part of the program, and in alignment with the requirements in Section 33.8 of the Draft Contract, behavioral health discharge coordinators help Enrollees access an outpatient follow-up appointment within seven days of discharge if the provider does not schedule one. They also provide telephonic appointment reminders and contact Enrollees who miss an appointment within 24 hours to reschedule.

In January 2019, we implemented a **new program that rewards CMHCs for** each **Enrollee who kept their seven-day post-discharge visit.** Based on 2019 data, a total of 1,347 follow-up after hospitalization (FUH) appointments were kept at CMHCs. Of the five facilities, 602 FUH appointments were kept. This resulted in $53,880 for the CMHCs and $24,080 for the facilities. We have also offered the same incentive to five psychiatric hospitals. Along with the financial incentive, we have provided a care coordinator assigned to each of the facilities to assist with discharge planning.

v. Process for ensuring continuity of care upon discharge from a Psychiatric Hospital.

In accordance with Section 33.10 of the Draft Contract, WellCare of Kentucky coordinates with providers of Behavioral Health Services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and Discharge Planning, treatment objectives and projected length of stay for Enrollees committed by a court of law and/or voluntarily admitted to the state psychiatric hospital. We ensure continuity of care for successful transition back into community-based supports.

WellCare actively participates in coordination of care meetings with Central State Hospital, Western State Hospital, Eastern State Hospital, and Appalachian Regional Hospital. When we receive notification prior to Enrollee discharge we work collaboratively with the hospital to ensure the Enrollee is connected to a case manager to provide basic, targeted, or intensive case management services. During the first quarter of 2019, WellCare successfully engaged 84

Enrollees discharging from a state hospital into our care management program. The challenge to continuity of care is that many discharges take place without communication. During the first quarter, we were not notified of 53% of the discharges. We are excited by DMS' renewed interest in the Kentucky Health Information Exchange (KHIE).We believe the opportunity to leverage the KHIE data repository with these three hospitals to connect Enrollees to care management prior to discharge is an important and positive step in reaching them upon release.

Emily's Successful Transition from Inpatient Psychiatric Care

In January 2017, Emily, a 23-year-old Enrollee in Louisville was enrolled in OB case management after being referred by Jim, a Behavioral Health Advocate in guardianship case management. Emily has a history of substance abuse, prostitution and possible human trafficking, mental illness with a probable diagnosis of borderline personality disorder and pregnancy at approximately 16 weeks gestation. She has also been under State Guardianship for most of her life and remains with a state-appointed adult guardian.

She was first admitted to University of Louisville Inpatient Psychiatric Unit for treatment. Jim, David, the unit staff and Sara, the field case manager worked together to secure Emily a place at Freedom House in Louisville upon discharge, but Emily refused to receive care there and left. This began a transient period for Emily during which communication was sparse, housing was insecure, and most appointments for outpatient therapy and OB care were missed. Jim, David, and Sara continued to work together to maintain contact with Emily throughout. Ultimately, due to concern that Emily was not receiving prenatal care and was engaging in a dangerous lifestyle, state guardianship determined that she would not receive checks without complying with regular prenatal care.

Sara scheduled an appointment with University of Louisville Outpatient OBGYN along with transportation through Bluegrass.org. She and David agreed to accompany Emily to this appointment. During the appointment, Emily reported recent drug use and that her current boyfriend and possibly the baby's father, gave her drugs and made her have sex with people to get money for himself. She also reported that he was physically and mentally abusive. In response, Sara and David contacted law enforcement.

Following this appointment, Emily continued to refuse assistance from anyone. A week later, state guardianship obtained a court order to admit Emily to Good Samaritan Inpatient Behavioral Health Unit, planning to keep her admitted at least until the baby's delivery and Emily's recovery from the immediate postpartum period. Sara visited her there and was impressed with the care she is receiving. She is taking her prescribed medications and the staff helps her work through any outbursts she has or negative news she receives. She has also been through detox, which has helped her to understand that she was in a bad environment complicated by drug use.

Contact between the team and Emily has been consistent since then, and she is agreeable to working with her treatment team, which includes unit staff, Jim, David and Sara, as well as Lisa, WellCare's transitional care coordination nurse, and Mike, the OB care management manager. This team meets every other week to discuss Emily's progress and a safe discharge plan for her and the baby. Emily recently delivered a healthy baby boy and has been discharged from obstetric care. She is currently in an inpatient behavioral unit awaiting discharge to Chrysalis House for further follow-up and treatment. This will allow her to continue to receive behavioral health treatment and a safe place to transition to and develop a plan for long-term care. The baby has been placed in foster care by Child Protective Services, as Emily has been deemed unable to care for him at this time.

WellCare of Kentucky has continuously worked to ensure Emily is safe and progressing toward a more positive lifestyle. Sara calls Emily every weekday and Lisa visits her at least weekly. While Emily has been admitted, Barb, the unit social worker, Karen, the unit doctor, and Sara have had detailed discussions about what OB care and education Emily needs. Mike has arranged for an OB educator to come to the unit and do one-on-one education with Emily when she began to question the labor and delivery process. Jim has kept the whole team informed about guardianship issues. The WellCare team, along with the University of Kentucky staff, has arranged for Emily to have a safe, supportive place to transition in Chrysalis House and their program.

MODEL TO ENSURE CONTINUITY AFTER PSYCHIATRIC DISCHARGES

WellCare of Kentucky ensures all Enrollees continuity of care upon discharge from a psychiatric hospital. Built on evidence-based care and best practices, our discharge planning process uses the Coleman model to address the myriad of changes Enrollees face during discharge, including changes in their physical environment, health status, care regimens, and relationships with providers. The transition of care program is fully integrated for Enrollees receiving care coordination. WellCare of Kentucky policies and procedures, proven management techniques, and targeted initiatives support integrated care delivery. Applied to our population, the discharge planning process we employ ensures seamless, continuous, and appropriate care and services through coordination of care, services, and benefits that enable safe transitions.

Discharge Planning. WellCare of Kentucky utilization care managers begin discharge planning upon admission. When we receive notification from a hospital representative indicating Enrollee admission to or pending discharge from a psychiatric hospital, we send notification to a behavioral health field outreach coordinator to ensure they receive necessary case management services at time of discharge and as they return to the community. We hold regular case conferences to maintain communication and ensure a plan is in place for the Enrollee's transition to outpatient care. The local WellCare of Kentucky care coordinator and other BH providers participate in discharge planning meetings to ensure the Enrollee receives needed supports in the least restrictive environment to meet their whole person needs, including psychosocial rehabilitation and health promotion. WellCare also participates in the quarterly continuity of care meeting among state hospital representatives, CMHCs, and state representatives to discuss Enrollees that have been discharged from each of the four state facilities.

Our local behavioral health care coordinators participate in transition planning and continued care coordination for Enrollees with SMI who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing. Working from the monthly list that DBHDID provides, behavioral health care coordinators perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community-based housing within 14 days of the transition.

Along with Guardianship Case Management, Behavioral Health Case Management attends monthly Regional Transition Meetings, coordinated by the DBHDID and held at the state hospitals. These meetings focus on reviewing the list of identified individuals, current treatment issues, barriers to receiving treatment services, and transition plans to move these individuals to community-based housing.

Once referred, a care coordinator is be assigned. He or she reaches out to CMHC lead staff and the Enrollee. The care coordinator continues to reach out the CMHC lead staff weekly, or as needed, via email to request updates on Enrollee status. He or she also requests copies of the Enrollee's person centered recovery plan, developed by the CMHC provider, who also provides the anticipated date of transition. Within 14 days after the Enrollee's move/transition from the facility into community based housing, the care coordinator meets with the Enrollee to complete the comprehensive physical and behavioral health assessment. Additional phone calls

and emails are directed to CMHC lead staff to ensure adequate communication is occurring regarding Enrollee needs.

The care coordinator assesses whether the Enrollee needs behavioral health case management services by completing the Health Risk Assessment and the Standard Case Management Assessment (SCM) or Initial Case Management Assessment for adult guardianship individuals. If the Enrollee requires behavioral health case management, the care coordinator completes the following:

- Community Mental Health referral
- PHQ9 and CAGE assessment, along with the SF 12
- Care plan development with the Enrollee and CMHC lead staff, focusing on incorporating the Enrollee's personal recovery plan. The care plan indicates the problem and the goal(s) and objectives of case management for the Enrollee

HARD TO REACH ENROLLEES

Kentucky-based **member outreach coordinators**, who use our Unable to Contact (UTC) program, REACH, to locate Enrollees for whom we have incorrect or missing contact information. The REACH program aims to enroll high utilizers who have either refused to engage in care management or are unable to contact in the case management program. The Member Outreach Coordinator conducts outreach to Enrollees who are identified as the most vulnerable population, as well as providers, and community organizations to support Utilization Management and Case Management. MOCs visit a minimum of 13 PCP offices per month and visit a minimum of seven Enrollees while inpatient. They establish alternative means to engaging Enrollees in care management by meeting with PCPs to flag Enrollee charts, hospital visits (both UM and ED visits), etc.

BEHAVIORAL HEALTH CARE MANAGEMENT FOR ENROLLEES DISCHARGING FROM STATE HOSPITALS

Supported by CMHCs and Kentucky's state hospitals, WellCare of Kentucky's SMI+5 Program is directed at ensuring Enrollees with complex behavioral health care needs and co-occurring chronic medical conditions receive appropriate care and coordination of needed services. It provides behavioral health care management for Enrollees who have severe mental illness. Specific program features include:

- Coordination of seven day follow-up after hospitalization for behavioral health services
- Coordination with providers of behavioral health services, and Commonwealth-operated or Commonwealth-contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives.
- Participate in transition planning and continued care coordination for Enrollees with SMI who are transitioning from Personal Care Homes, psychiatric hospitals or other institutional settings to integrated, community-based housing.

Through SMI+5, behavioral health care managers ensure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services for Enrollees. We identify Enrollees for

the program through the health risk assessment, evaluation of claims data, or physician referral.

The mission of the SMI program is to engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Enrollees with SMI and SED, including Enrollees with co-occurring developmental disabilities and substance use disorders.

Through this program, we have seen a 66% decrease in inpatient expenses and a 10% decrease in ED visits for participating enrollees, while at the same time, visits to PCPs increased as well as pharmacy utilization demonstrating that individuals are starting to seek appropriate care.

Successful Behavioral Health Case Management

Johnny is 58-Year-old black male who has, schizophrenia, seizure disorder, Hepatitis B and C and had not taken any medication for a significant period. He had nine emergency room visits within six months. During the last visit, paramedics took him to the emergency room after he was found on the side of the road laying in a ditch following a seizure. The hospital believed him to be homeless. Member was triggered by ER Over usage, and when trying to contact member, found emergency number for a brother that lived in Texas. His brother was also unable to locate him and was very worried for his safety. Katie, LCSW care manager, called Eastern State and found out that member had been taken to the Hope Center. Member brother flew in from Texas to find member and try to get him help. Member and his brother met with Katie and her colleague Patty, RN. During assessment, member was found that he had not seen his PCP or Neurologist in almost a year and had many bottles of medications, but could not tell what he really was supposed to be taking. Member's schizophrenia and psychosis was very apparent during visit. The comprehensive needs assessment was done with the help of Brother and medical records from prior hospitalization that Johnny had in his backpack. The assessment revealed that Johnny lives alone in his mother's house, does not have a phone, gets food stamps, walks were he needs to go, has been banned from local pharmacies, doctor office, using local transportation and business due to his mental illness and unable to control his anger at times. Member has no local support. Member has never attended appointments at the CMHC.

WellCare care managers were able to set up the following:

- PCP appointment with Dr. Allen
- Neurologist Appointment with Dr. Owens
- CMHC program with ACT Team doing home visits
- Free Cell Phone with Assurance filled out
- Enrolled in transportation in Scott County
- KY Vision project application filled out
- Educated member on local food banks
- Educated on KY Quit Smoking Program
- Referral and visit to Shady Lane Residential Center

Weekly care management visits were made with member to address barriers of the care plan. Over time, Johnny started trusting Katie and Patty. He started taking his seizure medications and keeping a daily log for Patty to check weekly. He would occasionally miss a dose, but overall he was taking his seizure medications more regularly and having less ER visits for seizures. Johnny started working with the ACT team. Six months into the program, Johnny had a psychiatric relapse and was admitted to Eastern State Hospital where medications were evaluated and stabilized.

Upon discharge from Eastern State, ACT meet with member twice weekly and WellCare care managers met with him weekly. For one-year post discharge from Eastern State, Johnny had not had any emergency room visits in several months, had adhered to medications, had consistent ACT team participation, had maintained PCP, Dental and Vision appointments, and had maintained telephone contact with his brother.

b. Describe the Contractor's approach to meeting the Department's requirements for operating seven (7) days a week, twenty-four (24) hours a day emergency and crisis hotline as defined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

WellCare of Kentucky has maintained a 24/7 behavioral health hotline since 2011 and has consistently met contract standards. **In 2018, the hotline answered more than 900 calls with an average speed-of-answer of fewer than seven seconds. Zero calls were placed on hold and 19 calls were warm transferred to emergency/suicide support services.** In addition to the hotline services, we consistently offer provider and Enrollee support to improve access to crisis and emergency services.

Hotline Hours. A live person answers the WellCare of Kentucky Behavioral Health toll-free crisis services hotline 24 hours per day, seven days per week, year round, throughout the Commonwealth. Enrollees will never receive a busy signal or be placed on hold. The hotline is supported by our fully integrated call centers. Applying a person-centered approach to service, our hotline associates provide crisis triaging to assess Enrollees'' behavioral and physical health, pharmacy requirements and social determinants of health needs, including need for crisis services. Our high level of overall responsiveness rests on our "no-wrong door" point of entry for phone calls, regardless if a call comes from an Enrollee, provider, or caregiver.

Hotline Staffing. Our dedicated behavioral health crisis services hotline staff are licensed behavioral health professionals who hold undergraduate and graduate degrees in social work or a related field, and include Licensed Mental Health Counselors, social workers, as well as registered nurses and IDD professionals with advanced behavioral health training. They intervene, de-escalate and support Enrollees in emergent situations and are available every shift across our integrated call center with additional coverage on our behavioral health crisis line 24-hours a day, seven-days a week, 365-days a year. The Behavioral Health Crisis Line is never answered by automated means.

In addition to our dedicated behavioral health crisis services hotline team, each member of our more than 3,750 Enrollee Services staff is trained to respond to the unique physical, behavioral, pharmaceutical, and social determinants of health needs of our Enrollees, including assessing the need for a crisis response, in the event an Enrollee calls Enrollee Services.

Call Routing Process. When an Enrollee Services Representative (ESR) receives a call on our Enrollee service or designated crisis line, or determines that a caller is in crisis, they never place the caller on hold or transfer them. ESRs follow specific crisis call procedures for all callers in crisis. Behavioral health clinicians make an immediate determination of an Enrollee's acuity level and document as either routine, urgent, emergent or life threatening and follow related protocols until the crisis is resolved. This includes activating emergency services or local mobile crisis providers when available, or helping the Enrollee de-escalate and connect to their Provider, depending on need.

When a call to Enrollee Services is determined to be a crisis, the call representative activates the red crisis button in CAREConnects, our call management platform, which generates emergency/crisis guidance scripts and triggers a licensed behavioral health clinician to immediately join the call. There is no call transfer; instead, a licensed behavioral health clinician

is patched into the call with the Enrollee. The non-clinical staff associate remains on the line and works with the clinician until the immediate situation is safely resolved. Enrollees assessed with emergent needs receive a follow-up call from our service management team within 24 hours after the episode has been addressed.

We train staff to listen for triggering phrases and situations. These include callers directly expressing urges to harm themselves or someone else; suicide attempts; speech that is slurred, tangential or not making sense; Enrollees who are emotionally distressed and cannot be calmed down; and Enrollees unable to be assisted due to disposition. WellCare's word recognition program, Interaction Analyzer, automatically flags calls based on specific keywords that have been identified as high risk. For example, when a Enrollee mentions words or phrases such as "I'm going to kill myself," "I'm having difficulty," "Emergency," or "Having a hard time," the system directs the WellCare staff to immediately escalate the call to a supervisor and the behavioral health crisis services hotline staff for prompt intervention and resolution. Our lexicon includes more than 100 key words and continues to be refined and expanded.

For all other, non-crisis behavioral health calls, our fully integrated call center staff is trained and equipped to address all calls regardless of behavioral, physical, pharmacy, or other need, as depicted in **Figure C.23-1**. This integrated approach promotes a streamlined experience for Enrollees and caregivers.

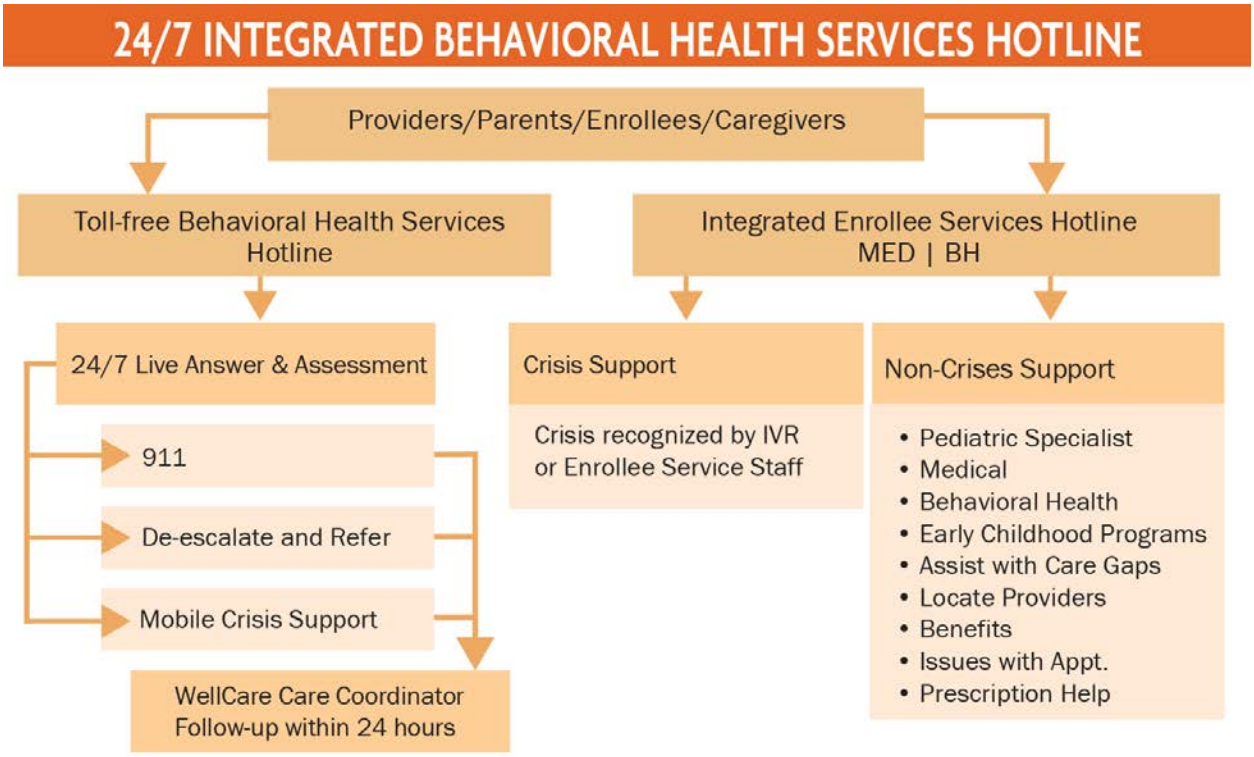


Figure 23-1. Behavioral Health Services Hotline

Hotline Training Curriculum. Through WellCare University, our training and education hub, our Enrollee Services staff train for 160 hours in a blended training environment. Training modules are delivered by Instructor-led Training, E-Learning, and supervised experiential training. We

provide scenario-based training curriculum for all non-clinical behavioral health services hotline staff members, which includes a focus on identifying trigger words and crisis situations, and requires that each staff associate pass an exam before transitioning to live support. The program includes self-led training curriculum and a designated "nesting period" where staff receive one-on-one crisis call coaching by a qualified supervisor. Our behavioral health clinicians also receive training in accessing emergency crisis services and in the treatment and management of behavioral health conditions, including specific behaviors related to Enrollees with IDD.

Enrollee Satisfaction. We administer automated surveys for callers who access support through our integrated Enrollee Services Call Center, as clinically appropriate. Enrollees who receive a behavioral health clinical response for emergent crisis are contacted within 24 hours by a clinical staff and do not receive automated surveys. This direct connection after a crisis is critical to help Enrollees get the follow-up care they need to avoid the next crisis. Our Medicaid **Enrollee post-call satisfaction rate was 94.9%, which exceeded our goal of 90% satisfaction**.

c. Describe the Contractor's approach to coordination and collaboration between the Contractor, Behavioral Health Providers and the PCP as defined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

Since our program inception in 2011, WellCare of Kentucky has recognized the prevalence of behavioral health issues in the Commonwealth, and the importance of coordination and collaboration in addressing them through a comprehensive set of behavioral health services integrated into the broader continuum care. We have provided truly integrated care from the outset, and we remain one of the only Medicaid plans to offer in-house integration. Through experience, we know that it is essential that providers see the whole person and approach their care in a manner that encompasses their behavioral health needs as vital component of their care plan. WellCare encourages PCPs and physical health specialists to screen for behavioral health conditions by including information about SBIRT during visits from provider relations and Quality Practice Advisors. Additionally, we ensure that physical health clinicians have the tools to feel comfortable with mental health services available for members. This includes incentivizing providers to have staff trained in Mental Health First Aid (MHFA).

There are challenges inherent to coordinating care for individuals with behavioral health conditions, including a higher incidence of unmet medical needs and addiction to tobacco, alcohol, opioids, and other substances, an increased likelihood of being homeless or housing insecure, and more difficulty stabilizing upon transition from inpatient to outpatient care. WellCare of Kentucky provides a behavioral health program that meets these challenges through integration, coordinated partnerships, and collaboration with a comprehensive network of medical, behavioral health, and community service partners. Our behavioral health care managers play a critical role, securing Enrollees to a coordinated care plan for receiving behavioral health, medical, pharmacy, and social services.

We work to identify and develop community alternatives for Enrollees currently receiving inpatient psychiatric facility services who could be discharged if a community alternative were available. Our approach to doing so involves collaborative meetings with CMHCs and provider

summits that bring behavioral health providers and PCPs together. In addition, we offer targeted education for PCPs and behavioral health providers and host coordinated care team meetings to ensure everyone with an interest in the Enrollee's wellbeing remains fully informed and engaged in locating a suitable alternative to inpatient psychiatric care.

- *Collaborative Meetings:* Each year, WellCare hosts four regional provider summits across the Commonwealth. **In 2019, nearly 500 providers attended these summits.** Agendas include general presentations from leadership, presentations from key departments that impact all providers, and breakout sessions about plan highlights such as our work with Community Connections claims adjustments, behavioral health, and quality improvement. We also hold regular medical-behavioral health integration meetings with network providers around the Commonwealth, to continue building our holistic, person-centered model of care. These meetings include executive management, medical directors, network leadership, and behavioral health management.
  Provider summits and CMHC meetings bring entities together, facilitating communication and fostering an environment that develops the necessary relationships for coordinating the best placement for Enrollees with the most complex conditions. **Currently, four CMHCs have signed contracts to include PCPs in their practices*:*** Adanta, Centerstone, Kentucky River, and River Valley. This is in part due to these collaborative meetings.
- *Targeted Education:* Informing PCPs and behavioral health providers is critical to coordination. Our efforts to do so include our Provider Newsletter, Provider Portal, and the Provider Handbook, which requires that behavioral health providers communicate and coordinate care with the Enrollee's PCP at initiation of services and at least every 90 days thereafter. In addition, WellCare of Kentucky conducts comprehensive **provider audit trainings**, during which we emphasize to providers how essential PCP-behavioral health collaboration it is for meeting patients' needs and preferences in the delivery of safe and effective high quality, high-value health care. Following an audit there is a feedback, training, and corrective action processes, which have demonstrated improvement in provider process. **From 2017 to 2018, there was a 34% increase in obtaining consent to communicate with PCPs across inpatient, outpatient, and targeted case management chart reviews. For the same period, there was a 9% increase in provider's having documented communication with the PCP in charts reviewed.**
- *Care Team Meetings:* We host the multi-disciplinary team for coordinated case review meetings, inviting the PCP, behavioral health provider, family, and social workers to participate. Every case is addressed from a multi-disciplinary approach and care teams work together to identify and address comorbid conditions. Every care plan is sent (with Enrollee permission) to both their behavioral health provider and their PCP. The care plan is updated as the Enrollee's health status changes. Our scores for 2018 indicate that this integrated approach is working in Kentucky, including a score of **4.0 for Schizophrenia: Diabetes screening for schizophrenia or bipolar disorder. In calendar year 2018 we also improved on psychosocial counseling before prescribing ADD medication from 3.0 to 4.0.**
- *Local Care Coordinators:* WellCare of Kentucky care coordinators live and work in their communities and are steeped in the local culture and well informed about the provider landscape and the numerous resources available to the Enrollee through their benefit

package, value-added services (VAS), or non-benefitted services and supports through Community Connections. Care coordinators are aware of the nuances of matching an Enrollee to the appropriate resource or treatment as many shelters or treatment centers are tied to diagnoses or the Enrollee's special circumstances. For example, pregnant women who have an SUD diagnosis may be best served in an outpatient facility offering supportive housing, such as HOPE House, Karen's Place, Serenity House, Chrysalis House, or VOA in Manchester.

In accordance with Section 33.7 of the Draft Contract, we:

- Ensure, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
- Provide training to PCPs on how to screeen for and identify BH disorders.
- Have a referral process for behavioral health services and clinical coordination requirements including training on coordination and quality of care (including BH screening techniques for PCPs and new models of BH interventions).
- Clinical coordination between BH providers and PCPs.
- Requiring BH providers to send initial and quarterly (if clinically indicated) summary reports of an Enrollee's BH status to the PCP, with the Enrollee or Enrollee's legal guardian's consent. We specify this in our provider manuals.

WellCare believes sincerely that a truly integrated medical-behavioral-social model for delivering and managing care is far superior to fragmented care. This is why we don’t subcontract BH, we do have a single CareCentral clinical system that includes real-time medical-behavioral-SDOH-pharmacy information and we do have a statewide presence with six regional offices and dispersed staff across the Commonwealth.

24. Population Health Management (PHM) Program

C.24. POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

a. Provide a comprehensive description of the Contractor's proposed Population Health Management (PHM) Program, including the following at a minimum:

i. Innovations and program elements the Contractor proposes to incorporate into this Program to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their healthcare.

ii. The Contractor's understanding of the National Committee for Quality Assurance (NCQA) PHM Model, and components of the Model the Contractor will incorporate into its PHM Program. If the Contractor, holds NCQA PHM Accreditation, describe the Contractor's implementation of related models, lessons learned, challenges and successes.

iii. Plan to ensure high levels of Enrollee participation across all priority populations and conditions, including innovative methods for contacting and engaging Enrollees to initiate completion of Health Risk Assessments and Enrollee Needs Assessments.

iv. The Contractor's approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level:

a. Tools the Contractor will use to identify Enrollees and their risk levels and to support services provided.

b. Risk stratification methodology and descriptions of the types of data that will be used.

c. Methods to identify Enrollees for each of Kentucky's priority conditions or populations.

d. Services and information available within each risk level.

e. Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.

f. Stakeholder engagement strategies, including involvement of community resources to meet social needs.

g. Technology and other methods for information exchange, as applicable.

h. Frequency of provision of services.

i. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).

j. Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of care managers.

k. If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.

l. Methods for evaluating success of services provided.

m. Methods for communicating and coordinating with an Enrollee's primary care provider or other authorized providers about care plans and service needs.

n. Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor's PHM Program as a resource.

v. Provide the Contractor's proposed approach to coordination with other authorized providers such as the WIC program and others.

vi. Describe the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues.

C.24. POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 34.0 Population Health Management Program of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

a. Provide a comprehensive description of the Contractor's proposed Population Health Management (PHM) Program, including the following at a minimum:

Every day, in every corner of the Commonwealth, WellCare of Kentucky staff work with our Enrollees, providers, and community partners to improve health outcomes for the most vulnerable populations while empowering Enrollees to engage in their health care to improve their own health. Our dedication to population health and improving Enrollees' lives and health outcomes has been key to making us the plan of choice for both Enrollees and providers, and the leading managed care organization (MCO) for quality in Kentucky.

Under the leadership of Medical Director, Howard Shaps, MD, MBA, Vice President of Health Services, Terri Flanigan, and Population Health Management Director, Shannon Maggard, and in partnership with our fully integrated leadership team of quality, network and operations executives, our Population Health Management (PHM) program is the centerpiece of our health plan. Many of WellCare of Kentucky's core PHM programs have been leveraged by our affiliate WellCare health plans to evolve WellCare's PHM programs across the country.

Outcomes Matter

Our PHM Program has proven successful. From 2016-2018 our Enrollees participating in our PHM Program (all levels) experienced:

- **13%** reduction in Inpatient readmissions
- **24%** reduction in Hospital Admissions
- **17%** reduction in ER Utilization
- **20%** increase in Specialists Visits

Kentucky faces population health challenges that are varied and deeply entrenched in its culture and environment. Through our early engagement efforts with stakeholders, we recognized early on that these challenges require unique solutions. The prevalence of chronic conditions exacerbated by lifestyle, cultural, and environmental conditions (e.g., smoking, environmental cancers, obesity, and teen pregnancy) prompted us to consider innovative approaches to best serve our Kentucky Enrollees. We spent time learning about the unique obstacles so many individuals face in Kentucky, including entrenched poverty, co-morbid behavioral health and substance use conditions, isolation, lack of education, transportation barriers, food deserts, and food insecurity, all of which ultimately have an impact on overall health. In addition to these challenges, it was clear that providers, our most crucial allies in addressing these challenges, were skeptical of managed care. We knew that we would need to

develop trust with both Enrollees and our provider partners on the front lines of these challenges daily.

Farmacy: A Prescription for Good Nutrition

In 2015, WellCare of Kentucky was a founding partner of Farmacy, an innovative voucher-based nutrition program run by Mountain Comprehensive Health Corporation (MCHC), a Federally Qualified Health Center. Farmacy provides eligible MCHC patients (Pregnant, Type 2 diabetes, obesity, hypertension, at or below federal poverty guidelines) in Letcher County "prescription" vouchers for locally grown fresh fruits and vegetables. Showing positive health trends for weight loss, BMI reduction, and glucose levels after the first market season, WellCare of Kentucky provided further funding for 2016, enabling the program to reach even more individuals. The University of Kentucky Department of Dietetics and Human Nutrition facilitated a survey showing 95.6% of participants ate more fruits and vegetables because of Farmacy and 94.1% were motivated by the program to eat a healthier diet. The Farmer's Markets sales increased by $135,861 when comparing markets held prior to the Farmacy program with the sales of the 2015 and 2016 markets, making a much needed positive economic impact on the local community, which has been hit hard with job loss related to the coal mining industry. In 2017, WellCare provided further funding to expand the Farmacy program to Owsley and Harlan counties in Eastern Kentucky and further west into Warren County where Fairview Clinic, another Federally Qualified Health Center partnered to provide the program for their patients.

Community Farm Alliance has written, "To say the least, WellCare has been a creative, out-of-the-box partner with Community Farm Alliance in addressing nutrition-related health issues."

WellCare of Kentucky understands that regardless of the challenges they face, the people of Kentucky are fiercely loyal to their communities and to one another, and want what is best for their families and neighbors. As a first step toward integrating into the community, we built trust by listening and learning, being present, taking on some of the most challenging cases, and being flexible. We are now a trusted MCO partner in every region of the Commonwealth. To meet the varied population health challenges discussed above, and leverage the strengths of communities across Kentucky, we launched our PHM program with a few key components, which were unique among health plans at the time and are described in more detail in our response to innovations and program elements later in this response. We wanted to be local, integrated, and holistic in our approach; knowing that the only way to succeed is to employ highly skilled and local individuals who worked and lived in the communities we serve. This is what initially prompted us to offer in-person Complex Care Management in Kentucky – a model that WellCare now offers to affiliate health plans in other states.

Person Centered

Additionally, because we are so familiar with the behavioral health landscape in Kentucky, and so committed to an integrated approach, we launched and maintain a fully integrated behavioral and physical health plan. WellCare of Kentucky is the only MCO with a presence in every region of the Commonwealth, including field-

based clinical, provider, quality, and community engagement staff who all support the PHM program through direct engagement with Enrollees, providers, and community stakeholders. We were also the first MCO to introduce a social determinants of health program that supports the larger PHM program by connecting Enrollees to social services that address non-medical drivers of poor health outcomes and by supporting individual communities to build sustainable and expandable programs.

Spreading Innovation with Hotel Inc

The Community Connections program supports organizations who provide services to individuals experiencing homelessness and has funded Kentucky based street medicine programs with organizations like HOTEL INC and Welcome House. WellCare has invested in the growth of HOTEL INC's programming since beginning a partnership in 2013. HOTEL INC provides a food pantry, financial assistance, Transitional Housing, Street Medicine Program, and Respite House. In efforts to end homelessness rather than maintain it, HOTEL INC seeks to serve people who are experiencing homelessness efficiently and effectively. They currently provide program infrastructure that are best practices in the US.

Additionally, the formal adoption of coordinated entry for those applying for housing services has created an organized and effective flow that directs clients from program intake to program exit with aftercare case management. With coordinated entry and case management, it is HOTEL INC's vision to meet the person where they are and then remove barriers to move forward. In 2017, WellCare provided $12,100 to Welcome House of Northern Kentucky to launch the Street Medicine Program across the state after a local homeless health care clinic closed, leaving a gap in services for a vulnerable population. The organization recently received $104,000 in grant funding to create a mobile unit as part of their Street Medicine Program after using data from their initial pilot to apply for the grant funding.

Through WellCare of KY's successful partnerships with Street Medicine, our Hawaii market reached out to see if we had a mentor to refer a community partner in Hawaii to that was interested in launching a similar program. WellCare's Sr. Manager, Elizabeth Starr, connected the Hawaii community partner to Rhondell Miller at HOTEL INC who sent the following thank you after they connected. "Hi Elizabeth, Thank you so much for connecting me with Rhondell, she is amazing! We had a great conversation, she is so easy to talk to and so generous with her time and information." It is great that supporting local Kentucky community agencies in successful innovative programs is having a positive impact in other agencies across the county.

As our PHM program has progressed, we adjusted our focus to address the evolving health care challenges, and continue to do so. There is an increasing need to focus on Substance Use Disorder (SUD) and behavioral health needs, while continuing to address other prevalent conditions including tobacco use and obesity. Through a combination of data analytics and our community collaboration, we actively identify new trends, such as vaping among young people, and the challenges of health care disparities based on region, age, gender, race, and ethnicity. One of the things we are most proud of is our ability to flex and develop the PHM program to meet emerging needs,

pilot new programs, and use data to determine the highest value programs to promote across the Commonwealth. We continue to refine our tools and systems, as described below, to support and promote the use of predictive analytics and health informatics, smart care management assignment and workflows, consistent application of clinical practices, value-based care, prevention and wellness programming, and chronic and complex condition management. What does not change, even as our PHM program becomes more advanced, is the dedication of our local Kentucky staff and our commitment to DMS that our approach to population health remains local, person-centered, integrated, and uniquely tailored.

i. Innovations and program elements the Contractor proposes to incorporate into this Program to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their healthcare.

Making a Difference: One Family at a Time

Brandi felt challenged as a mother to her son, Dylan, due to her being deaf, a lack of a natural support system beyond immediate family, food insecurity, and her long-standing chronic stomach condition. Brandi was anxious about being a good mom and chronic pain due to her stomach condition interfered with parenting. Then she met Dewana, a field-based care manager assigned to Brandi to conduct an in-person Enrollee Needs Assessment. During the home visit, Brandi shared with Dewana her concerns about and goals for Dylan, particularly around a better life for him. Assigned to other Enrollees in eastern Kentucky, Dewana knows the financial pressures in this area experience due to the loss of coal mining jobs in the region. Dewana knows the resources available to support Brandi and her family. During collaborative, person-centered care planning, Dewana and Brandi agreed upon the following interventions, including those for their physical health and social service needs:

Interventions for Brandi: Connected her to a specialist for stomach issues and arranged transportation to appointments; helped her apply for Food Stamps; helped her get Dylan into a preschool program; and helped her set up a checking account to deposit Dylan's SSI benefit checks

Interventions for Dylan: Arranged for physical therapy to strengthen his leg muscles; occupational therapy for his fine motor skills; and speech therapy

Today, Dewana feels good about making a difference in the lives of our Kentucky Enrollees. She built on Brandi's strengths, helping her define goals for herself and her son, and connecting Brandi and Dylan to the care and services they urgently needed. Regarding her interactions with WellCare, Brandi says, "I am just so thankful to WellCare. You helped me so much."

WellCare of Kentucky has designed, implemented, and evolved our PHM program over time. The key imperatives foundational to our PHM approach encompass innovations and program elements that collectively support Enrollees across the care continuum. **Table C.24.1** summarizes those imperatives, and related innovations and program elements, each of which is subsequently described in more detail.

Table C.24.1 Innovations and Program Elements

Key Imperative to PHM Approach	Innovations and Program Elements
Understand the population through a combination of data analytics, health informatics, and in-person collaboration with stakeholders.	• Membership Dashboard • Predictive Analytics • Stakeholder Engagement • Identification and Stratification (ID/Strat) Engine • Care Needs Heat Maps • Utilization Reports
Empower and Engage Enrollees by meeting them where they are physically, culturally, and through technology and other modalities that support their engagement.	• High-touch in-person care management • Focused programs for specific conditions/populations • Finding and engaging difficult to reach Enrollees • Addressing Social Determinants of Health • Leveraging new and emerging technologies • Health Coaches to help Enrollees navigate their care • Care Center outbound calls to close care gaps • Educational Materials • Value-Added Services • Community Events and Outreach • Enrollee support for work and community engagement • Transitional Care Coordination
Partner with Providers to help them succeed by streamlining the administrative burden of working with MCOs and empowering them with data and other supports to deliver the highest quality care to Enrollees.	• Supporting Enrollee engagement with their PCP • In-Person Provider Engagement Model • Incentives for high-quality care • Sharing of Enrollee Care Needs • Multi-disciplinary care teams, care planning and engagement • Provider Portal
Integrate a holistic, community-based approach for both individual Enrollees and the community at large to address non-medical drivers of health outcomes.	• Supporting social service • Single whole-person IT platform • Integrated Clinical Guidelines • Integrated Staffing • Integrated Clinical Training

Within each of these key imperatives, we ensure our PHM program remains clinically superior, applying evidence-based programs and gold standard clinical practice guidelines consistently regardless of risk level, Care Manager, or coordinator, provider, or intervention.

We describe just some of the innovations and core program elements within each of these imperatives, followed in subsequent sub-sections by a more detailed discussion of how we apply those innovations and program elements within each defined risk level and along the PHM continuum. Innovations and programs specific to conditions (e.g., asthma remote patient monitoring) or population (e.g., first year of life NICU supports) are outlined in the subsection related to priority areas later in this response.

UNDERSTANDING THE POPULATION

Our innovations to understand the population begin with a combination of stakeholder engagement and data analytics. Data tells us not only about prevalence of conditions and disease states, but allows us to break that down by region and county, age, race and more to help us target the right interventions. It also allows us to test programs and expand those with successful outcomes, which we have consistently done throughout our time in Kentucky. Our personal engagements with stakeholders help us understand the barriers to improving population health. For example, we know that the isolation Eastern Kentuckians face often makes it challenging to attend to preventive care visits, which exacerbates their chronic health conditions. This understanding led us to create new approaches to engagement, such as hiring Enrollee Outreach Coordinators to knock on doors and help connect people to care.

Some of our innovations around understanding the population include the following:

Membership Dashboard: As shown **in Figure C.24-1**, this overall dashboard allows us to break down Enrollee demographics, diagnoses and utilization patterns in a variety of ways to help us understand who our Enrollees are and their basic needs. This information helps us establish priority needs and clinical programs, identify the best value-added services, and develop engagement techniques that meet Enrollees where they are.

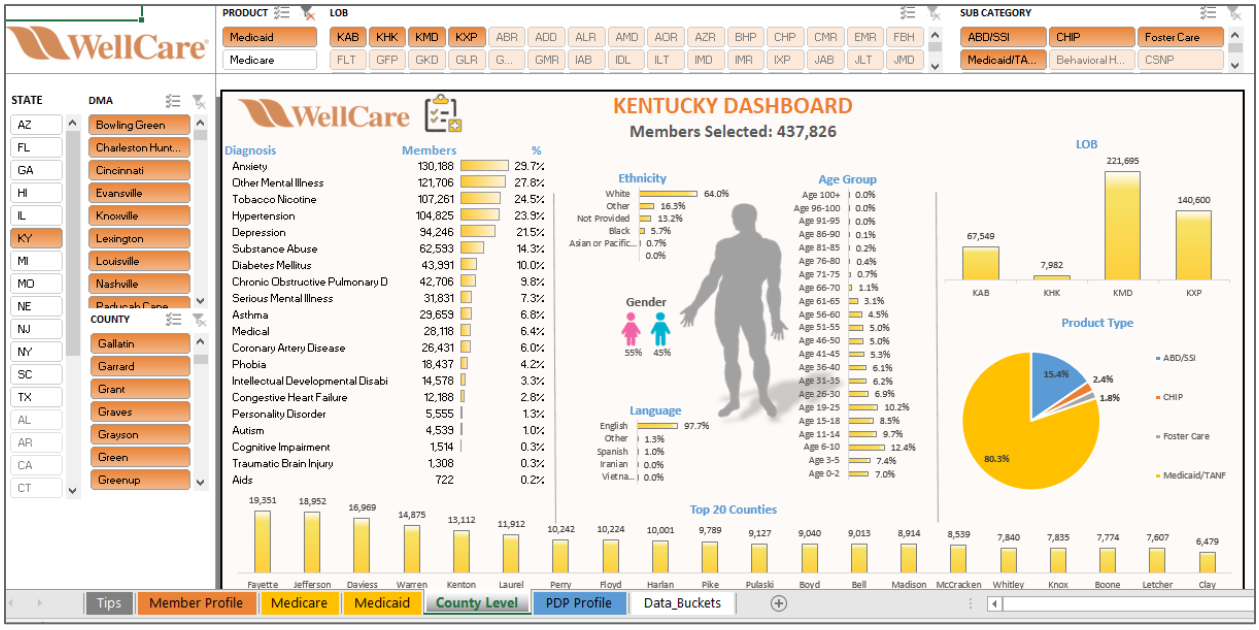


Figure C.24-1 Membership Dashboard

Predictive Analytics: Through several of our program elements (e.g., stratification methodology, targeted Enrollee outreach, and unable to contact initiatives) we incorporate proprietary predictive analytics that look at Enrollee behavioral patterns, demographics, social needs, and other factors to help us best understand which Enrollees will be at the greatest risk for not accessing needed preventive and wellness care or chronic disease management services.

Stakeholder Engagement: Understanding that data only takes us so far, we also use a variety of stakeholder engagements to help us drive continuous improvements in our PHM program. One

example is our Behavioral Health-Clinical Advisory Council (BH-CAC), which we formed because we understood the challenges of behavioral health in Kentucky, such as a lack of available services and shortages of providers. The BH-CAC providers from across the Commonwealth inform our PHM efforts by keeping us up to date on the latest challenges our Enrollees, providers, including social service providers, and the system faces.

In addition to these innovations**, Table C.24-2** shows other program elements that help us understand the populations we serve.

Table C.24-2 Program Elements to Understand the Populations

Program Elements to Understand the Populations	
Program Element/Innovation	**Description**
Identification and Stratification (ID/Strat) Engine	As described in detail below, our ID/Strat methodology helps us determine the risk of our overall population and identify individual Enrollee risk levels.
Care Needs Heat Maps	Care Gap Mining and Sharing: Promotes prevention and wellness. For example, heat maps help create targeted community-level interventions to address prevalent local conditions.
Utilization Reports	As described in our response to question C.10 Utilization Management, we use a suite of over and under-utilization reports both within the health plan and with providers to drive population health programming and interventions, such as the creation of our Transition Care Coordinators, to help ensure Enrollees can get care they need upon discharge from the hospital.

b. Empowering and Engaging Enrollees

From day one, we understood that the best way to engage Enrollees was to be present, which is why we launched, from inception, a field-based care management program, which has now become standard across our affiliates. As we continue to evolve the program, we have broadened our focus beyond the highest-need Enrollees to innovate around chronic conditions and populations as well as broader prevention and wellness activities. Just some of our innovations to empower and engage Enrollees include the following:

High-touch in-person care management: WellCare at Home is the centerpiece of our Complex Care Management approach in which field-based Care Managers (licensed nurses and social workers) engage Enrollees and their families in person at a time and place most convenient to the Enrollee. Being able to see an Enrollee's challenges first-hand allows our Care Managers to better help address barriers to positive health outcomes. WellCare at Home remains one of our most successful programs. In an analysis of Enrollees enrolled in Complex Care Management receiving WellCare at Home interventions, in a one-year period, we saw their **ER use decline 21%, their inpatient admissions decline 27%, with corresponding increases in pharmacy spend of 16% and specialist visits of 27%.**

Focused programs for specific conditions/populations: We continually review data and rely on our experience on the ground to identify areas in need of focused programs. We then build specific condition-based interventions on priority areas and populations that we identify. For example, in March 2019 we rolled out our **Good Measures** diabetes prevention program to our Medicare members. Good Measures empowers participants to better manage their health through food. We saw a 25% decrease in per member per month (PMPM) costs by the end of calendar year 2019 for participants in the program. Considering the success of Good Measures in our Medicare program and prevalence of diabetes among our Enrollees, we are preparing to begin offering the Good Measures program to our Medicaid Enrollees in 2020. We focus on bite-sized goals that are highly personalized based on an Enrollee's preference, location, health status, lifestyle, budget, and access to food. We work closely with Enrollees to set realistic goals that help build confidence and self-reliance so they can make lasting behavior changes that deliver results. Using the Good Measures app, Enrollees can track meals and snacks, physical activity, blood sugar, and medications to learn how different foods, medicines, insulin, and activity affect their blood sugar. The app suggests the best meals and snacks to eat next. Notably, nutrition plays a key role in mitigating side effects and increasing efficacy. As Enrollees begin to understand how food impacts their health and as they begin to feel better, sustainable behavior change occurs. The result: improved health outcomes, Enrollee satisfaction, and Enrollee empowerment.

Finding and engaging difficult to reach Enrollees: The WellCare REACH program, designed to help find Enrollees who are often more transient, is integrated into every aspect of our PHM program, including our wellness and prevention initiatives and complex care management. Described in more detail in our response to encouraging participation in the PHM program, REACH combines high-tech data collection and mining of contact information with personal "feet-on-the street" outreach to find and engage Enrollees. **One innovation to place Enrollee or Member Outreach Coordinators (MOCs) to knock on doors in Region 8 resulted in dramatic improvements in engagement with primary care and prevention services, resulting in a reduction in higher-cost services of more than 16% for those Enrollees served.**

Addressing Social Determinants of Health: WellCare's Community Connections program helps engage and empower Enrollees by giving them real tools to address non-medical drivers of poor health outcomes such as food our housing insecurity. As it relates to Enrollee Engagement, Community Connections offers our social service IT platform and database used by internal teams and by external partners to refer individuals to social resources. It also includes our Community Connections Help Line, one of which is located in Hazard, which is our social service referral line that connects Enrollees to community resources. We track and follow-up to ensure the Enrollees received the needed service. The Robert Wood Johnson Foundation and the University of Kentucky have studied the effectiveness of Community Connections, with

Making a Local Impact on SDOH

Since launching the Community Connections program in Kentucky, we have connected more than 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in emergency department visits, and a 53% decrease in inpatient spending.

multiple studies showing a direct impact on population health, including reduced use of high-cost services.

Community Connections: Helping Enrollees with COPD

One of our Enrollees with COPD called the Community Connections Help Line (CCHL) reporting that she could not afford to pay her electricity bill of more than $200, and had received a shut-off notice from her electricity provider. The Enrollee is medically dependent on electricity because of her dependence on an oxygen machine, which helps her to breathe. CCHL provided the Enrollee a referral to the Community Action Council-Fayette West Neighborhood Center to help her access assistance with paying for her utilities. One day after she called the organization to apply, they provided life-saving assistance by paying a large portion of her electricity bill.

Leveraging new and emerging technologies: As more Enrollees, particularly among our younger populations, rely on technology, we are continuing to innovate with web-based and mobile engagement tools. For example, we have implemented a mobile phone app, known as JOOL, for our Foster Care Enrollees to help them life plan for aging out of the system. We also implemented self-help web tools for wellness and chronic condition management, such as MyStrength, which is an evidence-based digital BH platform, empowering Enrollees to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges. It also supports the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care.

In addition to these innovations**, Table C.24-3** describes other program elements that help us empower and engage Enrollees.

Table C.24-3 Program Elements to Empower and Engage Enrollees

Program Elements to Empower and Engage Enrollees	
Program Element/ Innovation	**Description**
Health Coaches	Enrollee-dedicated coaches guide Enrollees along a path to better health. Health Coaches focus on motivating Enrollees to receive consistent care from their PCP to avoid more costly services, providing education on appropriate prevention services, and maintaining appointment adherence for chronic conditions. They work closely with Enrollees to ensure they understand their care needs and assist with barriers to care through referrals to our care management and Community Connections programs.
Care Center Outreach	Our Care Center is an outbound call center dedicated to contacting Enrollees with open care gaps and alerting them of upcoming recertification deadlines so they do not lose their eligibility and access to health services.
Educational Materials	Available through various modalities (mail, mobile, online, through community partners), we develop culturally appropriate education materials to empower Enrollees to better engage in their health care and

	improve their outcomes.
Value-Added Services	As described in C.20. Covered Services, these additional benefits include bonus rewards for expecting mothers, enhanced vision benefit, the Community Connections Helpline, GED program, Healthy Rewards Program, home-delivered meals, over-the-counter benefits, college scholarships, and more.
Community Events and Outreach	We sponsor and meet Enrollees at events including the Black Gold Festival, Perry County Fair, Mountain Heritage, Poke Sallet, ARH Health Fair, MCHC Health Fair, Poage Landing Days, Grayson Co 1st Annual Mental Health Fair, HOTEL INC Homeless Resource Fair, Recovery Entry Expo, and Feeding America.
Enrollee Support for Finding Employment	Our innovative program, WellCare Works, assists Enrollees in preparing for the workforce and finding employment suited to their experience. We provide one-on-one trainings, including webinars, summits with workforce agencies, and train community partners in an effort to increase education about the program at various Enrollee touchpoints.
Transitional Care Coordination (TCC)	Described in more detail below, our TCC program, places nurses in high-volume hospitals to engage Enrollees before they discharge to support their discharge plan and participation in any one of our PHM programs.

Breaking Barriers to Good Health Empowering Enrollees for a Lifetime

In 2018, Family Health Center in Louisville, KY reached out to WellCare of Kentucky to request education and case management services for their pediatric population with BMI/Obesity concerns that were being identified at well-child visits. Our care manager, Brooke, began enrolling those pediatric Enrollees into short-term pediatric case management to provide education, support, and resources related to nutrition, physical activity, and the promotion of an overall healthy lifestyle. The clinic had limited resources and appointments available with their nutritionist/dietitian therefore case management enrollment allowed these children and their families to receive valuable education to promote healthy nutrition and activity choices they may have otherwise not received. Since Family Health serves a large Spanish-speaking population, all of these particular referrals were for children with Spanish-speaking families. Through the use of an interpreter service, Brooke contacted each family and reviewed their basic knowledge of nutrition and activity, which was consistently lacking. One child Brooke helped was an 8-year-old boy whose BMI was 27.2. His mother was not aware of any nutrition guidelines and did not know how to read a nutrition label or what typically caused weight gain. Brooke discussed with his mother the foods her child typically eats in a day, and she asked her to keep a food log over several days to review at the next call so they could see what food choices they were making and what the typical portion size was. Brooke provided education about reading food labels and discussed the percentage of each that the child should have each day based off of resources from AAP Institute for Healthy Weight and healthychildren.org as well as USDA guidelines. Brooke reviewed limiting sugar, healthy choices and physical activity both verbally and by mailing Spanish-language documents related to nutrition to the family. Brooke also provided education on being physically active 60 minutes per days at minimum, ideas for indoor play and activities such as jumping jacks, run in place, pushups, walking up and down stairs several times, among other options outside. Brooke encouraged family to schedule 10-minute breaks each hour where video games (the child's most time consuming activity) are paused and he gets up and does several sets of these activity options. Brook also encouraged family activity outside such as a walk or time at the park. Through the interventions, the mother reported to Brooke that her son's weight had stabilized and his clothes were fitting better and that she was using what she learned with the whole family.

PARTNERING WITH PROVIDERS

No MCO can operate a successful PHM program without the support and engagement of the provider community. WellCare's approach to provider engagement, quality, and high-performing networks has allowed us to build relationships that best serve Enrollees. Our annual Provider Satisfaction survey shows that **91.6% of our providers would recommend WellCare of Kentucky to other providers** because of our willingness to partner with them to improve outcomes. Just some of our innovations to partner with providers include the following:

Supporting Enrollee engagement with their PCP: Through our engagement with providers, we found many were eager to address gaps in care but lacked resources needed to conduct

Enrollee outreach and follow up. To solve this, we placed Patient Care Advocates (PCAs) in select provider offices to help schedule appointments for targeted Enrollees with identified gaps in preventive and chronic condition care including immunizations, ADHD follow-up, asthma medication adherence, and well child visits. **We have seen compliance in preventive care increase, achieving many HEDIS improvements from 2016 to 2018 including a 27.64% increase in Adolescent Well Care, a 23.83% increase in Well Child Visits in the first 15 months of life, and a 55.11% increase in Weight Assessment and Counseling for Nutrition and Activity for Children with a High BMI. Because of all our improvements, our 2018 HEDIS Scores for Child and Adolescent Access to PCPs for ages 12-24 months, 25 months to six years, and seven to 11 years were all in the 90th percentile.**

In-Person Provider Engagement Model: Co-located with quality and PHM staff, our locally based, high-touch provider relations staff often partner with Care Managers to support PHM initiatives, whether it is training providers how to make a referral to Complex Care Management or sharing new guidelines for Opioid prescribing, for example.

Incentives for high-quality care: Paying for value, as described in more detail in our response on value-based purchasing below, is tightly woven into our overall approach to population health management. Our national WellCare clinical design team even includes specific expertise on incenting high-performing networks to help us achieve PHM goals. While we offer a variety of incentive payment types, our Pay for Quality, or P4Q program, which pays providers bonuses for conducting certain preventive and chronic care services, has been among the most successful. **For example, Comprehensive Diabetes Care - Eye Exams and Cervical Cancer Screens showed improvement through the P4Q program with the former improving 22.2% and the latter improving 18.19% from 2016 to 2018.**

In addition to these innovations**, Table C.24-4** describes other program elements that help us partner with providers.

Table C.24-4 Program Elements to Partner with Providers

Program Elements to Partner with Providers	
Program Element/Innovation	**Description**
Sharing of Enrollee Care Needs	Ensuring Enrollees, particularly those in the Prevention and Wellness risk level, get necessary preventive services is foundational to the PHM program so we use multiple modalities to share care needs, including our "Appointment Agenda," which tells a physician, in one view, everything the Enrollee needs during that visit to be compliant with evidence-based preventive and chronic care clinical guidelines.
Multi-disciplinary care teams, care planning and engagement	Providers play a critical role on an Enrollee's multi-disciplinary care team, helping to ensure complex service needs are met timely and supporting the Enrollee care planning process. We engage them through direct contact and continued follow-up with technologies that allow us to share care plans.

Provider Advisory Panels	Provider Advisory Panels serve as a consulting resource to WellCare of Kentucky in policy and operational matters, and further strengthens the bridge between WellCare and the provider community. We hold quarterly Provider Advisory Panel meetings in each of our six regional offices. WellCare's Kentucky leadership team reviews and considers all panel recommendations and meeting outcomes.
Provider Portal	Our provider portal is connected to our CareCentral clinical platform, which allows us to share the outcomes of health screens, EPSDT information, social determinants of health obstacles, Enrollee assessments, care plans, and multi-disciplinary team contacts with providers. Providers can view open and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, EMR interchange or submission of supplement medical record information.

INTEGRATING A HOLISTIC, COMMUNITY-BASED APPROACH

Whole-person, person-centered care is the hallmark of our PHM program. Our staff, systems, call centers, and other operations are fully integrated, and we engage in our communities in a way unique among MCOs. Just some of our innovations to integrate a holistic approach in our PHM program include the following:

Supporting Social Services: Because non-medical drivers of health are as critical to improving health outcomes as the medical drivers, we consider the work we do in our communities a critical innovation to support the PHM program. As noted above, we use our social services database of more than 330,000 services to connect Enrollees to needed services. The database serves another critical purpose in helping us identify gaps in the social safety net, which ultimately make it difficult for Enrollees to access needed preventive and chronic condition care, leading to poor health outcomes. This knowledge informs our next steps, which is the creation of our Community Impact Councils, where we bring together public health departments, private businesses and community organizations to determine how we can help close the gaps in the social service safety net. Since 2011, WellCare of Kentucky has held more than 100 Community Impact Councils to address a verity of issue from transportation and housing to food insecurity and childhood obesity. We use the Councils to guide our Community Health Initiatives, in which we often partner with a provider group or community organization with an investment to address a specific health problem in that community. All of these efforts to help sustain the social service network and create needed services, is vital to our PHM program because we know that when

> "The insights you share at our monthly partnership meeting and at our special events are invaluable and our partnership Enrollees appreciate your dedication to the cause, especially because you are the only Medicaid provider to have attended our meetings."
>
> – MASON COUNTY TOBACCO FREE PARTNERSHIP

an Enrollee who has a social gap, does not close that gap, ER costs for that Enrollee can increase by 8.5% and they are 4.9 times less likely to see their PCP.

Team Ultra in Marshall County is an example of how we apply the features of our Community Connections program to a specific community initiative by supporting a community-based organization to achieve improved health outcomes. Marshall County is a rural area in Kentucky and the opportunities for after-school activities, outside of organized team sports, are limited. The Marshall County Health Department created Team Ultra in response to a request from the Kentucky Department of Public Health to increase physical activity in school aged children. The mission of Team Ultra is to teach students about physical activity, good nutrition, and upstanding character traits. We collaborate with Team Ultra and provide grants to fill the funding gap to ensure all students in the county who wanted to participate could. The program began with one elementary school and has grown to serve all six of the county's elementary and middle schools. Between September 1, 2016 and January 6, 2019, 136 students received 2,441 total services from Team Ultra. Among the WellCare of Kentucky Enrollees who participated, the average age was 11.5; 53.2% were boys and 46.8% were girls. One-year post intervention, we saw a 35.9% reduction in ED visits and a 98% increase in routine child health exams for those participating.

Single whole-person IT platform: Our integrated CareCentral system supports our PHM program by ensuring a holistic view of each Enrollee. Our Member 360 view provides a full view of an Enrollee's record, risk factors, gaps in care, utilization trends, and disease profile on a single screen with easy-to-read red and green flags to indicate risks. This 360-degree view allows

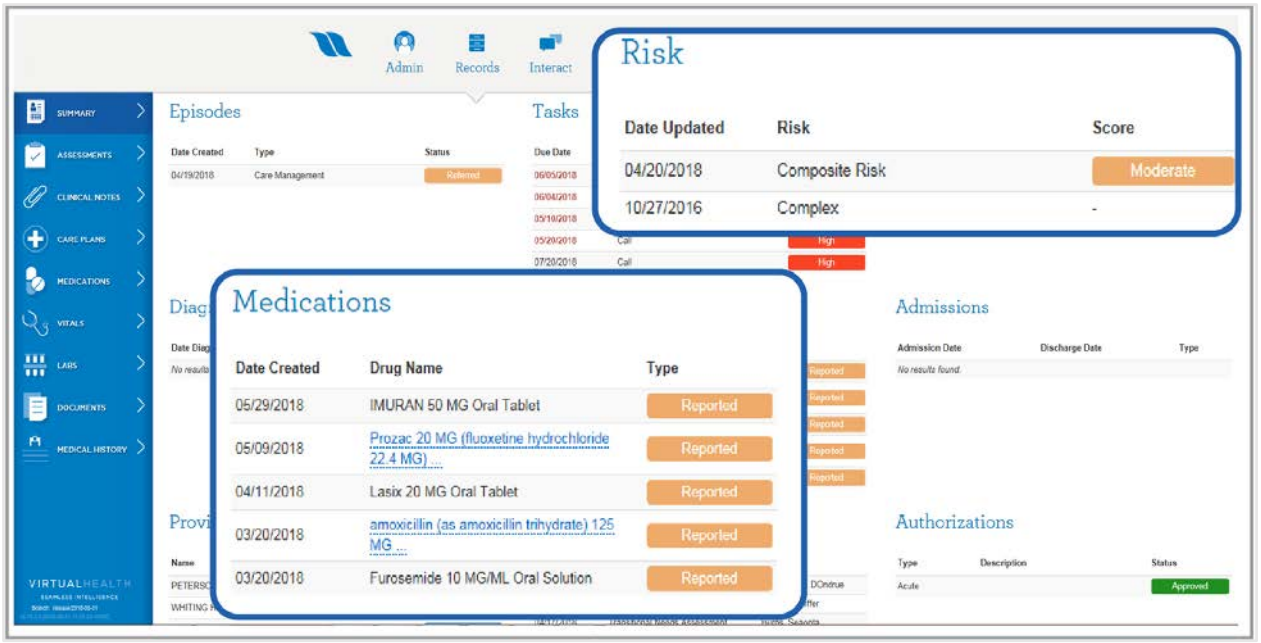


Figure C.24-2 360-Degree View

Enrollee-facing staff to quickly partner with an Enrollee to assess the Enrollee's care needs and risks and then help drive interventions, such as assisting a mom make an appointment to close an EPSDT need or addressing a social service need.

The Member 360-degree view, depicted in **Figure C.24-2**, includes screening results, comprehensive assessment results, admissions/readmissions, diagnoses, medications, eligibility verification, PCP assignment, authorization history and status, claims status, service and benefit limits, care need reports, preferred drug list, important updates and notices, multi-disciplinary team contact information, and population health training materials.

Table C.24-5 Program Elements to Integrate a Holistic Approach

Program Elements that Enable a Holistic Approach	
Program Element/Innovation	**Description**
Integrated Clinical Guidelines	Our PHM staff uses a set of standard and fully integrated clinical guidelines that allow our clinicians to address holistic needs of the Enrollee. These guidelines address co-morbid conditions (e.g., depression during pregnancy) to help guide the right interventions for Enrollees engaged at any risk level.
Integrated Staffing	Nurses and social workers work side by side with engagement partners and quality specialists, under a single integrated clinical leadership team with medical and BH medical directors working hand-in-hand on individual and systemic needs that cut across the continuum of care.
Integrated Clinical Training	WellCare of Kentucky staff, providers, and other stakeholders engage in training that reinforces integrated care delivery to improve the health and well-being of the population. Our fully integrated in-house care team cross-trains to manage co-morbid conditions and guide the Enrollee as they navigate and address their physical, behavioral, pharmacy, and social needs.

In addition to these innovations**, Table C.24-5** shows other program elements that help us integrate a holistic approach.

ii. If the Contractor, holds NCQA PHM Accreditation, describe the Contractor's implementation of related models, lessons learned, challenges and successes.

We understand and comply with NCQA's PHM Model and the requirements outlined in the Draft Medicaid Managed Care Contract 34.1. Our PHM program aligns with the components of NCQA's PHM Model, however we currently do not hold the NCQA PHM. Our PHM model, described throughout this response, addresses NCQA's four areas of focus:

- Keeping Enrollees healthy
- Managing Enrollees with emerging risks
- Enrollee safety or outcomes across settings
- Managing multiple chronic illnesses

The upcoming 2020 KY Health Plan Accreditation will include the new NCQA PHM standards.

WellCare of Kentucky earned #1 NCQA Customer Satisfaction in 2016-2019 among all Medicaid MCOs, has maintained a two year Commendable accreditation status and has the highest NCQA quality ranking in the State Medicaid program at 3.5, see **Figure C.24-3**. As per the new NCQA standards, on an annual basis, we conduct an assessment of Enrollee population characteristics to identify the needs of our Enrollees' including relevant sub-populations. We develop and implement population-based programs in alignment with care management to improve the quality of our Enrollees' lives.

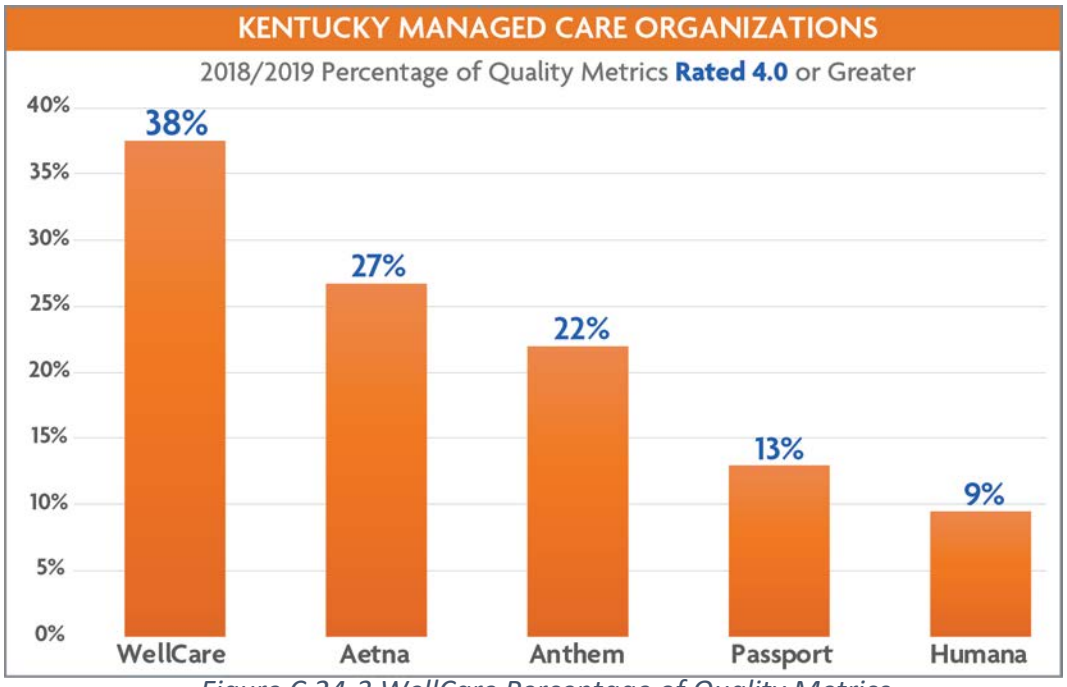


Figure C.24-3 WellCare Percentage of Quality Metrics

Experience developing care management programs has taught us that a field-based team is necessary to positively impact the lives and health of our Kentucky Enrollees. To be most effective, we need to meet face-to-face with our Enrollees, their families, and their providers. We want to ensure that our Care Managers have firsthand knowledge of the communities in which Enrollees live, and understand the challenges our Enrollees' encounter. We have learned through working with vulnerable populations that impacting the lives and health of our Enrollees requires addressing their social determinants of health. Our Care Managers work closely with Enrollees to link them to non-health care related services such as food pantries, heating assistance, housing resources, and transportation to meet their unique individual needs. WellCare of Kentucky Care Managers use our Community Connections database to quickly locate the specific services needed by our Enrollees. We know that Enrollees' basic needs must be addressed before we can effectively address their gaps in care. As our Care Managers work to ensure that all of our Enrollees' needs are met, they also establish trusting relationships with our Enrollees.

WellCare has defined its population health model as:

Driving health care from reacting to individuals' medical needs towards evidence-based, proactive approaches centered on larger, socially grouped medical and behavioral needs and prevention efforts while reducing disparity and variation in care delivery. Analytics allow identification of opportunities to create and implement evidence-based, best practice initiatives delivering excellent and innovative care in the most cost-effective ways.

WellCare of Kentucky's PHM Model is consistent with NCQA PHM standards and encompasses the following key elements:

Improving and Optimizing Health: Most importantly, our programs and measurement metrics are designed to yield the most favorable health status attainable for our Enrollees.

Partnership: We deliver excellent service to our Enrollee, provider and government partners. Enrollees are the reason we are in business; providers are our partners in serving our Enrollees; and government partners are the stewards of the public's resources and trust.

Enrollee Satisfaction: Enhancing Enrollees' experience and satisfaction with their care is essential under WellCare's person-centric approach. Ease in accessing care, satisfaction with the "care experience," and Enrollee/caregiver perceptions of the quality of care received are emphasized, with the Enrollee being the focus and core of the model. WellCare focuses on individualized Enrollee needs and preferences that address social determinants to achieve improved clinical outcomes.

Clinical Integration: All programs use a single integrated care management model. This integrated model strives to increase Enrollee engagement and provide clinical support throughout the care spectrum (crisis to prevention). Staff credentials, culture, and ethnicity reflect the membership served. Care Management is holistic in nature and strives to meet all of our Enrollees' biopsychosocial needs.

Provider Satisfaction and Engagement: Similarly, minimizing providers' administrative burdens and maximizing their satisfaction with WellCare is a key objective of each PHM program component. WellCare connects Enrollees to informed and engaged providers who work to transition Enrollees to high quality, lower acuity settings throughout the care continuum.

Delivery System Alignment: WellCare is striving to transform delivery systems. Our objectives include ensuring our providers work toward the same objectives as WellCare (as well as our shared objectives with our government payer entities). We expect individual provider services to occur in a well-informed environment that achieves whole-person health. This includes assessing and treating (or referring to treatment) all aspects of an Enrollee's health during care, sharing clinical information efficiently among an Enrollee's various providers and with WellCare – as well as similar 360-degree sharing of social determinants of health information (to the extent permissible within confidentiality limitations and requirements).

Through 10 of our national affiliates, we have provided the required documentation successfully for NCQA's PHM standards since the 2018 standards were released. WellCare of Kentucky will be evaluated on these new standards in 2020. We have documented a variety of lessons learned from the challenges we faced in working toward NCQA PHM accreditation and continue to apply those to our PHM program here in Kentucky and beyond. As part of the process, we analyzed our populations and categorized every Enrollee into one or more of

NCQA's focus areas, we identified additional diverse populations of Enrollees. The new NCQA PHM standards have helped us achieve an improved understanding of our membership and afforded us insights to improve our approach to programs based on population specific needs.

WellCare of Kentucky has been improving the lives of Kentuckian's for almost a decade. We will be evaluating our Kentucky-based PHM programs using the new NCQA PHM requirements for effectiveness. We will make any needed adjustments to our programs to continue to support our Enrollees with improving their overall health. In compliance with the Draft Contract, WellCare of Kentucky confirms our PHM Program Plan will be sent to DMS for approval by the end of Q1 2020, and annually thereafter.

iii. Plan to ensure high levels of Enrollee participation across all priority populations and conditions, including innovative methods for contacting and engaging Enrollees to initiate completion of the Health Risk Assessments and Enrollees Needs Assessments.

Our approach to ensuring high levels of participation in our PHM programs across all priority populations and conditions is informed by a deep understanding of how best to identify and engage Enrollees and their families. This understanding is supported by our locally placed clinical and outreach staff, comprising mostly native Kentuckians who know the unique populations they serve.

Enrollees are identified through the Health Risk Assessment (HRA), medical and pharmacy claims, physician referral, or Care Manager referral. Enrollees are stratified by risk according to a proprietary predictive modeling algorithm. Enrollees identified as low risk are enrolled in the educational materials program, where they receive materials and tools to help them understand and manage their condition. Enrollees identified as high and moderate risk, including those who are predicted to experience high utilization or disease progression, are contacted for enrollment in the enhanced program. With the enhanced program, a Care Manager is assigned and assesses the severity of the Enrollee's condition, presence of co-morbid conditions and barriers to care.

Tailored Solutions for Unique Challenges

As the only MCO that maintained a contract with Appalachian Regional Hospital in Region 8 continuously since the program began, we understand the unique challenges faced by the isolation and poverty of the area. After seeing lower than average participation rates in our PHM program in that area, we hired a dedicated team of Enrollee Outreach Coordinators to help us find and engage Enrollees identified with needs for PHM interventions.

In the first year alone, the program resulted in a 19.6% reduction in ER care; 21.4% reduction in inpatient care; and a 16.6% reduction in medical expenses for those served.

Our approach focuses on those Enrollees who are difficult to reach, those in rural, isolated and underserved communities; as well as those with pressing social service resource needs, Enrollees resistant to intervention and Enrollees who have literacy, language, cultural, disability, or other challenges that make engagement and participation more difficult.

The first step to ensure high levels of participation is identifying Enrollees within priority populations and conditions. To do so, we filter our larger population to identify specific needs aligned with interventions, regardless of which risk level the Enrollee falls in.

One method we use is flags built into our enrollment systems. These indicate Enrollees who fit certain priority populations (e.g., Adult Guardianship Enrollees) as they come through on DMS' 834 file. By identifying Enrollees who are part of a priority population, in this way we can move them to automatic Complex Care Management referral and escalate an Enrollee Needs Assessment and care planning process. Subsequently, we use the claims data from the 834 file, augmented with our predictive analytics algorithms, to identify needs specific to priority condition (e.g., an Enrollee with a history of opioid use) that flow through our risk scoring and stratification process.

This effective risk scoring and stratification process ensures Enrollees who need services and support the most receive it quickly. Our ID/Strat process is an innovative multichannel approach that leverages data sources from our integrated platform to identify priority populations, such as those with emerging risk or high-risk needs like pregnancy with substance use disorder. The model can accept inputs of varying frequency. It uses a proprietary predictive algorithm that considers all variables (e.g., readmission risk, Health Risk Assessment results, chronic diagnosis classifications, claims and pharmacy data, pharmacy adherence, ZIP codes, and race and ethnicity) to identify Enrollees at risk early. It then directs them, using our care management assignment logic, to the appropriate intensity of care and the most appropriate Care Manager or other support person based on their hierarchy of condition and specific needs.

We have invested significant resources into our Unable to Contact (UTC) program, known as REACH, to both find and engage Enrollees who are transient or isolated or who do not answer the phone. We offer flexible programs so that Enrollees who may not be quite ready to engage in complex care management still get support because of our close interdisciplinary approach. For example, even if an Enrollee refuses Complex Care Management, the outreach coordinator can help in real time with immediate needs, such as closing a social service need or making an appointment. Additionally, the coordinator provides education about recommended uses of medical services, such as visiting a PCP for non-emergent conditions. They refer Enrollees who refuse Complex Care Management to our Quality team for condition-specific or provider-led interventions to ensure they stay engaged in their care. Finally, we leverage provider and community partnerships to help us engage people in the best PHM program or intervention to meet their specific needs. We recognize many Enrollees prefer to engage in prevention and chronic condition management through their smart phone or web-based applications (e.g., JOOL, MyStrength).

CONTACTING AND ENGAGING ENROLLEES TO INITIATE COMPLETION OF THE HEALTH RISK ASSESSMENT

Our PHM continuum begins with efforts to screen every new Enrollee within 30 days of Enrollment or earlier and every Enrollee annually to assess for new or emerging needs. For current Enrollees we have reason to believe are pregnant, we also reach out to conduct the HRA within 30 days. We use the standardized HRA, as designated by DMS, to determine general needs, including behavioral and physical health, and identify Enrollees who may need an Enrollee Needs Assessment. Contacting and engaging Enrollees to participate in and HRA has traditionally been a significant challenge in the Medicaid population. We have worked to overcome some of those challenges through the following strategies:

Going the Extra Mile to Enable Enrollees with Disabilities to Access Care

Not only do we ensure providers have the proper access for Enrollees with disabilities, we work to make sure Enrollees are able to overcome barriers due to disabilities that prevent them from getting to their appointments. In Region 7, a WellCare Care Coordinator identified an Enrollee who uses a wheelchair for mobility who could not get to her PCP appointments because her house did not have a ramp. Through our Community Connections program, we partnered with a Christian biker group who built a wheelchair ramp onto the Enrollee's home. She can now see her doctor and also attend church and social events.

Partnership efforts like this not only benefit the Enrollee in enabling them to get to their appointments but also benefit providers in reducing no-shows, one of the key reasons why many providers drop out of a Medicaid program. By supporting our networks with community programs that coordinate access, we also sustain and build our provider network.

Contacting Enrollees through multiple modalities: We send a paper version of the initial HRA as part of our Welcome packet to all new Enrollees. We also call Enrollees, making three attempts at different times, to try to engage them to complete the HRA. If an Enrollee calls into our call center, the representative can see if they have had an HRA and can complete one in real time.

Ensuring complete and updated contact information: With expertise in serving Medicaid populations, we know that the first critical step to conducting an HRA is finding our Enrollees. Sometimes more transient or disconnected, Medicaid Enrollee demographic data can be outdated by the time we get it. To help combat this, our REACH program leverages our Enrollee Data Management (EDM) system, which maintains a database of all 834 files ever received, providing us an exhaustive history of Enrollee phone numbers, addresses, and other demographic information we can use at any time. We maintain historical discharge plans and care management notes, allowing us to use artificial intelligence to mine historical files for possible phone numbers or other contact information. We supplement our EDM with external sources, such as the Kentucky Health Information Exchange (KHIE), Lexus/Nexus databases, the Post Office Change of Address database, and the Homeless Management Information System (HMIS) to help us find Enrollees. We extract phone numbers embedded in medical, behavioral and pharmacy claims data to aid in further research. We call providers, pharmacies, and community resources to cross-reference their contact information with our data to update Enrollee information. **The combined approach of data mining and search mechanisms has yielded a 46% success rate in finding previously difficult-to-reach Enrollees.**

Community Partners: Through our community engagement work across the Commonwealth, we have built relationships with social service partners who are often the first line of contact for Enrollees particularly difficult to find, such as transient and homeless Enrollees or those dealing with interpersonal and domestic violence. For example, we are a major partner in Hotel Inc.'s Street Medicine Program in Bowling Green, which includes an arrangement with them to identify our Enrollees they come across when they are working directly with individuals living on the street and making referral for assessment. Because of our support, in part, Hotel Inc. has been able to serve as a model to other similar programs in other cities.

CONTACTING AND ENGAGING ENROLLEES TO INITIATE COMPLETION OF THE ENROLLEE NEEDS ASSESSMENT

Understanding individual barriers to participation is critical to engagement. We have found that local care management delivered in-person in a place most convenient for the Enrollee is the No. 1 method for building trust and dissolving barriers to participation. WellCare of Kentucky has nurses and social workers who live and were raised in the community as our Enrollees, who then connect with Enrollees and their families on a personal level. Other strategies we use to ensure we conduct the Enrollee Needs Assessment within 30 days of identifying the potential need for care management services and continue to improve participation rates include:

Field Outreach Coordinators: Our local Field Outreach Coordinators make the initial outbound call to the Enrollee once identified for needing an Enrollee Needs Assessment. Before they even begin the call, the coordinator looks at the Enrollee's dashboard to understand their conditions, current utilization patterns, fully integrated history, including medications and needs. This allows them to be ready to engage the Enrollee, connect them to the right physicians, and educate them even if they initially decline care management interventions. Field Outreach Coordinators make multiple attempts at different times of the day to try to contact an Enrollee. They leverage the EDM system outlined above to mine different phone numbers and outreach to physicians and pharmacies to get better contact information. The coordinators use KHIE when they struggle finding an Enrollee. Using KHIE resulted in a significant reduction in unable to contact rates. In the first half of 2018, we reduced the number of Enrollees we were unable to contact from more than 2,000 to approximately 1,000.

Education and Smart Coordination with Care Management: Field Outreach Coordinators use every connection with an Enrollee to promote positive engagement in their healthcare. Based on the Enrollee's specific history, the coordinator supports the Enrollee and educates them on the importance of regular PCP visits, preventive care, connections to social services, appropriate emergency department (ED) use and alternatives, and more. Field Outreach Coordinators have learned that one of the key ways to ensure participation in care management is to empower Enrollees to engage in their health care through active Care Management follow-up. For example, if an Enrollee says they need transportation assistance and agrees to talk to a Care Manager, the coordinator encourages the Enrollee to discuss setting up transportation with the Care Manager. In this way, the care coordinator helps to ensure the Enrollee will engage with the Care Manager and assists in establishing a relationship of trust. The Enrollee soon realizes that the Care Manager is a valuable resource who will work together with them to overcome any barriers in meeting their physical health needs.

Supports for Social Service Needs: Through our Community Connections Program, we offer direct connections to thousands of social services to address social determinants of health that may keep someone from participating in Care Management as well as with his/her provider's recommended medical care. For example, a woman dealing with domestic violence may need to find support for that situation before agreeing to have a Care Manager in the home to support a child with a special health care need. In those cases, the Field Outreach Coordinator or Care Manager connects the Enrollee to one of our community partners and follows up to ensure they receive needed services.

Care Manager Training: Care Managers use motivational interviewing and cultural-awareness to help remove barriers that may make Enrollees resistant to care management support. Our Care Managers remain flexible working with individuals on their terms agreeing to meet people when it is most convenient for them, to reach them while hospitalized or in the ED to ensure proper transitions or to use telephonic support based on Enrollees preferences. We provide ongoing training to our Care Managers to consistently improve their ability to use motivational interviewing and provide culturally appropriate care. Independent tests of our scripts and materials identify language and word choice that have the most success in engaging Enrollees in Care Management.

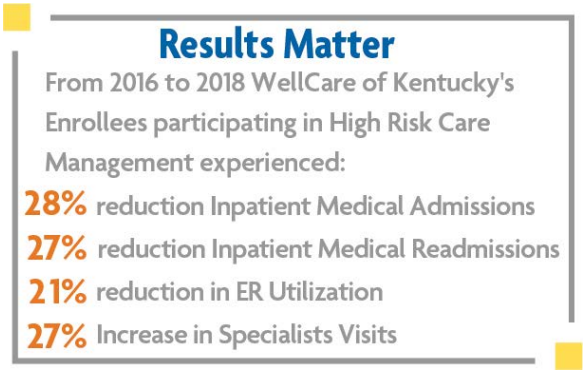
Convenience Technologies: A barrier for some Enrollees is access to a phone or enough minutes on their own phone for regular contact with their Care Manager. We provide SafeLink phones to high-needs Enrollees with pre-programmed phone numbers, and a direct link to the WellCare app, to track care needs, find providers and to get help making and keeping appointments. We provide biometric monitoring to Enrollees with certain chronic conditions (e.g., asthma), as an alternative to traditional care management. This remote monitoring alerts us to an Enrollee's emerging health risk so we can intervene prior to escalation to an ED visit or admission.

OTHER ENGAGEMENT ACTIVITIES

Care Center Outbound Calls: In 2018, we opened our Care Center to support Kentucky HEALTH Enrollees who required assistance with navigating the obstacles of the 1115 Waiver program. With the suspension of the 1115 waiver, we decided to leverage the resources and technology of the Care Center to focus on reaching out to Enrollees with open care gaps or with upcoming recertification deadlines to assist them closing their care gaps and maintaining their enrollment in Medicaid.

Health Coaches: Health Coaches guide Enrollees along the path to better health while providing education on healthy behaviors. Coaches use motivational interviewing techniques to engage Enrollees and develop trust. Our Health Coaches focus on motivating the Enrollee to receive consistent care from their PCP to avoid more costly services, providing education on appropriate prevention services, and maintaining the appointment adherence for chronic conditions. They work closely with Enrollees who have health literacy barriers to ensure they understand their care needs and assist with other barriers to care through referrals to our care management team and the Community Connections program.

Provider Engagement: Our Provider Relations Representatives (PR Reps) partner with our Quality Practice Advisers (QPAs) to educate and help providers engage Enrollees to become active participants in the management of their own care. This ultimately improves quality measures and provides more cost-efficient care. QPAs are trained nurses who review HEDIS measures, clinical practice guides and leave toolkits that support ongoing Enrollee engagement and quality



improvement activities. QPAs and PR Reps frequently meet with providers together to provide the best possible services to providers in their offices in the most efficient manner.

iv. The Contractor's approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level:

Our approach to improving health outcomes and empowering individuals to engage in their health care within each PHM-defined risk level (**Figure C.24-4**) is informed through our understanding of how to best find, identify, stratify, and engage Enrollees in our integrated, person-centered PHM program. Our PHM program is fully integrated and holistic so regardless of where an Enrollee stratifies or tiers within each risk level, they have access to consistently-applied evidence-based interventions and education tailored to their specific needs and conditions, including medical and non-medical drivers of health, with a focus on improving health outcomes and reducing inappropriate utilization and costs. Whether it is holding a community baby shower to encourage healthy pregnancies, collaborating with a local public health department to engage select Enrollees in a year-long diabetes prevention program or sending Care Managers into individual homes to conduct intense complex care management, our approach to each risk level aligns perfectly with the NCQA PHM standards. Additional unique touches built after years of serving Kentucky Medicaid Enrollees, include:

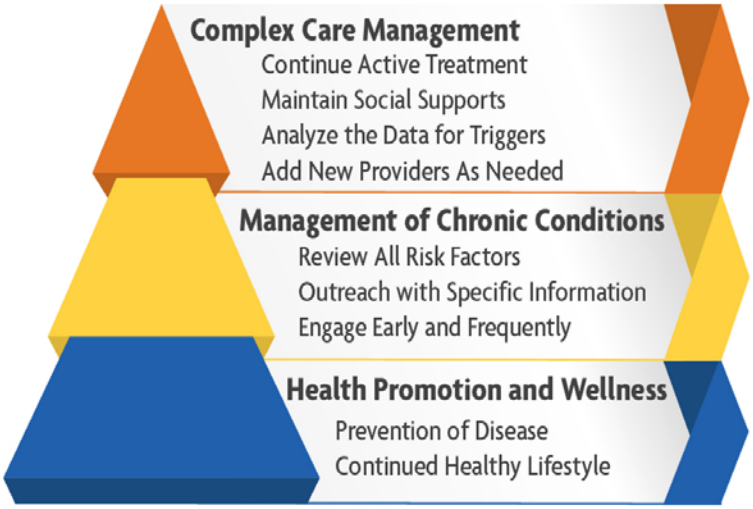


Figure C.24-4 Risk Levels

- Enhanced predictive analytics (including the addition of machine learning and artificial intelligence) to better identify and stratify Enrollees and unmask Enrollees who are often overlooked in traditional stratification models that depend on cost
- Smart assignment for Care Managers to tap into specialties and unique local relationships
- Our intensely local high-touch approach to finding and engaging Enrollees for assessment and screening as well as serving them through care management interventions
- Fully Integrated care planning and multi-disciplinary team approach to engage providers and multiple specialties in individual Enrollee care
- Holistic social services program that not only address individual Enrollee needs, but also broader community needs to improve overall population health
- Strong community and provider partners who support our high-touch model of care

"Pediatric Associates has offices located in Southeastern KY and has had the privilege to serve this area for years. Since the inception of managed care in the state of Kentucky, we have cared for many patients insured by WellCare Health plans. Enrollee health and well-being is a top priority for WellCare and they offer many programs to help support and promote this such as Case Management and Healthy Rewards. ... WellCare has been the most responsive managed care organization to do business with. We consider them to be a partner in improving the overall health and well-being of patients in our community."
– GENE SO, OWNER/OPERATOR, PEDIATRIC ASSOCIATES

a. Tools for identifying Enrollees and their risk levels, and to support services provided

As required in Section 34.3 of the Draft Contract, WellCare of Kentucky uses a variety of tools to support identification of and care for Enrollees within the PHM Program. The tools include our proprietary ID/Strat process and service tiers, the standardized Health Risk Assessment (HRA) tool, and our comprehensive Enrollee Needs Assessment.

We supplement the required tools to enhance identification of Enrollees and stratification of their risk levels as well as to support the services provided within each level with the following:

- Supplemental assessments specific to populations (e.g., a targeted screening for pregnant women and specific assessment for Foster Care children)
- Smart care management assignment algorithms
- Standardized care planning tools guided by integrated and consistent evidence-based clinical standards
- Social Service needs database, assessment, and referrals
- Member 360 degree view for internal staff and through the provider portal for holistic care
- Prevention and wellness education materials through MyWellCare mobile app and online platforms

All of our tools are foundationally supported by our CareCentral Clinical IT Platform and central EIM database that absorbs Enrollee-level data and provides bidirectional data feeds that provide all Enrollee-facing staff with the comprehensive, holistic view of Enrollees' medical, pharmacy, behavioral health, and social needs.

ID/Strat: Risk Scoring and Stratification. Key to the success of our PHM program is how we adapt tools to meet the specific needs of the populations we serve and how we leverage these tools in a fully integrated manner. For example, while all health plans have a risk stratification system as required, WellCare has designed our stratification process with predictive analytics specific to the Medicaid population, which allows us to better identify emerging risks as well as behavioral health and substance use risks that are often masked in traditional cost-based stratification models. Our Opioid risk identification and stratification process, for example, can identify, after the first opioid prescription is written, who is at risk for misusing that drug. We assign Enrollees a Risk of Unsafe Use Score™, which identifies Enrollees at risk of unsafe use of prescription opioids and predicts the likelihood that an opioid user will be diagnosed with unsafe opioid use in the next one-year period. This allows us to intervene early with specially trained Care Managers to prevent Opioid misuse. Generally, our risk stratification methodology allows us to determine the risk of our overall population and identify Enrollee risk levels. As descried in more detail in our response to the next prompt below, our stratification

methodology uses integrated data sources to identify Enrollee needs for services and is run on continuous intervals to ensure new and emerging risks are identified.

Health Risk Assessment. The HRA is a standardized tool, as designated by DMS, which is one way we identify urgent needs to assign Enrollees to one of our PHM programs. We include the HRA in our new Enrollee welcome packet and reach out by phone multiple times at different times to encourage Enrollees to complete the screening within the first 30 days of enrollment. We also do specific outreach within 30 days of identifying an Enrollee who we believe is pregnant and annually for all Enrollees to identify any new needs. With historically low rates of HRA completion across Medicaid populations for all MCOs, WellCare of Kentucky continues to evaluate the best approach to encourage Enrollee completion, such as incentives and different modality options (e.g., mobile).

Enrollee Needs Assessment. We conduct a comprehensive Enrollee Needs Assessment for individuals identified as potentially needing a higher level of PHM program services. This assesses their immediate, current and past healthcare, mental health, and SUD needs; psychosocial, functional, and cognitive needs; social determinants of health, including employment and housing; ongoing conditions or needs that require treatment or care monitoring; current care being received; current medications; and their support network. The goal of the Enrollee Needs Assessment is to gain a whole-person understanding of the individual's goals, strengths, needs, preferences, abilities, functional needs, and physical and BH status. Within 30 days of identifying an Enrollee as part of a priority population, or 30 days from being referred to care management, a local WellCare Care Manager conducts an Enrollee Needs Assessment in a location and manner that meet their needs to validate which level of care management is required for the individual and, if so, the individual's needs.

Our CareCentral clinical IT platform includes a dynamic, configurable comprehensive Enrollee Needs Assessment module that allows us to drill down to specific Enrollee needs. We maintain methodologies and tools for conducting comprehensive Enrollee Needs Assessments for differing demographics and needs while respecting individual choice. Care Managers use supplemental assessments for individuals in priority populations. We share the results of the Enrollee Needs Assessment with the Enrollee and their PCP within 14 days of completion to inform care planning and treatment planning, as consented to by the Enrollee to the extent required by law.

Supplemental Assessments: Variation in the comprehensive Enrollee Needs Assessment tool relies on branching logic. Branching logic streamlines the Enrollee experience and avoids unnecessary questions, which supports completion of the assessment. Supplemental assessments target particular health conditions like diabetes, asthma, depression, or social determinants of health, as well as different priority population needs, such as asking different questions of a woman with a high-risk pregnancy than those asked of a parent for a child under age five with complex needs.

For all Enrollees, as indicated by certain answers, Care Managers can use validated supplemental screening tools:

- CAGE (Drug and alcohol use screening tool for individuals 16+)
- CRAFFT (Screens for high-risk alcohol and other drug disorders for people ages 12 to 21)

- PHQ-9 (Depression screening tool for individuals age 13+)
- AUDIT-C (Alcohol Use Disorders Identification Test) to screen adults for alcohol use
- Edinburgh Postnatal Depression Scale, a screening tool for postpartum depression

In addition, experience in managing individuals with chronic pain has led us to include screening for opioid use disorder. Care Managers can use the Opioid Risk Tool (ORT), which is a brief, validated screening tool to use to monitor the risk for opioid addiction among adults prescribed certain medications. **Table C.24-6** shows other tools to support identifying and stratifying Enrollees to support services.

Table C.24-6 Additional Support Tools

Additional Tools to Support Identifying and Stratifying Enrollees and To Support Services	
Supplemental Tool	**Description**
Smart Care Management Assignment	We generate a daily census report of Enrollees, by risk level, who may benefit from varying levels of PHM intervention. We subsequently segment Enrollees based on risk score and population such as SMI, SED, Disease Management, Behavioral Health, Transplant, Foster Care, etc. to allow for timely referral to the appropriate resource in the field or telephonically within our clinical teams.
Standard care planning tools	Our Care Plans are built in CareCentral guided by standard evidence-based guidelines.
Social Service Needs Assessment, Database and Call Center	Through our database of social service resources, we can track the needs of the population and intervene at the Enrollee, organization and systemic level to support PHM services.
Holistic view of Enrollee needs	As described above, our Member 360 view helps quickly identify Enrollee needs and supports services provided them by showing any Enrollee-facing staff a holistic view.
Provider Portal and Data Exchange Process	Our provider portal is connected to CareCentral, which allows us to share the outcomes of health screens, EPSDT information, social determinants of health obstacles, Enrollee assessments, care plans, and multi-disciplinary team contacts with providers. Providers can view open and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, EMR interchange, or submission of supplemental medical record information.
Mobile and web Prevention and Wellness education	Through digital platforms, which comply with Federal Section 508 standards and web content accessibility guidelines, Enrollees learn about benefits and services, how to access care, learn about preventive care, how to self-enroll in our health and wellness programs, and how to order a new ID card. Engaging Enrollees through their mobile devices and helping them to take even small steps, such as downloading our mobile app, is a step toward empowering them to be active participants in their health and health care.

b. Risk stratification methodology and descriptions of the types of data that will be used.

Our proprietary **ID/Strat** process for risk stratification, in **Figure C.24-**5, generates an aggregate Enrollee risk score through predictive analytics of multiple types of data, which stratifies the Enrollee into risk levels that define the level of intervention they receive.

We created our proprietary Identification and Stratification (ID/Strat) process for our Kentucky market in 2011. Based on its success we have since applied it to all of our health plans and have continued to advance the tools with multiple types of data, including predictive analytics and smart algorithms that go beyond cost-based stratification. This effective risk scoring and stratification process ensures Enrollees who need services and support the most receive it quickly. Our ID/Strat process is an innovative multichannel approach that leverages data sources from our integrated platform to identify priority populations, such as those with emerging risk or high-risk needs like pregnancy with substance use disorder. The model can accept inputs of varying frequency. It uses a proprietary predictive algorithm that considers all variables (e.g., electronic health record (EHR) data, readmission risk, Health Risk Assessment results, chronic diagnosis classifications, claims and pharmacy data, pharmacy adherence, zip codes, and race and ethnicity) to identify Enrollees at risk early. It then directs them, using our care management assignment logic, to the appropriate intensity of care and the most appropriate Care Manager or other support person based on their hierarchy of condition and specific needs.

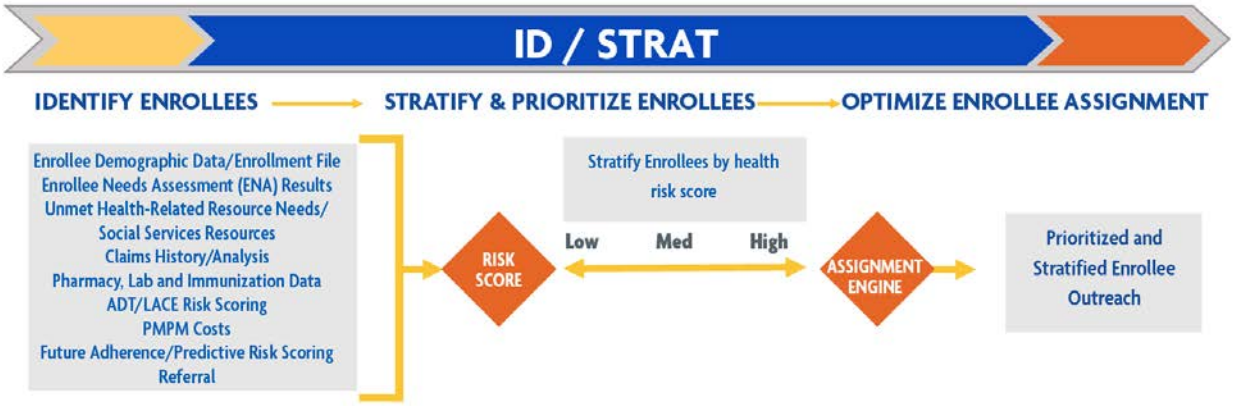


Figure C.24-5 WellCare ID/Strat

Our identification methods are scientifically based and use a combination data aggregation, and analytics combined with predictive analysis and risk scoring to ensure the identification of every Enrollee who needs intervention. The approach analyzes a volume of inputs, the way they combine, and then weighs them in a manner that identifies individuals in priority populations who might be masked by traditional ID/Strat methods. The ID/Strat process leverages our integrated data warehouse as a source of all claims, adherence, and demographic data used as shown in **Table C.24-7**.

Table C.24-7 ID/Strat Data Sources

Types of Data Used in Our Identification and Stratification Tool (ID/STRAT)		
Inputs	**Algorithm**	**Frequency**
Manual Referrals	Care Coordinators, PCPs, community partners, Health Coaches, etc., can flag Enrollee for high risk at their discretion.	Multiple Times Daily
Inpatient authorizations, claims data including Length of Stay, Admission acuity, comorbid conditions and ED use in the last six months	*Discharge Risk Score:* The modified readmission prediction tool improved from the nationally recognized LACE score.	Continuous on-demand at Admission
Enrollee responses to physical and behavioral health screens and supplemental assessments	Care Needs Screenings scored for risk and mathematically validated. The screening identifies health conditions and unmet social resource needs.	Annually or as needed
California Disability Payment System (CDPS) score as an input for the severity of a Enrollee's chronic conditions	*CDPS Risk Score*: Our algorithms also identify specific impactable chronic conditions, behavioral health conditions, asthma, or diabetes, information we use to engage Enrollees in our evidence-based education programs.	Monthly
Per Enrollee Per Month Cost	*PMPM Costs*: Although shown to have a lower predictive power, total PMPM cost can capture some Enrollees who have fewer chronic needs but a sudden, dramatic escalation in care	Monthly
Enrollee claims/encounters, demographics, lab, pharmacy, pharmacy claims	*Decision Point's Predictive Risk Score*: This proprietary algorithm assigns a future risk score based on admission/readmission risk, ER use, and disease progression predictions that estimates Enrollees who will experience a future decline in health	Monthly
Claims for current prescribed medications, adherence to clinical practice guidelines for preventive health	*Value of future adherence/Medication Adherence Risk Score:* This claims-based algorithm calculates a value of future adherence score (VFA) based on the pattern of taking currently prescribed medications. The VFA identifies how active Enrollees are in their health care, the best methods to engage them and their overall responsiveness.	Monthly
Various demographic data	*Propensity to Reach Score:* This algorithm uses Enrollee demographic, income, residence, employment, age, and summarized credit data to predict the likelihood of reaching an Enrollee during outreach.	Monthly

We continuously run our risk stratification algorithm against Enrollee data, such as new claims and authorizations, to enable timely, proactive outreach and care planning for Enrollees with high needs, or those at risk of future high needs. Included in our algorithm are rules for co-morbid behavioral health and substance use disorders and co-morbid physical and behavioral health conditions, and other factors that may necessitate a higher level of Care Management.

Additional Sources of Referral Identify Enrollees for Care Management:

- Enrollment files with special health care needs indicators
- Welcome call to Enrollees
- Incoming Enrollee Services calls
- Geographic population health analysis
- Enrollee or caregiver requests
- Event Triggers
- Provider or caregiver referrals
- Prior authorization referral
- Discharge planning and retrospective review and team rounds
- Community program referrals (WIC, First Steps)
- 24/7 Nurse Line and Behavioral Health Crisis Line
- Our Community Connections line
- Care Center calls

Evidence of Effectiveness of Our Risk Scoring and Stratification Approach

WellCare monitors the effectiveness of our ID/Strat model to confirm our PHM program is engaging the right Enrollees at the right levels of intervention. We also received independent verification of its effectiveness from an outside organization. In particular, we evaluate retrospective data to test the predictive power (using backward testing techniques) of each factor embedded in our algorithm – adjusting the weights of factors as we add new ones, or eliminating factors all together if they are over indexed. This new algorithm is then compared to our prior model to evaluate increased predictive power. We also compare cost and outcomes data for the high-risk Medicaid population engaged in care management with similar cost and quality outcomes data for the high-risk population of Enrollees who choose to not participate in care management. Our cost and quality outcomes for Enrollees across all of our affiliated health plans gives us confidence in the effectiveness of our risk scoring and stratification approach to appropriately identify Enrollees for the right interventions.

c. Methods to identify Enrollees for each of Kentucky's priority conditions or populations

There is **no wrong door** to access our PHM Program for Enrollees in priority populations, such as adults and children with special health care needs or women with a high-risk pregnancy. The same is true for Enrollees with priority conditions, such as Asthma, Heart Disease, Diabetes, obesity, tobacco use, cancer, infant mortality, low birth weight, behavioral health or substance use disorder. In addition to continuously running the ID/Strat engine described above, methods to identify Enrollees include:

- *Enrollment Files:* Certain conditions and populations, such as Enrollees with Adult Guardianship and Pregnancy, appear in enrollment files from the Commonwealth and are flagged automatically for various PHM programming.
- *Referrals:* Every Enrollee-facing associate and all of our providers receive training to identify needs and make direct referrals to a PHM program. Enrollees may self-refer or their family/legal representative may refer an Enrollee at any time. We receive referrals from

providers; the 24-hour Nurse Advice Line; Behavioral Health Crisis Line; Department or Agency staff; community partners; hospitalists; and other MCOs.

- *Diagnosis Flags:* We can identify Enrollees needing condition-specific prevention and wellness education and intervention by identifying diagnoses placed on claims and through exchange of flat files for care needs closures with providers.
- *Enrollee Needs Assessments:* Assessments provide Enrollee-specific and in-depth data about Enrollees and their holistic needs, which allows us to identify priority conditions and populations in real time. Because our condition-specific management is fully integrated within our PHM program, our Care Managers are empowered in real time to provide education and intervention based in priority condition or population without having to pass off to another Care Manager or health coach if the Enrollee has already been identified for Care Manager interventions

d. Services and information available within each risk level.

Table C.24-8 shows the PHM services and information available for Enrollees at each defined risk level. Enrollees with specific priority conditions receive additional services and information specific to that priority condition as outlined in our response to Priority Conditions below.

Table C.24-8 PHM Services and Information Available for Enrollees at Each Risk Level

Risk Level	Risk Level Services Information
Low (Health Promotion and Wellness)	• Transitional care management (e.g., discharge from a hospital or ED), medication reconciliation, and UM/prior authorizations for services or procedures • Enrollee services support with locating an in-network PCP, and immediate connection to an RN/BH specialist during business hours • 24/7 Nurse Line and BH Crisis Line • Wellness promotion and self-management condition-specific educational mailings including EPSDT periodicity and outreach • Care coordination and HRA, including wellness and prevention activities • Healthy Rewards incentive program and value-added services • Healthy Pregnancy support, as needed • Community Connections Help Line and database referrals, including community-based training and coaching • Increased interventions when ID/Strat identifies an emerging risk trend toward Management of Chronic Risk level • Enrollee welcome letter with condition specific educational material to support interventions • On-demand virtual education, coaching, and support for various conditions or populations • Enrollee quarterly newsletter
Moderate (Management of Chronic Conditions	• Includes all low risk interventions • Telephonic care management and coordination • Monitoring and follow-up for indications of increasing risk level • Discharge planning and transitional care management

Risk Level	Risk Level Services Information
Outreach)	• Engagement with a Care Manager whose qualifications align with an Enrollee's medical or BH connections or SUD • Behavior modification education when applicable (e.g., smoking cessation education, healthy weight management) • Person-centered care plan, follow-up and monitoring, and annual reassessment if an Enrollee experiences a change in condition or circumstance • Assistance with integrated care needs • Multi-disciplinary care team (MDT) engagement in care planning • Increased interventions when ID/Strat identifies a high risk
High Management of Chronic Conditions Outreach (Complex Care Management)	• Includes all low and moderate risk interventions and UM/prior authorizations, as needed • In-person interactions in an Enrollee's home or other supplemented by phone contact • More frequent and intense MDT Enrollee engagement with more disciplines involved • Increased interventions when ID/Strat or a Care Manager identifies rising risk toward higher intensity care

e. Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.

One of WellCare of Kentucky's defining characteristics is our person-centered culture that promotes an integrated care planning process in which the Enrollee is the decision-maker for their own needs and care plan goals. When Enrollees participate fully in the care planning process, they are more likely to meet their health and wellness goals. A person-centered approach means going beyond assessment data to gain in-depth understanding and insight into an Enrollee's needs and goals. Care Managers facilitate development of the care team and the care plan. They guide and support Enrollees, helping them understand the connection between interventions and the interim steps they must take to control their chronic conditions and achieve their desired quality of life. This approach often means focusing on tangible tasks to build on an Enrollee's capacity to change and develop trust. These Specific, Measureable, Attainable/Achievable, Realistic/ Relevant and Timely or Time-framed (SMART) goals are included in each care plan and help the Enrollee stay on track. For example, an Enrollee may have a SMART goal of increasing physical exercise by 10 minutes a day by walking down to the end of the road and back or a SMART goal of scheduling and keeping a PCP appointment.

Care Managers support and empower Enrollees as they navigate the complexities of managing their health through the care planning process. They help Enrollees develop their health literacy to build confidence and gain self-management skills for independent living. Care Managers develop a written care plan for all Enrollees participating in care management. All care plans are stored in our CareCentral platform and are made available to Enrollees and others (with

consent) participating in their care. Flags and triggers within CareCentral help the Care Manager track that indicated interventions are being completed and new risks are identified and addressed timely.

ENSURING DEVELOPMENT OF AN INDIVIDUALIZED AND PERSON-CENTERED CARE PLAN

Our Care Managers facilitate a collaborative multi-disciplinary team approach to develop an individualized care plan with the Enrollee based on individualized needs. The care plan is personalized. It includes Enrollee or caregiver participation, as well as support of the PCP, Behavior Health practitioner, pharmacist, social worker and others, as appropriate. Our fully integrated care plans address physical and behavioral health goals, functional and psychosocial goals, environmental, and social services. Care Managers use findings from the Enrollee Needs Assessment, claims analysis and risk scoring, any available medical records, and condition-specific clinical practice guidelines, to form the basis of an initial care plan.
Care plans are individualized based on engagement with the Enrollee and family, as well as their PCP and other physicians to inform the Enrollee's goals, preferences, and priorities.

Primary care plan components include:

- Prioritized and Measureable Goals: Enrollee-desired or anticipated results based upon identified opportunities and needs. These are person-specific, measurable, achievable, and time-bound.
- Opportunities/Needs: Medical, behavioral, dental, pharmacy, educational, and social service-related resource needs identified during screening, assessments, and conversation with the Enrollee, family, and caregiver.
- Enrollee/Family/Caregiver-Defined Interventions: Steps taken to achieve a goal, remove a barrier, and eliminate a need.
- Intended Outcomes: Expectations the Enrollee would like to achieve are also included. To continue to support them in meeting their identified goals, Care Managers monitor Enrollee progress and identify barriers to goal completion.

The individualized care plan includes the following components in alignment with Section 34.4 of the Draft Managed Care Contract.

- Identification of appropriate medical, behavioral, and social services consistent with the PCP or specialist diagnoses and treatment and recovery plans
- List of medications and documentation of medication reconciliation activities
- Initial assessment of Enrollee risk factors and plans in place to minimize them including detailed crisis plans for Enrollees with a behavioral health risk
- Evaluation of cultural and linguistic needs, preferences, and limitations; visual and hearing needs, preferences, and limitations; available benefits; and community resources
- Description of Enrollee’s psychosocial needs including any housing or financial assistance needs; how such needs will be addressed to ensure the Enrollee’s ability to live safely in the community;
- Prioritized goals taking into effect Enrollee and caregiver goals, preferences, and desired level of involvement in the care management plan
- Timeframe for re-evaluation

- Resources to be used, including the appropriate level of care
- Plans for continuity of care, including transition of care and transfers
- Collaborative approaches to be used, including family participation
- Self-Management Plan of activities for the Enrollee to manage his or her condition based on caregiver instructions or materials. Activities include maintaining a prescribed diet, charting daily readings (e.g., weight, blood sugar), adhering to provider treatment plan, monitoring of all activities and report generation from a common electronic medical record platform.
- All other planned interventions (e.g., agreement to attend an AA meeting or participate in a healthy eating cooking class)
- Development of a schedule for follow-up and communication

IDENTIFYING BARRIERS TO MEETING GOALS OR COMPLYING WITH THE PLAN:

The Care Manager partners with the Enrollee to identify potential obstacles to receiving or participating in the care management plan. This can include issues such as language or literacy; lack of or limited access to reliable transportation; an Enrollee's need for additional education and support on their condition; an Enrollee's need for motivation; financial barriers; cultural or spiritual beliefs, environmental barriers, and visual or hearing impairments.

Care Managers live and work in Enrollee communities, so they are familiar with the community, the culture, and the barriers that the Enrollee faces. We match Care Managers to the most appropriate Enrollees based on their hierarchy of conditions and the Care Manager's individual experience and training. The Care Manager guides and supports the Enrollee using motivational interviewing and teach-back techniques to empower them to realize their health improvement and recovery goals.

SUMMARY OF APPROACH TO INCLUDE ENROLLEES, CAREGIVERS AND MULTI-DISCIPLINARY CARE TEAMS IN THE CARE PLANNING PROCESS

WellCare of Kentucky's fully integrated care model factors in a member's physical health, behavioral health, pharmacy, long-term services and supports (LTSS), and social resource needs under a single fully in-sourced infrastructure with a single line of accountability, single integrated technology system (CareCentral), and an integrated team-based approach. We ground our care model in our organizational mission to help members live better, healthier lives. Person-centered care reflects the choice and voice of each member and their family or caregiver, as applicable, and addresses a member's unique personal goals. Our approach:

- Begins with a clinically robust identification process supported by Enrollee outreach and deep data analytics to stratify the Enrollee by acuity and ensure the right level of intervention based on need, site of care availability and local resource allocation
- Supports a comprehensive assessment process, including identification of social determinant of health needs
- Encourages the involvement of MDTs
- Supports a person-centered approach to care and service planning that is fully integrated addressing Enrollee physical, behavioral, pharmacy, and social service needs as well as long-term supports and services where applicable with a focus on community placement in the least restrictive setting of the Enrollee's choice

- Emphasizes local care and service coordination at the site of care for Enrollees with complex needs
- In addition, our care model offers evidence-based integrated medical and behavioral clinical guidelines and leverages our custom-built clinical platform, CareCentral, to connect the care model through a single integrated IT system.

The MDT wraps around the Enrollee to coordinate the delivery of whole-person care. MDT participants work together to establish the care plan and to monitor and assist in meeting specific goals outlined in the plan. They alert the Care Manager to changes in an Enrollee's health status or needs. CareCentral aids in the formation and operation of the MDT by tracking contacts, sharing information collected through screens, assessments, and reassessments, sharing of care plans (goals, interventions) and integrated workflow management to assign tasks and follow-ups to MDT members.

Creating an MDT: Enrollees choose who they want to be included in the MDT and who gets to speak and advocate for them. As part of the Enrollee Needs Assessment, Care Managers ask Enrollees about trusted providers and specialty providers like pediatric specialists or BH specialists. The core MDT includes the Enrollee, the Care Manager, and the PCP who serve as primary contacts for care. The core MDT engages participation by others involved in an Enrollee's care, such as BH providers, specialists, housing specialist, state agency staff, community support staff, discharge planning teams, housing specialist, pharmacist, nutritionist, school personnel, and more depending on an Enrollee's needs or desires. CareCentral identifies all members of the final MDT and their contact information and their preference for contact.

Engaging MDTs: WellCare makes it easy for MDTs to participate in and stay informed about an Enrollee's care. We meet providers where they are—in offices, hospitals, and nursing facilities—and use technology where available and when appropriate to facilitate meetings to discuss an Enrollee's case. CareCentral empowers real-time collaboration among MDT Enrollees. Workflows extend beyond shared notes and secure text messages to incorporate multi-dimensional media, video-conferencing, shared dashboards and reports, and alerts. Care Managers make personal contact with an Enrollee's suggested MDT members to explain their responsibilities on the team and its importance to the Enrollee's care. The Care Manager provides a copy of the care plan to MDT members.

In addition to creating an MDT for high-needs Enrollees to establish a care plan, a Care Manager may engage the MDT when an Enrollee:

- Undergoes a care transition from one clinical setting to another
- Has a change in level of care, or experiences an unplanned inpatient admission or ED visit
- Is identified by a pharmacist or predictive modeling as being on a high-risk medication regimen, not following a medication regimen, or overusing opioids or other medications
- Experiences a significant change in circumstance or non-health changes, including loss of a caregiver, housing, or other natural or social support
- Wants or needs support to remove barrier(s) to achieving goals

It takes a Village: Working Across Steakholders to Serve Those in Need

A WellCare of Kentucky member in Louisville with limited cognitive function and with a state-assigned financial guardian became a frequent visitor to the emergency room, sometimes having multiple visits a day. When he came to the attention our Care Manager, Mike, the Enrollee had more than 30 ER visits in one month. Mike not only engaged the Enrollee, who suffered with early Alzheimer's, COPD, and chronic asthma, but he engaged a broad MDT to help the Enrollee address the isolation he faced and health conditions driving him to the ER. Mike worked with the coordinator of counseling services at Norton Hospital, the Enrollee's PCP, the Louisville Fire Department's Paramedical unit, the Enrollee's financial guardian, and the APS worker. Over time, the Enrollee's ER utilization waned, but Mike continued to watch closely even after the Enrollee declined further help. After more than a year, when the Enrollee started showing back up in the ER and the hospital, Mike once again engaged with the Enrollee and his MDT to look for better long-term solutions to the Enrollee's living situation and health needs, as his cognitive function and ability to perform activities of daily living independently were continuing to deteriorate. Eventually connecting him with the long-term care program, Mike was able to help the Enrollee stabilize into a program and residence that allows him to be in a safe and caring environment with ample socialization.

f. Stakeholder engagement strategies, including involvement of community resources to meet social needs.

Every element of our PHM program is foundationally supported by our unique approach to stakeholder engagement and involvement of community resources to meet social needs — our Community Connections program. We know through research from the Robert Wood Johnson Foundation and County Health Rankings that the majority of what affects health outcomes occurs outside of the doctor's office. If a family wakes up and their electricity has been cut off, they will not prioritize getting their child to a well-child checkup that day. In turn, this could cost our health care system more, especially if Enrollees are going to the ED just to receive a hot meal and a warm bed to sleep in for the night. We recognized this and created the Community Connections model in 2011, long before addressing social determinants of health became part of standard Medicaid managed care operations. Through Community Connections, advocacy staff and PHM staff partner to engage stakeholders to address both individual Enrollee needs as well as larger population health challenges. We know that serving the community as a whole is not only the right thing to do, but it ultimately affects our Enrollees' wellbeing. To do this, Community Connections focuses on four distinct elements.

Making a Local Impact on SDOH

Since launching the Community Connections program in Kentucky, we have connected more than 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in emergency department visits, and a 53% decrease in inpatient spending.

Social Service Database: First, we created a database that our Community Engagement Partners populate on a local level. The database consists of every type of social resource our Enrollees may need, such as food access, transportation, links to services for people experiencing homelessness, etc. We want to have a robust database that can aid our Enrollees in finding what they need with information that is as current and detailed as possible. For someone who has not accessed those services before, it can be daunting and having details only helps break down barriers. For example, food banks often are only open certain days or require certain documentation to be considered eligible for assistance. That is why our local staff works to gather information at the local level about what a resource offers so we can share that information with our Enrollees before they step foot in a community organization's office for assistance.

We do this by keeping a finger on the pulse of what is going on in the community. By working with our community partners to gather what they offer, by being present in the community, we can help our Enrollees more holistically. With our database, we are also able to check back in with our Enrollees to see if they accessed the service to close the loop on the referral and if not, why. This helps us identify what we can do to further help our communities. The most important way we stay connected to our community partners is through participating in community activities, such as coalitions, interagency councils, and sitting on the Boards of Directors of nonprofit agencies.

Building Close Connections through Community Engagement

WellCare's relationship with Prevent Child Abuse Kentucky (PCAK) began through a conversation with a local Community Engagement Partner and PCAK's Engagement Manager during a community coalition meeting. This initial conversation led to a joint meeting with PCAK and WellCare's Community Connections leadership where we brainstormed opportunities to collaborate. Those brainstorms led to various projects including community grants to promote PCAK child abuse awareness events across the state and funding of a Safe Sleep/Abusive Head Trauma video to PCAK for a partnership with Kentucky Hospital Association to show the video to all new moms to help prevent shaken-baby syndrome and other abuse. Through these collaborations PCAK requested Sr. Manager of Community Engagement, Elizabeth Starr join the Board of Directors where she now sits on the External Public Affairs Committee. This partnership also led to WellCare of Kentucky's State President, Bill Jones, providing opening remarks and introducing Gov. Matt Bevin before beginning the Pinwheel Planting on the Capitol front lawn in 2018.

Community Impact Councils: Another way we engage stakeholder is by facilitating Community Impact Council's (CIC). This process brings together different community members to talk about the strengths in the community, but also where there are some opportunities. Local Community Impact Councils are strongly rooted in local communities and CIC membership typically includes individuals who have strong connections in their community, with social and financial capital connected to their community. One particular area of attention is the availability and sustainability of social resource organizations that remove social barriers to accessing health care for our Enrollees. Our goal is to understand the community's existing

services, to pinpoint the most urgent gaps and to identify action steps to address those priorities while seeking creative ways to sustain social resource organizations and the services they provide in local communities.

Social Service Resource Help Line and Call Center: Knowing that the need existed for Kentucky's Enrollees outside of higher risk levels of care management to be connected with social resource organizations, WellCare created the Community Connections Help Line (CCHL) in 2014. In 2018, WellCare opened a Care Center in Hazard, which houses one of the four national locations for the CCHL. This telephonic social service referral line is manned by Peer Coaches and liaisons who assist callers in finding and accessing needed social services. They provide Enrollees with information about available benefits and connect individuals to social resource organizations to address social determinants of health. These peer-support coordinators, hired through workforce innovation represent many diverse cultures including individuals with disabilities, seniors, caregivers, students, veterans and military families. Coordinators have first-hand experience navigating social services or have "lived" experience and can skillfully identify primary cause issues present in individuals' lives. For example, a Peer Coach could uncover that a mother calling for housing support is actually experiencing domestic violence and needs a referral to a domestic violence shelter such as Turning Point in Eastern Kentucky that covers Floyd, Johnson, Magoffin, Martin, and Pike Counties. We also employ Health Coaches, who work closely with Enrollees to ensure they understand their care needs and assist with barriers to care through referrals to our care management and Community Connections programs.

Since launching, 6,466 Enrollees have been referred to 18,955 services in Kentucky through the Community Connections Help Line.

Addressing a Statewide Need, One Community at a Time

From 2015-2019, Community Engagement Partners have facilitated 8 Community Impact Councils (CIC) in counties across the Commonwealth to bring community leaders together who have identified transportation as the most urgent social safety net gap within their county. Using WellCare's internal database, Community Connections has also seen transportation as a top referral in Kentucky. WellCare has partnered with Bluegrass Community Action Partnership (BGCAP), LKLP Community Action Agency, Pennyrile Allied Community Services (PACS), and Rural Transit Enterprises Coordinated (RTEC) as local transportation providers who attended the CICs held in their communities. As a result, WellCare invested to provide free transportation to non-billable medical services as well as to employment and education services, WIC appointments, grocery stores, pharmacies and more to individuals in 20 counties. For Enrollees using PACS, we saw a 12.6% decline in ER use and 29% drop in inpatient admissions among Enrollees with diabetes, as just one example of the success of this collaboration.

Community Investments and Data Exchange Agreements with Partners: Another important part of our program is the investments we make in communities across the Commonwealth. WellCare's Community Connections team leverages the data captured through our internal database along with information gathered from being part of the communities we serve to

determine where the greatest needs are and how WellCare can assist social resource organizations in sustainably providing their programming.

In 2011, we made a conscious choice to invest dollars back in the community instead of using traditional marketing techniques because we saw grant funding to community-based organization's disappearing as the economy was changing. Using the social service data, the Community Engagement team identifies when services are needed and then mobilizes resources to (re)create the needed service by establishing community contracts to assess impact and pilot new outcome-focused payment models with community partners. The savings we see in reduced ER and inpatient use from removing social barriers are reinvested back into the community through investments and contracting designed to increase data-sharing capabilities or sustain critical social services.

In 2018 WellCare learned about the faith based organization Water into Wine Food Pantry located in Magoffin County Kentucky when they were mentioned as a partner of the Christian Appalachian Project in a community meeting. At the beginning of July 2018, the local Community Advocate reached out to Jeff Tackett, Water into Wine's Community Outreach Coordinator, to learn more about their program. After an invitation to visit their campus to see the food pantry and meet the staff that work there every day, Mr. Tackett explained that the federal government released a $50 million grant aimed at subsidizing dairy framers for milk products. In return, this milk was pledged to local pantries to distribute on a monthly basis, yet they did not have the needed refrigeration to maintain such donations. Mr. Tackett stated that the only reliable refrigeration they had at the time was a freezer and expressed a need for refrigerators/coolers for the additional milk that they would soon be given. WellCare was able to provide a grant to Water into Wine to purchase commercial refrigeration to store milk and dairy products, and also assisted in the storage of fresh fruit and vegetables that are susceptible to a short shelf life. Today, they receive close to 50 gallons of milk three days a week. This milk is given to their clients which is increasing the nutritional value of their pantry visit, which ultimately supports better health.

g. Technology and other methods for information exchange, as applicable.

Our PHM staff uses CareCentral, our fully integrated clinical platform, as the single gathering point for all Enrollee-level information. With our implementation of CareCentral, we integrate information from multiple sources in a single source of truth for an Enrollee, including data we get from providers, either directly or through KHIE, such as ADT information. CareCentral stores all authorizations for services, as well as assessments and care plans. We track individual Enrollee utilization and identify gaps in care, which is stored and easily accessible in the CareCentral system. CareCentral then connects to our provider and Enrollee-facing systems to share information as needed and appropriate.

Exchanging information with providers: We provide Enrollee data and care plan access to our network providers using the secure provider portal. Detailed information on individual Enrollees is available through our "Appointment Agendas," which give providers a checklist of things the Enrollee needs based on diagnoses, conditions, and open care needs. We encourage the use of electronic health records (EHRs), using KHIE for provider data exchanges. When the

new contract period begins, we will begin requiring all our network providers to sign a Participation Agreement with the KHIE. Our Network Management, QPAs, and PR Reps will train providers on the benefits of EHR and KHIE adoption in person and telephonically.

We offer a variety of other data sharing modalities, and have recently improved our data analytics capabilities to include more customized provider reports and tools with the ability to:

- Provide actionable data, including reason for non-compliance with A1c Control (e.g. measure is above 9 or the test was not even completed or Enrollee hasn't been seen)
- Customize reporting based on specific measure sets or specific data elements by Enrollee, by provider, or by ZIP code
- Prioritize Enrollees or families based on Quality Stratification Index which identifies Enrollees/families with multiple care gaps or Enrollees with difficult to address care needs
- Create a task at the household, provider or Enrollee level to coordinate across the multidisciplinary care teams, quality and provider relations

Another way we exchange information with our providers is through the Provider Engagement Model (PEM), which includes a dedicated team of regionally dispersed local experts who live and work in the communities they serve. This team helps providers improve performance in VBP arrangements by analyzing provider performance data, sharing this data with providers, assessing opportunities for improvement, recommending ways to improve performance and holding providers accountable for action plans.

EXCHANGING INFORMATION WITH ENROLLEES

We offer Enrollees information, such as care needs, in the secure Enrollee portal and through our mobile Enrollee app. Because not all Enrollees access technology, our PHM staff also prints out materials such as the Enrollee Needs Assessment, care plans, and educational information as needed so that all Enrollees have a complete package of material to guide their engagement in the PHM program.

Our experience in the Commonwealth has taught us that engaging Enrollees in their health care increases the likelihood that they will receive recommended preventive care and improve their health outcomes. When Enrollees receive preventive care, providers are able to close care needs, and manage total cost of care. We have improved our Enrollee engagement through the following programs:

- Our **PCAs** co-locate in provider offices to work side-by-side with practices in accessing our latest Enrollee care needs and provider-based reports and can work inside the practice to engage Enrollees.
- Our **QI Care Needs Coordinator** program conducts continuous telephonic outreach to Enrollees not engaged with a PCA, a **Health Coach,** or **Care Manager.**
- Our Unable to Contact **(UTC) REACH program** is designed to locate hard-to-find Enrollees and connect them with our **Community Connections** resources, such as community supports to promote stable housing, utility assistance, and support groups in addition to connecting to appropriate medical and behavioral health care.
- We are organizing Enrollee focus groups throughout 2020, which our newly hired Director of Enrollee Experience will lead. These forums will help us to continue learning about our

Enrollees' experience and needs, ensuring we invest in resources and drive operational improvement to provide the best managed care environment leading to happier, healthier Enrollees.

- We send **targeted mailings** to Enrollees, reminding them of recommended preventive care including **periodicity screenings** and the importance of medication adherence.
- Our **PSO** outbound Enrollee activation and calling program is informed by advanced analytics, based on open care needs and guided by behavioral analytics of how to best engage Enrollees.
- Our **Healthy Rewards program** offers Enrollees opportunities to receive reloadable debit cards or gift cards (which comply with state and federal guidelines) for stores to purchase needed personal, home, baby, and family-related items that promote good health behaviors for practicing healthy behaviors, such as visiting their PCP for wellness visits. **In 2019 WellCare of Kentucky closed 43,738 care needs using our Healthy Rewards program with $1,018,155 distributed to Enrollees in the form of gift cards.**

QUALITY DEPARTMENT INFORMATION EXCHANGE

In addition to technology-enabled information exchange, WellCare of Kentucky's Quality Department teams, which consist of local experts, from leaders to support staff, who live and work in the communities they serve, collaborate with our Population Health Management department to provide comprehensive and holistic care for our Enrollees. Our integrated and focused regional team of Kentucky-based associates engage our Enrollees, providers and stakeholders through various channels, including:

- *Health Coaches conduct* continuous telephonic outreach to our most vulnerable Enrollees and have made more than 13,000 successful coaching calls to Enrollees, educating them on recommended critical screenings and preventive services, helping to bring awareness to Enrollee health needs and transform Enrollee lives since the program's inception in February 2019. In addition, we will expand our program to include two additional Health Coach teams comprising local experts, focusing on smoking cessation, obesity and pre-diabetes/diabetes.
- *Care Needs Coordinators* continuously outreach to Enrollees telephonically to educate them on recommended care needs and help schedule appointments for those Enrollees not engaged in a PCA practice or in a care management program.
- *Patient Care Advocate (PCA) team* who are co-located in provider offices and assist Enrollees in scheduling appointments through telephonic outreach and direct Enrollee engagement, educate on care needs and assist in removing barriers to care.
- *Member Outreach Coordinators (MOC)* who use our Unable to Contact (UTC) program, REACH, to locate Enrollees for whom we have incorrect or missing contact information. We currently focus out UTC outreach in region 8 due to the prevalence of clinical complexities and social determinants of health that increase the UTC rate in this rural area.
- *Kentucky QPA Teams:* Three teams of regionally located QPAs are responsible for assisting providers in closing care needs. They educate providers on HEDIS and HPR measures and the importance of completing appointment agendas. Appointment agendas allow our physician partners to identify, in a single report, Enrollee chronic conditions and care needs

that need to be addressed during an appointment. QPAs assist provider groups in practice transformation in order to develop coordination of care for patients. In addition, QPAs are responsible for EPSDT and AMRR audits, reviewing results directly with providers and developing corrective action through identifying opportunities to increase efficient and effective use of EMR templates and care alerts, office work flows and coding to improve capture of quality services. In addition, QPAs assist with referrals to and coordination between care management as needed. In preparation of the new contract, we are implementing specialized QPAs to provide focused support to specialty providers, including Behavioral Health and OB/GYN. The Behavioral Health QPA will focus on care coordination between medical and behavioral health needs and the OB/GYN QPA will focus on women's health needs. Both will conduct visits with their respective specialty providers to educate them on performance management and our programs.

h. Frequency of provision of services.

Each Enrollee stratified in the Management of Chronic Conditions and Complex Care Management risk levels and engaged with care management will have a care plan to address his/her individual health related needs. Care plans are highly individualized and establish based on individual needs, individual frequency of interventions and service provision. However, we do establish standards of frequency based on high-level need so we can monitor compliance and efficacy of individual Care Managers and services provided, as described **in Table C.24-9**.

Table C.24-9 Provision of Services

Frequency of provision of services	
Health Promotion and Wellness	Annually through the HRA Access of self-management tools by Enrollee Care gap interface with educational materials and reminders, as needed (e.g., flu shots) New Enrollee welcome kit Quarterly newsletter
Management of Chronic Conditions	Includes all Health Promotion and Wellness service frequency, plus: *Moderate risk stratified* - Initial and monthly telephonic outreach for Enrollees with emerging risk or a chronic condition *High risk stratified* - Up to weekly face-to-face or telephonic outreach, along with coordination of medical, behavioral, pharmaceutical and social needs for Enrollees with emerging risk or one chronic condition
Complex Care Management	Includes all Health Promotion and Wellness service frequency, plus: *Moderate risk stratified* - Initial and monthly telephonic outreach for Enrollees with the complex care factors as stated in the contract *High risk stratified* - Up to weekly face-to-face or telephonic outreach, along with coordination of medical, behavioral, and social needs, for Enrollees with the complex care factors as stated in the contract

i. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).

We continually review data and rely on our experience on the ground to identify priority areas to focus on in partnership with DMS. We identify all the priority conditions noted by DMS in Section 34.2 of the Draft Contract**,** and identify additional ones as data and experience informs, such as transplant patients or Enrollees with significant social service needs. We build specific condition-based interventions on priority areas and populations. We also collaborate with the community as described in stakeholder engagement above to identify priority social determinants of health, such as transportation and food insecurity, to focus on our investments and engagement.

PRIORITY CONDITIONS

We understand the prevalence of lifestyle-based conditions across the Commonwealth and have designed a variety of condition-based interventions and programs to help Enrollees regardless of risk level. We continually refine and add specific risk areas, such as our recent emphasis on programming around Opioid Misuse. **Table C.24-10** indicates what our data shows related to prevalence of priority areas across the Commonwealth as well as the success of targeted interventions for each condition.

Table C.24-10 Outcomes by Priority Conditions

Priority Conditions, Populations and Risk Areas

Program	Prevalence	Improvement From 2016 to 2018	
Asthma	18.5%	Inpatient Admits/K ER Non-Emergent Visits/K	Reduced by 10% Reduced by 20%
Heart Disease	20.8%	Inpatient Admits/K ER Non-Emergent Visits/K	Reduced by 6% Reduced by 14%
Diabetes	8.7%	Inpatient Admits/K ER Non-Emergent Visits/K	Reduced by 4% Reduced by 12%
Obesity	27.4%	Inpatient Admits/K ER Non-Emergent Visits/K	Reduced by 2% Reduced by 17%
Tobacco Use	16.3%	Inpatient Admits/K ER Non-Emergent Visits/K	Reduced by 9% Reduced by 16%
Cancer	0.9%	HEDIS 2018 Breast Cancer Screening HEDIS 2018 Cervical Cancer Screening	Increased 10% (Ranked 1st in KY) Increased 18% (Ranked 1st in KY)
Infant Mortality	0.4%	HEDIS 2018 Well-Child 15 (6+ visits in first 15 months)	Increased 24% (Ranked 1st in KY)

Program	Prevalence	Improvement From 2016 to 2018	
Low Birth Weight	5.3%	HEDIS 2018 Timeliness of Prenatal Care	Increased 1% (Ranked 1st in KY)
Behavioral Health and Substance Use	39.4%	Inpatient Admits/K ER Non-Emergent Visits/K	Reduced 6% Reduced 18%

Table C.21-10-a through **Table C.21-10-h** below describes specific condition programming and interventions targeted to the highest risk areas, most prevalent conditions, and DMS priorities.

Table C.24-10-a Population Health Condition Priority: Asthma

Population Health Condition Priority: Asthma	
Our Breath of Life Asthma Program embodies a holistic, comprehensive approach. It promotes wellness, improves chronic condition management, and improves population health through collaboration with communities. Multi-modal, targeted interventions through various channels improve health outcomes through innovative treatment and prevention efforts. The program is working for participants in Kentucky, where we saw a 64% decrease in admissions of children with asthma, and a 51.8% decrease in admissions for adults with asthma in 2018. • *Across Kentucky, we saw improvements on the following measures between 2016 and 2018, indicating a shift from costly, uncoordinated care to more effective coordinated care: ER visits/1,000, Inpatient Admissions/1,000, and Specialist visits/1,000.* • In Region Seven, where 23% of the Enrollee population has an asthma diagnosis, we have seen positive utilization trends: *15.3% reduction in ER visits/1,000, 1% reduction in IP Admissions/1,000, and a 6.6% increase in specialist visits.*	
Interventions	
Enrollee Interventions • Value-Added Services: OTC options; free vacuum cleaner with HEPA filters; hypoallergenic bedding; medical masks • Support and Tools: care plan and appointment reminders; online self-management tools; peer support • Physical Activity: WellCare's Asthma App for Enrollees to update action plan and track medications and activity • Counseling/Consultation Services: Health coaching; in-home assessments for safety; education to family	• Education Materials: Living an active, healthy lifestyle; understand environmental factors; explanation of health conditions; the important of compliance with maintenance medications *Provider Interventions* • Value-Based Payments: Incentives to improve Enrollee asthma outcomes • Tools: RPM for controller and rescue measured dose inhalers and reminder calls; telehealth; MDLive partnership • Education: Educational information through Provider Portal; CareCentral, Provider Manual; Provider Newsletter articles

Population Health Condition Priority: Asthma
Program Goals
• Improved Enrollee perception of health at discharge from care management as evidenced by an increased score in on the short form health survey (SF-12/SF-10) • Positive Enrollee Satisfaction Survey results • HEDIS Care Gap Reduction • Admission and Readmission Reduction • ED Utilization Reduction • Decreased need for rescue medication over a specific period of time after Case Management engagement • Fewer exacerbations requiring acute medical care and intervention
Partnerships and Collaborations
Local Environmental Agencies: Support Enrollees, family, and the community to manage environmental issues and asthma; Indoor, outdoor and worksite air quality; and to emphasize the importance of reducing tobacco use and exposure to secondhand smoke and allergens that can affect the Enrollees breathing such as pets in the home Kentucky Homeplace (KHP): Partnered in 2016 to help remove barriers to access for rural individuals in 30 counties. Individuals with chronic diseases such as asthma, actively engage in a six-week program that includes weekly meetings to learn about and take steps toward improving nutrition, medication use, exercise, communication, and decision-making. American Lung Association: Refer Enrollees to smoking cessation and peer programs.
Innovating to Treat Asthma
WellCare of Kentucky conducted a six-month pilot program through the Boyd County Health Department, which targeted kids with uncontrolled asthma. Healthy Homes 4 Healthy Kids provided multi-level interventions delivered through home visits, follow-up phone calls, and other efforts by staff trained in environmental home assessments and in asthma education and medication. In an innovative approach to empowering Enrollees to engage in their health, we provided iPads for access to online asthma resources and tracking inhaler use.

Table C.24-10-b Population Health Condition Priority: Heart Disease

Population Health Condition Priority: Heart Disease
Our Heart Disease Program (coronary artery disease, congestive heart failure, and hypertension) supports Enrollees' condition management through education, guidance, and support to learn more about their unique health concerns and to increase their ability to self-manage in accordance with their provider's treatment plan. The programs use evidence-based clinical practice guidelines and guidelines from the American College of Cardiology (ACC), American Heart Association (AHA), the American College of Cardiology Foundation (ACCF), and the Institute for Clinical Systems Improvement (ICSI), with additional direction from National Committee for Quality Assurance (NCQA), United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), and Agency for Healthcare Research and Quality (AHRQ). **Our HEDIS scores are above average for the**

Population Health Condition Priority: Heart Disease	
Commonwealth on measures related to heart disease, including Controlling High Blood Pressure - Total (CBP18) and Comprehensive Diabetes Care - Blood Pressure Control (<140/90) (CDC18): We rank 2nd in Kentucky for coronary artery disease-related HEDIS measure, Persistence of Beta-blocker treatment after a heart attack.	
Interventions	
Enrollee Interventions • Value-Added Services: OTC options; Healthy Rewards-financial incentives for healthy decisions and care gap closures • Support and Tools: Care gap reminders and care plans; online self-management tools; peer support; provider search • Provider Outreach: Outreach based on risk level • Education and Training: Self-monitoring and reporting; regular provider visits, vaccinations; nutrition/activity guidance	*Provider Interventions* • Value-Based Payments: Incentives to improve Enrollee cardiovascular outcomes • Tools and Support: Provider Portal; CareCentral; locally embedded QPAs • Education and Training: Learn tactics to support Enrollee self-management; early identification and treatment • Coaching: Stress management; medication adherence and timely refills; supporting tobacco cessation efforts • Guidance for Information Sharing: As appropriate when risks are identified
Program Goals	
• Improved Enrollee perception of health at discharge from care management as evidenced by an increased score in on the short form health survey (SF-12/SF-10) • Positive Enrollee Satisfaction Survey results • HEDIS Care Gap Reduction • Admission and Readmission Reduction • ED Utilization Reduction • Improved LDL (target <70); based on provider's goal for Enrollee and Enrollee's personal goal; compare cholesterol lab data pre- and post-engagement at 6-12 months • Improved blood pressure: systolic (target <130) or diastolic (target <80); monitor and compare data sources pre-and post-engagement at 6-12 months • 5% weight loss for overweight members; monitor and compare weight documented in provider records pre- and post-engagement at 12-18 months	
Partnerships and Collaborations	
WellCare of Kentucky Plan President: Enrollee of the AMA board *Community Relations Team:* Participates in community events, including Healthy Hearts Wear Red; AHA Executive Challenge; Go Red for Heart Health - Health Fair; and the Happy Heart luncheon in Boyle County.	

Table C.24-10-c Population Health Condition Priority: Diabetes

Population Health Condition Priority: Diabetes	
Our Diabetes Program aims to prevent diabetes from occurring in at-risk and pre-diabetic Enrollees through diet, exercise, medication adherence, and lifestyle changes, helping empower them to achieve positive health outcomes. We refer Enrollees to local resources through our Community Connection model, which can connect them to area partners for physical activity and healthy eating opportunities, and to community prevention programs with the goal of reducing obesity, diabetes, and heart disease. The program uses evidence-based clinical practice guidelines and guidelines from the American Diabetes Association (ADA), American Academy of Pediatrics (APA), NCQA, USPSTF, NQS, and AHRQ, and specialty association, colleges, and societies. WellCare of Kentucky is a leader among MCO in addressing Diabetes. **We rank first for the following HEDIS measures related to diabetes care, nutrition, and physical activity counseling: WCC Child BMI, Adult BMI Assessment (ABA18), WCC Nutrition Counseling, WCC Physical Activity Counseling, and Comp Diabetes Care - Eye Exams (CDC18).** • **Our rank for the HEDIS Child BMI measure improved by almost 49 percentage points between 2013 and 2018 In 2018, 87% of our Kentucky Enrollees had HbA1c testing (4% above the US average), 92% had kidney monitoring, and nearly 60% had an annual diabetic eye exam. We attribute these successes to our Diabetes program interventions.** • **In Region Eight, where 12% of the Enrollee population has a diabetes diagnosis, we have seen positive utilization trends, including a 6.3% decrease in ER visits/1,000, an 81% decrease in inpatient medical-surgery admissions/1,000 and a 4.9% decrease in inpatient medical surgery 30 day readmissions.**	
Interventions	
Enrollee Interventions • Clean Out Your Pantry Program: Encourage Enrollees to adopt a healthy diet, active lifestyle, and healthy weight management • Fit4D: Diabetes coaching solution that provides personal care through human interaction and technology • Pharmacy Assistance: Pill splitter; home medication delivery; and CVS Pharmacy Advisor Support program • Counseling and Consultation Services: Health coach helps Enrollee understand symptoms, treatment, testing and exams • Value-Added Services: Healthy Rewards-financial incentives for completing preventive care and A1C testing; MyStrength	*Provider Interventions* • Education and Training: Importance of calculating BMI at every Enrollee visit and refer at-risk and pre-diabetic Enrollees to our prevention program. **We rank first among MCOs in the Commonwealth for BMI assessment measures.** • Support and Tools: Access to Prevent Diabetes STAT toolkit from the American Medical Association (AMA), AAP, and CDC
Program Goals	
• Improved Enrollee perception of health at discharge from care management as evidenced by an increased score in on the short form health survey (SF-12/SF-10)	

Population Health Condition Priority: Diabetes
• Positive Enrollee Satisfaction Survey results • HEDIS Care Gap Reduction • Admission and Readmission Reduction • ED Utilization Reduction • HbA1c < 7%; compare lab data pre- and post-engagement at 6-12 months • Maintain healthy diet; compare Enrollee's knowledge and dietary habits pre- and post-engagement at 6-12 months • Glucose control with target range of 80-120 before meals; compare lab data pre- and post-engagement at 12-18 months • Moderate physical activity regimen with minimum 30 minutes on most days; compare level documented pre and post-engagement 6-12 months
Partnerships and Collaborations
Team Ultra: We partner with the Marshall County Health Department to provide Team Ultra programming for school-aged children in the western part of the state. Through Team Ultra, children have access to this social support along with nutrition counseling and physical activity, **which can prevent the onset of diabetes.** ***"For the past three years, my girls have participated in Team Ultra at Central Elementary in Marshall County Kentucky. They love it! It has let them learn about getting more active and eating healthy. My girls always come home telling me what new thing they learn from Team Ultra. I hope that they get to continue to participate in Team Ultra for many years to come.*** ***-Thank you, Kendra James"*** *Kentucky Homeplace:* Links Enrollees in rural Kentucky to medical, social, and environmental services; Barren River District Health Department (BRDHD): Pilot to enroll Enrollees into a Diabetes Prevention Program (DPP) which is not currently covered by Medicaid; Come-Unity Cooperative Care: Operates a food pantry in Laurel County

Table C.24-10-d Population Health Condition Priority: Healthy Weight Management

Population Health Condition Priority: Healthy Weight Management
Our Healthy Weight Management Program embodies a holistic, comprehensive approach to addressing one of the most common chronic diseases in Kentucky and is a major risk factor for development of debilitating diseases, such as diabetes and cardiovascular disease. In 2018, 31% of adult Enrollees had an obesity diagnosis. **WellCare of Kentucky is a leader among MCOs in addressing Obesity. We rank first for HEDIS measures related to adult BMI and nutrition and physical activity counseling. We attribute these successes to our program interventions, particularly provider education.** Across Kentucky, we have seen improvements since 2016 that indicate a shift from costly, uncoordinated care to more effective coordinated care**. In Region Eight, where 36% of the Enrollee population has obesity, we have seen positive utilization trends, including a 5% decrease in inpatient admissions/1,000 and a 5% increase in outpatient visits/1,000. ER visits/1,000 showed a 11% decrease and specialist visits/1,000 increased by 8%, indicating a move to lower cost more appropriate places of service overall.**

Interventions	

Enrollee Interventions
• Enrollees enrolled in our six-month Healthy Weight Management Program work with a health coach and:
  o Learn to cook culturally sensitive healthy meals, and develop healthy lifestyle habits (e.g., weight loss)
  o Receive education materials on healthy eating choices, the benefits of exercise, diabetes symptom identification
• Healthy Rewards: Provides financial incentives for completing preventive care and A1C testing
• MyStrength: Online health coaching and support
	Provider Interventions
	• Education and Training: Importance of calculating BMI at every Enrollee visit and refer at-risk and pre-diabetic Enrollees to our prevention program. **We rank first among MCOs in the Commonwealth for BMI assessment measures.**
	• Support and Tools: Access to Prevent Diabetes STAT toolkit from the AMA, AAP, and CDC

Program Goals

- Improved Enrollee perception of health at discharge from care management as evidenced by an increased score in on the short form health survey (SF-12/SF-10)
- Positive Enrollee Satisfaction Survey results
- HEDIS Care Gap Reduction
- Admission and Readmission Reduction
- ED Utilization Reduction
- HbA1c < 7%; compare lab data pre- and post-engagement at 6-12 months
- Maintain healthy diet; compare Enrollee's knowledge and dietary habits pre- and post-engagement at 6-12 months
- Glucose control with target range of 80-120 before meals; compare lab data pre- and post-engagement at 12-18 months
- Moderate physical activity regimen with minimum 30 minutes on most days; compare level documented pre- and post-engagement 6-12 months

Partnerships and Collaborations

Community Farm Alliance and Mobile Market: Community farmers markets link Enrollees in Region Four to accessible health food

Phoenix Preferred Care and Phoenix Wellness: Projects that target sustainable nutrition initiatives, overall wellness, and community engagement in healthy lifestyles, such as community gardens

YMCA Kids Day: Community event in Henderson County to promote healthy eating

Strong Support from a Partnership

"I would like to extend Marshall County Health Department's support for WellCare's bid submission. Our organization has partnered with WellCare on Community Baby Showers, they have attended out health coalition meetings, and we have been fortunate to work with them on

Interventions
our after-school program Team Ultra. We have always been pleased with the partnership we hold with WellCare." ***-Jennifer Brown, MS, RD, LD, LDE, CLC,*** ***Public Health Services Manager, Marshall County Health Department***

Table C.24-10-e Population Health Condition Priority: Tobacco Use

Population Health Condition Priority: Tobacco Use	
Our ACT for Tobacco program encourages Enrollees to actively commit to healthy lifestyles and supports those who are ready to quit tobacco. We integrate anti-tobacco education into programming for adolescent Enrollees and continue to offer options for all our young people to make the ongoing decision to stay tobacco-free. Enrollees choosing to quit have access to custom quit programs and supports. Tobacco usage and its health effects disproportionately affect Medicaid recipients and diverse population groups. The program aggressively works to prevent anyone from becoming a user of tobacco products or e-cigarettes. The program makes cessation information and treatment available in clinical care settings and refers Enrollees to the WellCare Kentucky ACT for Tobacco Program and the Kentucky Quitline (1-800-QUIT-NOW). Between 2016 and 2018, WellCare of Kentucky saw positive utilization trends attributable to the ACT Program. ER visits/1000 decreased by 13% and specialist visits increased by 16%, indicating a shift from more expensive and uncoordinated care to more cost-effective coordinated specialist care Pharmacy costs increased by 8% a reflection of treatments to support tobacco cessation, such as NRT In Region Seven, specifically, where 19% of the Enrollee population uses tobacco, we have seen positive utilization trends, including a 10% decrease in ER Visits/1,000 and increases in PCP visits/1,000 (7%) and Specialist Visits/1,000 (7%)	
Interventions	
Enrollee Interventions • Value-Added Services: MyStrength self-directed online therapy to help Enrollees deal with tobacco use in relation to comorbid conditions such as anxiety, depression, or other substance use disorders; Healthy Rewards provides financial incentives for Enrollees to complete preventive screenings, attend appointments, and engage in healthy behaviors related tobacco cessation; access to NRT, non0nicotine prescription medications, and Kentucky Tobacco Quitline	• Vaping Interventions: Align with Commonwealth efforts toward prevention, recommending FDA-approved quit aids; Care Manager access; peer support services; motivational text messages; WellCare website and Enrollee portal *Provider Interventions* • Incentives driven by related EDIS measures; tobacco screenings in dental, vision and mental health settings • Engage providers to raise awareness about cessation services to Enrollees through the Provider Manual, Newsletters, and Website;

Population Health Condition Priority: Tobacco Use	
• Clinical Management: Personalized engagement and coaching • Physical Activity: Providers write Prescriptions for Activity	alert providers of Enrollee participating in tobacco cessation program • Education and training through the Provider Portal; includes access to clinical profiles, open care needs and chronic condition reports compared to state benchmarks

Program Goals

- Improved Enrollee perception of health at discharge from care management as evidenced by an increased score in on the short form health survey (SF-12/SF-10)
- Positive Enrollee Satisfaction Survey results
- HEDIS Care Gap Reduction
- Admission and Readmission Reduction
- ED Utilization Reduction
- Program completion/graduation
- 3% improvements in rate of medical assistance with smoking and tobacco cessation and behavior risk tobacco screenings
- Fewer admissions or ED visits related to cardiovascular or respiratory diagnosis; compare pre- and post-claims and service authorizations
- Increase in exercise endurance blood flow to the heart; decreased blood pressure and fewer respiratory symptoms; compare pre and post-documentation of Enrollee's vitals

Partnerships and Collaborations

Kentucky Tobacco Quitline: Offers 24/7 coaching, patches, and Text2Quit programs; Community Outreach Events: Distribute educational materials**.** To strengthen our partnership with the Kentucky Quitline, we will work to secure sharing of Enrollee information that will provide us.

Kentucky's Youth Program for Tobacco Cessation: Provide educational component; **Partner with the University of Kentucky**: Sponsor Kentucky Center for Smoke Free Policy, which provides assistance and financial support to Smoke Free Adair's efforts; **Smoke Free Coalitions in seven Kentucky counties** (Johnson, Caldwell, Henderson, Bracken, Gallatin, Carroll, and Adair); Provide funding for **Teens Against Tobacco Use** (TATU) peer mentoring program with Jessamine County Health Department and for **Freedom from Smoking** classes in numerous counties

Strong Support from a Partnership

"The insights you share at our monthly partnership meeting and at our special events are invaluable and our partnership Enrollees appreciate your dedication to the cause- especially because you are the only Medicaid provider to have attended our meetings."

-Mason County Tobacco Free Partnership

Table C.24-10-f Population Health Condition Priority: Cancer

Population Health Condition Priority: Cancer

Our Cancer Program approach includes interventions, goals, and expected outcomes that vary based on diagnosis, risk level, and various other factors. Our Cancer Programs address variations in practice around evidence-based treatments, give Enrollees and their families the knowledge to be actively engaged in their care, and aim to reduce economic waste from overtreatment spent on inappropriate care. We identify Enrollees for the program by referral or by using medical claim files populated with an ICD-10 code for cancer.

We recognize that nationally, 32% of cancer treatment plans deviate from evidence-based medicine, which increases clinical variation. There are wide variations in care along the cancer care continuum. WellCare approaches evidence-based cancer care management through a comprehensive, multi-faceted strategy to support our Enrollees in their treatment and survival. **Our approach is effective, and has positioned us first among MCOs in Kentucky in breast and cervical cancer screening.**

Interventions

Enrollee Interventions

- Work with Enrollees on the Importance of following recommended physician treatment plan, managing side effects of treatment per recommended treatment plan, taking medications as prescribed, education about mental health impact of cancer diagnosis, potential for bacterial infection while receiving chemotherapy, being aware of fevers, washing hands regularly, and education about behaviors that can increase survival rate, including not smoking
- Access to Krames education material on their specific condition and care gaps they should address

Provider Interventions

- Help Enrollees know when they are most susceptible to infection – when white blood cell counts are lowest (typically 7 to 12 days after chemotherapy is completed) to help them avoid infection
- Educate Enrollees about fevers, proper handwashing, and knowing the signs and symptoms that indicate a need to call the provider; and informing Enrollees about other important considerations during chemotherapy

Program Goals

Targeted health outcomes from successful Enrollee self-management: Enrollee experiences no symptoms requiring acute medical care and intervention, Enrollee satisfaction with cancer treatment team and plan

- *Care Goals* target specific care gaps or adherence issues, and measure the member's progress towards self-management and their adherence, which will lead to these targeted health outcomes. Examples:
- The Enrollee attends initial and follow-up appointments with cancer treatment team per treatment team recommendations over last 90 days (verified by claims or Enrollee/provider narrative)
- The Enrollee's prescription refills demonstrate at least an 80% adherence rate (verified by claims or Enrollee/provider narrative) over last 30 days
- The Enrollee is adherent to labs and diagnostics prescribed by the physician/cancer treatment team (verified by claims or Enrollee/provider narrative) over last 30 days

Population Health Condition Priority: Cancer
• Specific for Enrollees requiring hospitalization: The Enrollee participates in provider follow-up visit within 7-days of hospital discharge • Other measurable health outcomes may apply based on complications and comorbidities in the individual.
Partnerships and Collaborations
Kentucky CancerLink: Funds timely, reliable transportation assistance for Enrollees to access cancer screenings and treatment. The program provides $25 gas cards, local taxi rides, and third-party transportation services. *Community Relations Team:* Participates in community events such as Go Red for Women breast cancer awareness luncheon; and we hosted a Non-Profit Showcase where Hope Scarves spread the word about the amazing work being done locally and nationally to support those impacted by cancer.
WellCare Day of Service at Gilda's Club
Gilda Radner, of Saturday Night Live fame, passed away from cancer. In her honor, Gilda's husband formed Gilda's Club, a community clubhouse that provides opportunities to learn, share, and laugh in fellowship with others whose lives are affected by cancer. The first location opened in 1995, in New York with its signature red door to welcome families and individuals touched by cancer. In 2007, the red doors opened in Louisville. The organization provides support services such as yoga, art, mediation, support groups, and community dinner. In 2018, WellCare associates helped prepare for the Annual Thanksgiving Dinner at Gilda's Club, which 80 individuals attended.

Table C.24-10-g Population Health Condition Priority: Infant Mortality and Low Birth Weight

Population Health Condition Priority: Infant Mortality and Low Birth Weight
Our WellCare BabySteps program improves maternal health and birth outcomes through the delivery of services by multidisciplinary, integrated care coordination and care management services team. BabySteps is available to all pregnant Enrollees, regardless of risk level, from conception and up to a minimum of 60 days postpartum. The program works as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates maternity care management services and options to meet Enrollee needs. BabySteps delivers positive birth outcomes for both the mother and the infant, including a reduction in preterm births, NICU admissions, neonatal abstinence syndrome (NAS) newborns, and Caesarian section (C-section) rates. In addition, the program provides supports to ensure a strong start for the infant, with an emphasis on connecting the mother with needed services (e.g., WIC) and promoting attendance at well-child visits, including: • Early identification of pregnant Enrollees through authorizations, claims data, lab data, and eligibility files/834s • Assessment and stratification of pregnant Enrollees, using a standardized maternity assessment tool based on national best practice care guidelines, including those from the American College of Obstetricians and Gynecologists that evaluates the pregnant Enrollee's physical health, behavioral health, and social determinants of health.

Population Health Condition Priority: Infant Mortality and Low Birth Weight	
• Care Management, including a broadened focus to include minimal, moderate, and high-risk pregnant Enrollees o Coordination with providers to ensure delivery of appropriate physical, behavioral health, and social services for the individual member (e.g., delivery of 17P for members with a history of preterm birth, care for substance use) o Consistency in Care Manager assignment, even if the Enrollee's risk level changes o Services executed by internal staff Enrollees (not vendor personnel) located within the market that best know their Enrollee population, provider network, and local practice patterns. Across markets, care management programs may include Field and telephonic care management, with the flexibility for the Care Manager to engage the Enrollee in the most appropriate setting; Peer support, including doulas; and coordination with NICU and first-year care management, including promotion of postpartum care for mothers of children enrolled in the NICU programs	
Interventions	
Enrollee Interventions • Incentive program to encourage attendance at recommended prenatal care appointments, a postpartum visit with 21 days and a second postpartum visit between 22 and 84 days after delivery • Education materials related to pregnancy, including postpartum care • Mobile solutions, including smartphone applications that provide the Enrollee an opportunity to track their appointments and set reminders, access a 24/7 nurse line, video chat with a lactation consultant, or pediatric nutritionist; and maternity home care solutions (e.g., delivery of 17P for Enrollees at risk of pre-term delivery, members experiencing hyperemesis, gestational diabetes, and gestational hypertension).	• Enrollees with a high-risk pregnancy or chronic condition receive a free cell phone to stay in touch with your WellCare case manager, providers, and family members. *Provider Interventions* • Value-based contracting: Performance incentive programs related to maternity outcomes • Communication methods: provider website and handbook; provider relations; printed and electronic notification

Program Goals
o **Reduce preterm birth rate, low birth weight, NICU admit rate and NICU average length of stay** o **Decrease C-Section Delivery Rate** o **Reduce infant mortality rate** o **Reduce Early Elective Deliveries** o **Improve related HEDIS scores and achieve rates within the 75th percentile or above:** o Prenatal Timeliness o Postpartum Visit o Well Child 15 Months (6+ Visits) o Specific for Enrollees requiring hospitalization: The Enrollee participates in provider follow-up visit within 7-days of hospital discharge o Other measurable health outcomes may apply based on complications and comorbidities in the individual
Partnerships and Collaborations
WIC and HANDS: Partner since 2014, providing donations for baby showers and summer events *Community Relations Team:* Participates in community events such as Oh Baby Expectant Parent Fair and a Parent Empowerment Workshop *The Nest:* Provides parent classes, respite child care, domestic violence counseling, and crisis care

Table C.24-10-h Population Health Condition Priority: Behavioral Health and Substance Use

Population Health Condition Priority: Behavioral Health and Substance Use	
We are aware of and support the expansion of access to treatment and recovery services for individuals with SUD through a portion of the 1115 Medicaid demonstration waiver.	
Interventions	
Enrollee Interventions • Enhanced care management training; updated identification and stratification tool *Provider Interventions* Outlier prescriber program to reach out to the top 10 outlier for peer to peer consultation Resources and tools encouraging providers to become safe, judicious	We have created a comprehensive Opioid Misuse Prevention Program for members who are over-using opioid medications or appear to be at risk of doing so. The program contains interventions that support and promote safer prescribing of opioids, management of chronic pain with opioid sparing pharmacologic and non-pharmacologic modalities, early detection of opioid misuse and intervention, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and increased access to Naloxone and substance use disorder treatment, including Medication Assisted Therapy. To the extent possible, the program also engages Enrollee families and caregivers who are often impacted by behaviors of the index Enrollee. The program partners with Pharmacy Benefit relations to ensure customer communication of

Population Health Condition Priority: Behavioral Health and Substance Use	
prescribers of MAT services with support of behavioral therapeutic interventions Low back pain program involvement to explore alternative to opioid therapeutic treatment • Low back pain letters to support our care management program; outreach to outlier prescribers, information to providers on how to become MAT certified	the availability to Naloxone and MAT for our Enrollees, as well as education around the proper disposal of opioids. In 2017, we introduced an innovation to our lock in algorithm with the goal of improving identification of members at risk for opioid misuse and to decrease opioid utilization. In the first year of implementation we saw a decrease in: • Utilization of hydrocodone/acetaminophen and oxycodone/acetaminophen of 55% versus baseline • Benzodiazepine use by over 30% • Neurontin use by over 30% • Muscle relaxer use There are five components to our program: • Lock-In: outreach for above normal users of prescription pain medications to restrict them to one prescriber/pharmacy • Low Back Pain: outreach for selected members with low back pain who have been prescribed opiates and who are over-using opioid medications or appear to be at risk of doing so • Predictive Analytics: Outreach following proactive early identification of Enrollees prescribed opioids at risk of misuse • Point of Sale Pharmacy Edits: Implements prior authorization requirements, institutes quantity limits, and strengthens utilization review criteria for opioid prescriptions • Medication Assisted Treatment (MAT): Improves timely access to medications used in MAT by eliminating/modifying prior authorization requirements per state contact; encourages providers to consider being judicious MAT prescribers; ensuring customer service knows a 24-hour supply of MAT drugs can be given on an emergency basis, if needed
Program Goals	
The goals are to improve safety for Enrollees and decrease costs while cutting down on unnecessary opioid prescribing. Key success measures include: • Reduce Opioid Prescriptions/1,000 • Increase MAT Prescriptions/1,000 • Reduce Opioid Overdoses/1,000 • Reduce Opioid Related Deaths	

Population Health Condition Priority: Behavioral Health and Substance Use
Improve related HEDIS scores and achieve rates within the 75th percentile or above: • UOD (High Dosage) and UOP (Multiple Providers)
Partnerships and Collaborations
Shelter of Hope: Provides temporary, emergency shelter and food for veterans, families and individuals who are homeless or at risk of becoming homeless in Boyd and Greenup counties; **Approximately 50% of Shelter of Hope's client base is battling opioid use**; *Community Relations Team:* Participates in community events such as the Third Annual West Kentucky Wellness Summit Community Mental Health and Breaking the Stigma!; **Chrysalis House** to fill transportation gaps; **Children, Inc. Pregnancy Substance Abuse Education**: financial assistance to provide education to youth

j. Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of Care Managers.

WellCare of Kentucky offers stratified caseloads to meet Enrollee needs in all risk levels. Staffing thresholds may need to be adjusted based on regional circumstances (such as travel distances) and the risk profile of our membership. We give our Care Managers the option to exceed these ratios (for example 1:80 for Management of Chronic Conditions) as needed to meet the unique needs of their population. Our Enrollee ratios and staff credentials for each risk level follows in **Table C.24-11**:

Table C.24-11

Enrollee Risk Level	Recommended Caseload	Staffing Credentials
Low (Health Promotion and Wellness)	1:4,800	Care Coordinators (non-licensed) Health Coaches (non-licensed or registered dieticians)
Moderate (Management of Chronic Conditions)	1:125	RNs Licensed Social Workers Licensed Clinical Social Workers Bachelor Social Workers
High Management of Chronic Conditions (Complex Care Management)	1:60	RNs Licensed Social Workers Licensed Clinical Social Workers Bachelor Social Workers

We believe in leveraging one integrated care team to cover all care needs, including physical, behavioral, pharmacy, and unmet social needs. With this in mind, we developed our WellCare at Home field-based care management program. Within this model, we have developed an innovative organizational structure in which WellCare provides and oversees local care management, which includes local, in-person, Care Manager resources from WellCare and our partners, such as designated care management entities. WellCare at Home, supported by our advanced CareCentral care management system, ensures the administration of a seamless continuum of care management from initial screening through follow-up and monitoring at a point of care closest to the Enrollee.

Interface and interventions for Enrollees at each risk level are showing in **Table C.24-12** below.

Table C.24-12 Interface and Interventions

Risk Level	Risk Level Modes of Interface and Interventions
Health Promotion and Wellness	• Care Coordinators (non-licensed) and Health Coaches (non-licensed or registered dieticians) • Administer HRA for all new Enrollees (not enrolled with WellCare of Kentucky in the prior 12 months, and annually thereafter • Reach out for care gaps related to diabetes, immunizations, women's health (e.g., breast cancer, cervical cancer, osteoporosis, chlamydia), colon screenings, and maternity care • Provide wellness and prevention support, as needed; self-managed through online education materials and videos; can trigger additional support with health coaches for smoking cessation and weight reduction; Community Connections Help Line
Management of Chronic Conditions	• Includes all Health Promotion and Wellness interface and interventions plus our Care Managers and Behavioral Health Advocates • Administer Care Needs Assessment with annual reassessment or when there is a change in an Enrollee's conditions or circumstances • Develop person-centered Care Plan and assist with integrated care needs • Telephonic care coordination • Monitor and follow-up for indications of increasing risk level • Discharge planning and transitional care management • Possible MDT engagement, as warranted • Increased interventions when ID/Strat identifies a rising risk trend toward the high-risk level
Complex Care Management	• Includes all Management of Chronic Conditions interface and interventions plus our Care Managers and Behavioral Health Advocates • In-person interactions in an Enrollee's home, supplemented by phone contact • Provide frequent and intense MDT Enrollee engagement with more disciplines involved • Increase interventions when ID/Strat or a Care Manager identifies rising risk toward higher intensity care

k. If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.

100% of Kentucky Medicaid Enrollees are assigned to PCPs participating in our P4Q program.

WellCare of Kentucky has extensive experience working with our providers to develop and implement Value-Based Payment (VBP) programs. We understand the importance of our providers' interactions with our Enrollees and know they need to be rewarded for ensuring our Enrollees receive the necessary preventive services. Our VBP programs start with **Partnership for Quality (P4Q) program that includes participation by 100% of our PCPs. Payments in this program have increased from roughly $1,400,000 in 2016 to more than $3,700,000 in 2019**.

Our VBP program rewards providers for closing care needs for our Enrollees as well as reviewing current diagnoses and medical conditions and ensuring appropriate care is being provided to address such conditions. **This program has been so successful that WellCare of Kentucky created a similar program for its behavioral health providers in 2019 (BH P4Q), which has paid more than $281,000 in incentive payments to providers and helped close 7,039 care needs.** Our BH P4Q program helped to address the integration of physical and behavioral health, which has been a cornerstone of WellCare's approach to care since its inception in Kentucky.

In addition to our P4Q program, we currently have 19 **VBP shared savings agreements** in Kentucky with practices and IPAs that focus on improving the quality of care and service provided to our Enrollees while also reducing the cost of care. Our goal is to reward our providers for improving quality by having them share in the cost savings that can be achieved by ensuring that an Enrollee's care is truly managed and is provided in the right place at the right time by the right provider. WellCare believes that by creating a focus on VBP we can also help to improve the health of the overall population by sharing evidence-based practices that support VBP.

Each of the VBPs summarized above, and detailed throughout our response, include extensive provider education not only on the tools and member specific information needed to be successful, but also on our Care Management programs. The importance of a provider being aware of our extensive Care Management programs, specifically how to access and refer their members in need, is a critically important component of their VBP.

Beyond the P4Q program, which incents providers to complete specific tasks to drive improved outcomes, we also offer **shared savings arrangements**, which reward providers for engaging in PHM programs by allowing them share in the savings generated by reducing costs for higher-level services. We can reward a physician for engaging in an MDT of a member who frequently visits the ER by supporting their care plan and ultimately reducing those unnecessary ER visits. This allows the provider to receive a share of WellCare's reduced medical expense. In addition to these programs for our PCPs, we offer other VBP programs to incent engagement in our PHM program for specialists and facilities:

- *Specialty Care VBP:* In conjunction with our PHM program for high-risk pregnant women (described above), we plan to develop a **VBP that rewards obstetricians for improving birth outcomes**. Metrics may include ongoing prenatal care, improved birth weight, postpartum care and C-Section rates. We appreciate the amount of time and effort an obstetrician needs to devote to our pregnant Enrollees to ensure a successful delivery. By focusing on successful birth outcomes, we create a better start in life for some of our most vulnerable Enrollees.
- *Hospital VBP:* We have a hospital **VBP program focused on readmission reductions** that is currently in place with two acute care hospitals for our Medicare Advantage plan. The focus is a withhold to payment that may be earned back by the hospitals by achieving readmission rates that are less than expected. We would like to develop similar programs with through our Medicaid program with acute care hospitals. We have entered into a withhold agreement with Sun Behavioral Health in which a withhold may be earned back based on success of Enrollee's follow-up visits after hospitalization HEDIS measure. In addition, we have a pilot withhold agreement with another behavioral health hospital that has a withhold that is tied to several HEDIS measures for both their SUD adolescent rehabilitation program and their adolescent sexual offender program.

l. Methods for evaluating success of services provided.

We use a combination of technology and tools along with supervision and audit oversight to provide continuous evaluation of the success of the services our Enrollees receive. Our PHM program evaluation process is data-driven and follows standard CQI methodology so we can address identified issues quickly and effectively. Our Integrated Clinical Leadership team works with our operational leaders across the organization to implement changes. The PHM program is further monitored by our national leadership through a variety of market performance analyses including reviewing trends by category of service, top trend drivers, ER utilization and others. This helps support the local teams in leveraging national best practices to drive improvements in the PHM program for our Enrollees.

Using our best-in-class software including Tableau, AccuReports, SAS Business Intelligence and P4Q Portal, our analysts developed a suite of reports, which look for improvements in measures for specific disease states or population health issues (e.g., diabetes, smoking cessation, colorectal cancer) as well as improvements in overall quality measures in order to determine how our efforts, including VBP arrangements, are improving health outcomes.

REPORTS TO TRACK IMPROVEMENTS IN HEALTH OUTCOMES

P4Q Portal Reports: Our P4Q portal reports including web portal and drill down capabilities, which QPAs and PR Reps provide to WellCare of Kentucky providers monthly, provide a snapshot of the care needs for their Enrollees collectively and individually, which are tied to performance payments, allowing them to prioritize those measures that will result in the most improved Enrollee health outcomes.

Performance Scorecards: Custom monthly scorecards monitor provider performance and calculate performance-based payments based on a specific set of quality measures tailored to the provider.

Members without PCP Visits for 16 Months: Included with the respective identifying Enrollee information, and respective PCP information, this is a detailed list of WellCare of Kentucky Enrollees who have not had a PCP visit with the last 16 months. It is the PCP who is the driver or the hub for an Enrollee's preventive and primary care initiatives. Routine PCP visits contribute to healthier Enrollees, and conversely lower cost. This report is distributed monthly via in-person PR Rep visits, email, or secure FTP.

ER High Utilizer Report for the last 12 Months: This report reflects the Enrollees who are assigned to the respective provider group or IPA who have used the ED; how many visits they have had; which hospital they used; when the last ER visit was; what their most frequent diagnosis was during all of their visits; and how much WellCare of Kentucky paid for the Enrollee's ER utilization during the respective number of ER visits. This report helps the PCP to address any non-emergent conditions the Enrollee may have, educating the Enrollee on the cost benefits of coming to the PCP office for non-emergent conditions. This helps the PCP develop a long-term care plan to help improve the Enrollee's health. This report is distributed monthly via in-person PR Rep visits, email, or secure FTP.

30-Day Readmission Report: This report reflects Enrollees who have been readmitted to the hospital as inpatient within the last 30-days. It reflects detailed information regarding both admission and re-admission including the facilities of both admissions, diagnoses, DRGs, and respective amounts paid. This report gives the PCP insight into any unresolved health issues that may contribute to poorer quality outcomes and higher costs. This report is distributed monthly via in-person PR Rep visits, email, or secure FTP.

High Cost Member Report: This report reflects Enrollees who have claims over $50,000 (catastrophic claims) for the last 12 months. It includes any claim with the amount paid over $50,000—inpatient hospital, outpatient/ER hospital, physician office, or pharmacy. This report allows the provider group/IPA to see which Enrollees are the more expensive (and, conversely have a greater impact on their Value-Base Contractual arrangement), and how better can the Enrollee's care be tailored to help improve quality outcomes while helping to mitigate cost. This report is distributed monthly via in-person PR Rep visits, email, or secure FTP.

Care Needs Reports: The Care Needs Report shows which outstanding Care Needs exists on individual Enrollees, allowing the provider to address the outstanding Care Needs to help improve quality outcomes. This report is distributed monthly via in-person QPA visits.

Pharmacy Utilization Reports: These reports reflect a provider's generic dispensing rate (which helps mitigate cost), 90-day fills (also helps mitigate cost and improves Enrollee compliance) and breaks down the provider group's/IPAs individual prescriber profiles, which helps address any therapeutic equivalent recommendations and ensure the Enrollee receives exactly the same care but at a much less cost. These reports are distributed to providers through monthly meetings with our pharmacy leadership and via secure email and FTP sites.

Enterprise Provider Dashboard (EPD): The EPD provides a single place for providers to access cost effectiveness, quality scorecards/care needs, utilization, Enrollee demographics (risk score), and other population health data for managing total cost of care and outcomes. EPD is a living dashboard that updates on a weekly basis as new information is available.

OPUS Specialty Provider Dashboard: WellCare of Kentucky leverages episodic grouper logic to assess the cost efficiency of specialists in Orthopedics, Cardiology, Neurology, Podiatry, Pulmonology, and OB/GYN using the OPUS Specialty Provider Dashboard. By comparing actual costs against expected costs for a specific episode, WellCare of Kentucky is able to identify efficient specialists and can share that insight with PCPs with the goal of reducing the overall cost of care. In addition, it allows WellCare of Kentucky to compare specialists against their peers within the same specialty by grouping treatment and services into risk-adjusted medical condition-based episodes. This level of analytics, in combination with traditional utilization metrics (ER/1,000, IP/1,000, MWOV), helps create a complete and holistic picture of health care costs for the PCP and in turn, allows us to create efficiencies that benefit our Enrollees. New claims data is provided quarterly through this system.

WellCare of Kentucky has made significant investments in strategic solutions aimed at improving health outcomes through quality management, measurement, and improvement. These investments are yielding positive improvements as evidenced by our year-over-year HEDIS performance or based on the results of individual program performance. For example, **91% of our HEDIS scores have improved year-over-year from HEDIS 2013 to 2019**, and we currently **lead the Commonwealth in 24 HEDIS measures for 2019**, including all three Well-Child Visit measures, Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits (through November 30, 2019). Additionally for the last two rating years, WellCare of Kentucky is the only Kentucky Medicaid MCO that has received the highest overall Mental and Behavioral Health rating of 3.5 in both the 2018/19 and 2019/20 NCQA Health Insurance Plan Ratings.

Monitoring Key Metrics

Our Integrated Clinical Leadership team, under the direction of Dr. Shaps, Terri Flannigan, and Shannon Maggard, in collaboration with our Quality Improvement team, led by Laura Betten, continuously reviews both process and outcomes measurements to monitor the success of PHM services provided at each risk level. Some metrics reviewed include:

- Enrollee perception of health at discharge from care management as evidenced by an increased score in SF-12/SF-10
- Satisfaction Surveys
- Care Manager performance standard
- HEDIS Care Gap Reduction
- Admission Reduction
- Readmission Reduction
- ED utilization reduction
- Enrollee complaints and grievances

Some of the tools we use to monitor the efficacy of services and PHM interventions including process metrics include the following:

- *Advanced Workflow Tracking:* CareCentral uses systematic task generation based on alerts or events integrated within the platform for effective management of turnaround times for outreach and assessment completion. These tasks are generated for appropriate follow-up

for care needs, reassessment, alerts, and re-certifications. The tasks assigned are time boxed based on the due date, which alerts the Care Manager to upcoming, due or overdue tasks which are color-coded. Additionally, the system integrates census reports and ADT notifications, which alerts Care Managers to an Enrollee admission, allowing for timely reassessments, care plan modifications, and the initiation of discharge planning. All of this information is monitored by supervisors through system alerts.

- *Oversight Tracking:* Leaders use CareCentral to assess compliance with care management performance standards like completing the Enrollee Needs Assessment within 30 days of being identified for care management and keeping WellCare and MDT members informed about an Enrollee's status. WellCare PHM supervisors not only are able to run reports to audit and monitor PHM activity, but they receive alerts so they can intervene more quickly to ensure Enrollee safety and timely coordination of needed services.
- *Supervisor Auditing:* Care Manager performance and member interaction and engagement are observed by the supervisor through audits of care plans to compare to CPGs, goals, and interventions as well as riding along with them as they visit members in their homes. Telephonic Care Coordination is also observed during follow-up calls to members.
- *Quality Monitoring:* Available PHM services beyond care management intervention, such as educational materials and remote patient monitoring, for example, fall under our QI department's Continuous Quality Improvement activity. For example, when we saw a lack of compliance at the national level with EPSDT reminders, we re-evaluated our "birthday card" reminders and changed the process to send them out earlier to ensure time for parents or guardians to make the pediatrician appointment.

m. *Methods for communicating and coordinating with an Enrollee's primary care provider or other authorized providers about care plans and service needs.*

Primary Care Providers (PCPs) are our primary partners in all of our PHM programs. They are the first line of defense for Enrollees with basic prevention needs as well as complex and chronic condition care needs. By working closely with our providers, we ensure our Enrollees receive timely access to the services they need and that our providers are focused on closing Enrollee care needs. We combine the deep relationships we build in the communities we serve with the technologies we have available to communicate and coordinate with an Enrollee's PCP or other authorized providers about care plans and service needs.

Hands-on provider support: Our PR Reps review care needs in collaboration with QPAs (described below). Our PCAs are co-located in select high-volume provider offices and assist in scheduling appointments for targeted Enrollees with identified care needs.

Provider Connections: Because we are locally placed in the same communities as our providers, our Care Managers often develop close working relationships with providers and communicate through telephonic and in-person touch points. They also work closely with their co-located colleagues in provider relations as needed to communicate with providers. For particularly complex cases, we will include PCPs or other providers on case rounds with one of our medical directors to discuss.

Provider Portal: Our provider portal is connected to our integrated Care Management system, CareCentral, which allows us to share the outcomes of health screens, EPSDT information,

social determinants of health obstacles, Enrollee assessments, care plans, and multi-disciplinary team contacts with providers. Providers can also view open and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, eMR interchange or submission of supplement medical record information. They can also view appointment agendas, which allow our physician partners to understand, in a single report, everything that they need to address for each Enrollee during an appointment including all known chronic diagnoses and associated care needs derived from evidence-based guidelines. We offer a wide variety of webinars through our provider portal as well as access to our provider newsletter, provider manual, claims, prior authorizations and clinical practice guidelines. As part of our collaborative effort to support providers, we held Quality-led focus groups with providers to discuss their needs for data analytics and the provider portal. As a result of these focus groups, we heard feedback on a few common themes: faster data generation, expand data capture tools, and more flexible reporting features. We incorporated this feedback to meet the needs of the provider community in our quality programs and provider portal.

Electronic Medical Records (eMR): Our eMR flat file transfer process allows physical and behavioral health providers to submit flat file information from their eMR to provide WellCare of Kentucky up to date and complete Enrollee information that is not captured on claims and encounters. Our recently updated process includes: Providing an accessible setup guide; providing a dedicated Quality and eMR team to help set up connections; leveraging consultants to help configure systems for export; providing error reports that show appropriate use and configuration of the system interchange; accepting appointment agendas in various formats for ease of transition.

Multi-disciplinary care teams (MDTs) and Data Sharing: Care Managers engage PCPs on Enrollee MDTs and we share assessments, care plans, and service needs with PCPs and other relevant providers. We use the provider portal to communicate with PCPs and other providers and give providers a detailed set of tasks to close care gaps and ensure service needs identified on the care plan are provided. Our provider portal is connected to our CareCentral clinical platform, which allows us to share the outcomes of health screens, EPSDT information, social determinants of health obstacles, Enrollee assessments, care plans, and multi-disciplinary team contacts with providers. Providers can also view open and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, EMR interchange, or submission of supplement medical record information.

Kentucky QPA Teams: We have three teams of regionally located QPAs, who are responsible for assisting providers in closing care gaps. They educate providers on HEDIS and HPR measures and the importance of completing appointment agendas. Appointment agendas allow our physician partners to identify, in a single report, Enrollee chronic conditions and care needs that need to be addressed during an appointment. QPAs assist provider groups in practice transformation in order to develop coordination of care for patients. In addition, QPAs are responsible for EPSDT and AMRR audits, reviewing results directly with providers and

In 2019, our QPAs conducted more than 6,000 visits to provider offices to educate providers and advance the Commonwealth's quality

developing corrective action through identifying opportunities to increase efficient and effective use of EMR templates and care alerts, office workflows, and coding to improve capture of quality services. In addition, QPAs assist with referrals to and coordination between care management as needed. In preparation of the new contract, we are implementing specialized QPAs to provide focused support to specialty providers, including Behavioral Health and OB/GYN. The Behavioral Health QPA will focus on care coordination between medical and behavioral health needs and the OB/GYN QPA will focus on women's health needs. Both will conduct visits with their respective specialty providers to educate them on performance management and our programs.

P4Q Portal Reports: Our QPAs and PR Reps present to providers our P4Q portal reports (**Figure C.24-6**), which show a snapshot of their patients' care needs and allow providers to prioritize Enrollee outreach based on those measures that will result in the most improved Enrollee health outcomes.

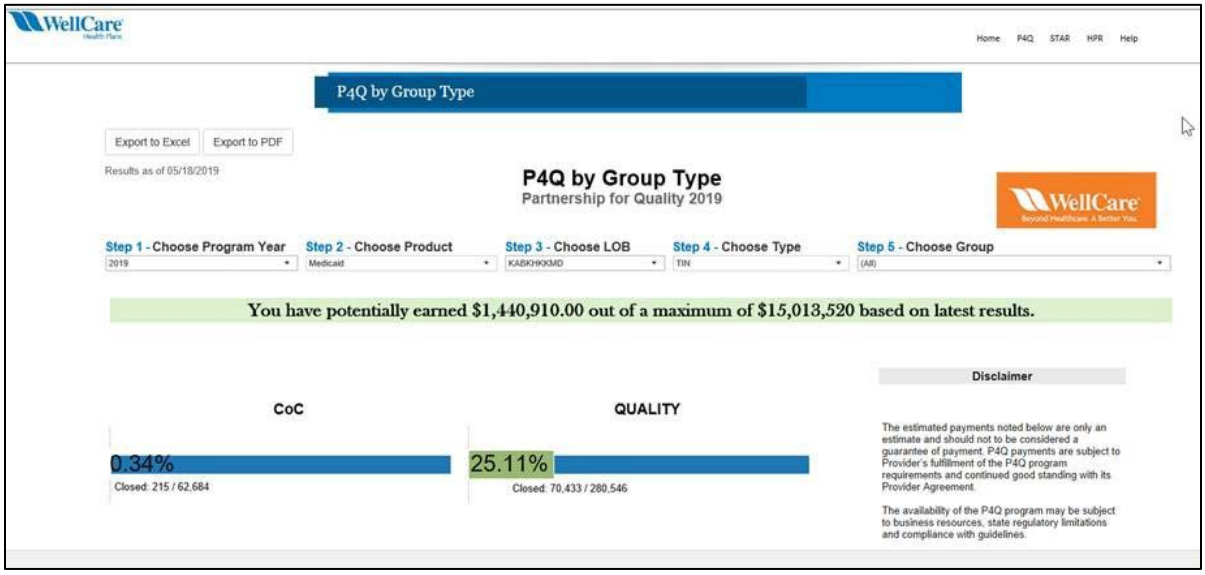


Figure C.24-6 P4Q Portal Report

n. Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor's PHM Program as a resource.

Already, KHIE has become an integral part of our PHM program, as field Outreach Coordinators use information within KHIE to help locate individuals in need of care management and other PHM interventions. As KHIE expands and matures over the coming years, we are fully equipped to leverage KHIE features and capabilities within our PHM program. The first step starts with helping to make sure our providers connect to KHIE and see it is as valuable tool to share clinical data in real time. In compliance with Section 17.1 Kentucky Health Information Exchange (KHIE) of Attachment C (Draft Medicaid Managed Care Contract), all our network providers will be required to will sign a Participation Agreement with the KHIE within one month of contract signing. This required sharing of data facilitates improved PHM interventions, so a PCP can know if one of his/her patients returns to the ER or allows the specialist to better understand a patient's history even if they cannot reach the Enrollee's PCP

in real time. Our Network Management Representatives, QPAs, and PR Reps will train providers on the benefits of EHR and KHIE adoption in person and telephonically. We will also develop and publish self-service training materials on our website, along with job aides to provide detailed explanations about EHR and KHIE use. **WellCare of Kentucky proposes to provide a grant of up to $1,000 for our eligible independent providers who successfully implement EHRs for the first time**.

Additional to provider engagement in KHIE is our internal connectivity and use of the system. Since 2012, we have been engaged in implementing and using data exchanges, deriving clinically intelligent insights from Enrollees' health risk assessments and sharing this information with providers through electronic health record connections to promote early intervention. We use this expertise to forward our engagement with KHIE in a more consolidated fashion. As noted above, our outreach coordinators already use KHIE to help find Enrollees, which has resulted in a steady decline in our Unable-to-Contact rates. When the system comes back online, we are fully prepared and look forward to having access to Admit, Discharge and Transfer information on Enrollees. Care Managers will use available information in KHIE, such as lab results, medications, and diagnosis history to supplement the Enrollee Care Needs assessment and care planning process with an accurate Enrollee clinical history.

v. Provide the Contractor's proposed approach to coordination with other authorized providers such as the WIC program and others.

Our Enrollees often engage in multiple areas of the public system to get the full range of services needed. Regardless of risk level, we seek to empower Enrollees to receive services from any authorized providers and have procedures in place to ensure we can coordinate with those providers in an effective way. Just some of the authorized providers we coordinate with include the following:

- WIC
- Low Income Home Energy Assistance Program (LIHEAP)
- ARC Pregnancy Centers
- Office for Children with Special Health Care needs
- HANDS program at local health departments
- Lifeline phone assistance
- HEAR NOW
- Schools
- Head Start

OUR COORDINATION PRACTICES INCLUDE THE FOLLOWING:

- *Education and outreach:* Enrollee outreach materials include information on various resources available to them and guides them on how to access those services. We also train these providers on our programs so we can make cross-referrals and work more closely together on individual Enrollee needs.
- *Enrollee-level referrals and supports:* Care Managers and outreach coordinators are trained on various authorized providers and help Enrollees navigate those programs, identifying and coordinating those that best support their needs and goals. These services are included in the Enrollee Needs Assessment to help guide the Care Manager to finding the right services and to identify what a family is already connected with, such as SNAP benefits or

the First Steps program. Care Managers educate Enrollees and families or guardians about the availability of special program services and help them engage in those programs. In many cases, assistance is simply helping Enrollees complete the necessary applications and explaining the guidelines for assistance. Enrollees who are not enrolled in care management can also receive assistance with referrals to social services by calling Enrollee Services or the CCHL. If a program needs information on an Enrollee to help provide the right services (e.g., WIC seeking information on nutrition deficits or conditions an Enrollee faces), we share the appropriate information as allowed by law and approved by the Enrollee.

- *Community-level engagement:* Our locally based PHM and Community Connections staff regularly engage with these programs, like WIC offices to educate and support their programming. These resources are also often included in our Community Impact Councils to round out coordination with key partners in serving local communities and ensuring access to a broad base of available resources.

vi. Describe the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues.

APPROACH TO ONGOING REVIEW OF THE PHM PROGRAM

WellCare of Kentucky has an established set of target metrics for each of our PHM programs that includes both process and outcome measures. Process measures evaluate compliance with the completion of required care management activities (e.g., member reach rates, assessment completion rates, plan of care completion rates). Outcomes measures include cost and utilization (e.g., ED visits, admissions, readmissions, pharmacy, outpatient visits); member satisfaction with care management and with their Care Manager (e.g., member surveys), and quality measures (e.g., HEDIS®).

Internally, we monitor daily Census reports, weekly and monthly utilization reports and annual quality surveys and scoring to evaluate the effectiveness of our PHM programming. Our PHM staff collaborate with our QI staff to review data by risk level and PHM intervention, watching, for example, ER utilization rates of our asthma Enrollees to identify if the asthma interventions are working. QI staff also drill down to outcomes for individuals in Complex Care Management, to monitor if the field-based interventions are successful. We even carry the review of our PHM programming into our social determinants of health, where we have conducted a number of studies including having external researchers validate our data, to demonstrate effectiveness of addressing social service needs.

We integrate feedback from our stakeholders as part of program evaluation. WellCare uses formal surveys, internal and external committees, and one-on-one interactions to obtain information and feedback from various stakeholders about the effectiveness of the service delivery system. Examples include, but are not limited to CAHPS surveys, the Enrollee, BH-CAC and more. Information and feedback obtained flows through our quality processes for opportunities for improvement. Based on the nature of the opportunities presented, actions for improvement are assigned to a department to lead those efforts. The progress of improvements are formally tracked through the Quality Department and reported back to all

applicable committees and up to Executive Leadership. **In 2018, 95% of those surveyed expressed satisfaction with their care management experience.**

Real-time Measurement: As described above, we have tools in CareCentral that provide real-time monitoring of productivity and process measures. With more advanced data available through KHIE, we can continue to advance real-time measurement evaluation by watching ER rates and care needs closures without a claims lag.

USING RESULTS TO ADDRESS IDENTIFIED ISSUES

Our PHM program evaluation process is data-driven and follows standard CQI methodology so we can address identified issues quickly and effectively. Our Integrated Clinical Leadership team works with our operational leaders across the organization to implement changes. One example is the introduction of our REACH program both locally and nationally. Evaluation of the our program showed very low rates of engagement and participation of Enrollees in the Complex Care Management risk level in Region 8, which was exacerbating poor health outcomes for those Enrollees. By hiring Enrollee Outreach Coordinators to knock on doors in those communities, we were able to increase contact rates and reduce ER utilization for those members. This program has expanded across our national footprint incorporating newer and more complex tools to mine contact information and conduct multiple modalities of outreach.

The PHM program is further monitored by our national leadership through a variety of market performance analyses including reviewing trends by category of service, top trend drivers, ER utilization and others. This helps support the local teams in leveraging national best practices to drive improvements in the PHM program for our Enrollees. As an example, recently WellCare's clinical team analyzed and noted a continual increase in Oncology related utilization and cost. After a detailed review and evaluation, we implemented a more comprehensive program to manage oncology-related costs. This program uses a holistic view of the Member's treatment plan and drug protocols. By working with the treating physicians, the program helps guide the member and physician through evidence-based medicine that has the proven best outcomes for the Member.

As requested, we will provide to DMS the results of our evaluations at a frequency and in a format defined by DMS, including monthly, quarterly, and annual reports.

25. Enrollees with Special Health Care Needs

C.25. ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

a. **Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 "Enrollees with Special Health Care Needs" including. Include a summary of how the Contractor's experience in providing services to these populations has informed the approaches.**

b. **Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:**

   i. Approach to identifying Enrollees.

   ii. Process for screening and assessing individual Enrollee needs.

   iii. Approach to providing education to Enrollees and caregivers.

   iv. Approach to providing transition support services.

C.25. ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 35.0 Enrollees with Special Health Care Needs of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

The Kentucky Medicaid program has an important role in the lives of our Enrollees with special health care needs--most of whom require health and related services of a type or amount beyond what is generally required by other Enrollees. Individuals with special health care needs (ISHCN) are adults and children/adolescents who face daily physical, behavioral, or environmental challenges that place their health and ability to function fully in society at risk. Factors include intellectual and developmental disabilities or related conditions; serious chronic illnesses, such as schizophrenia or degenerative neurological disorders; disabilities resulting from years of chronic illness, such as psychiatric disorders, depression, arthritis, emphysema, or diabetes; and children/adolescents and adults with specific environmental risk factors, such as homelessness or family problems that lead to placement of children in foster care.

In Kentucky, we work collaboratively with providers, ISHCN Enrollees, families, guardians, caregivers, state agencies, and others to remove barriers to good health and help coordinate timely ISHCN Enrollee access to individualized, whole-person care and services available in their local communities. This collaboration and a focused approach helps keep adults and children with intensive and chronic needs living at home with their families or in a community-based setting of their choice. For example, by covering and coordinating medically necessary home-based medical equipment, nursing services, occupational therapy, physical therapy, and more, we enable children with congenital conditions to receive medically complex care at home so that they do not spend their childhood in a hospital or nursing facility.

Our ISCHN Enrollees and their families often have social needs like transportation, which serve as barriers to accessing the care and services they need. Family and caregivers of ISCHN Enrollees report more hours taking care of ISHCN Enrollees at home than the general population. Some caregivers stop working to provide needed care and subsequently have trouble paying their utility bills and paying for over-the-counter medications. Our Kentucky Medicaid claims data and our own experience confirm that our ISHCN Enrollees have, or without intervention, they are at increased risk for chronic physical, developmental, behavioral, and/or emotional conditions. We also know that the prevalence of the ISHCN population varies by geographic region, race, and ethnicity. For example, while nearly 20 percent of all U.S. children under age 18 have a special health care need, prevalence varies between states, from a low of 14% in Hawaii, to a high of 25% in Kentucky (Data Research Center for Child & Adolescent Health National Survey of Children's Health 2016).

On our current Medicaid contract, ISHCN Enrollees are a subset of our general Medicaid population. Today, WellCare of Kentucky serves more than 430,000 Medicaid Enrollees statewide in Kentucky's urban and rural areas in all eight DMS regions. WellCare of Kentucky has diverse populations across the Commonwealth and has the largest majority of complex Enrollees, largely in eastern Kentucky in Regions 7 and 8 -- the most rural parts of Kentucky. For all EPSDT-eligible Enrollees, we cover EPSDT special program services for those who need those additional services. In addition, we offer a full range of population health management and supporting services for Enrollees when they need it. As of Q3 in 2019, our Kentucky Medicaid population included approximately:

- 229,000 individuals in the Temporary Assistance for Needy Families/Kentucky Children's Health Insurance Program (TANF/KCHIP) population
- 24,000 individuals in the Dual Eligible population
- 43,000 individuals in the Supplemental Security Income (SSI) population (adults and children)
- 8,100 individuals in the foster care/juvenile justice system/adoption assistance population
- 800 individuals in the Former Foster Care population
- 141,000 individuals in the Medicaid Expansion population

Per 42 C.F.R. 438.208, DMS defines the categories of individuals identified in the ISHCN population. Department-specified ISCHN populations include:

- Children in/or receiving foster care or adoption assistance (Kentucky SKY)
- Blind/disabled children under age 19 and related populations eligible for SSI
- Adults over age 65
- Enrollees experiencing homelessness
- Individuals with chronic physical health illnesses
- Individuals with chronic behavioral health illnesses

- Children receiving EPSDT special services
- Children receiving services in a pediatric prescribed extended care facility or unit
- Enrollees who are adult guardianship clients

We identify ISHCN Enrollees from our Kentucky Medicaid population. As described later in this section, we employ a focused, systematic, and multimodal effort to identify ISHCNs with chronic physical or behavioral health illnesses in all populations as quickly as possible so we can connect them to the care and services they need. We coordinate a broad range of primary, specialized medical, behavioral health, and or related services, including social services and non-covered services, for ISHCN Enrollees' respective conditions. This includes adults and children in the Kentucky Medicaid population with significant conditions that range from autism spectrum disorders to vision or hearing loss, diabetes, asthma, attention deficit hyperactivity disorder (ADHD), cancer, or cerebral palsy.

a. Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 "Enrollees with Special Health Care Needs" including. Include a summary of how the Contractor's experience in providing services to these populations has informed the approaches.

WellCare of Kentucky has served the Kentucky Medicaid ISHCN population for the past eight years. Nationally, WellCare Health Plans, Inc. (WellCare) has 30 years of Medicaid program has experience serving ISHCN. This includes but is not limited to experience in Florida, Hawaii, Michigan, Missouri, Nebraska, New Jersey, and South Carolina. WellCare of Kentucky collaborates with providers, state agencies like DMS, and other MCOs to improve overall health care quality and outcomes in a cost effective manner. In this section, we present a summary of our innovations and initiatives that facilitate the provision of services to Enrollees in the ISHCN population.

INNOVATIVE APPROACHES TO PROVIDING SERVICES TO ENROLLEES IN THE ISHCN POPULATION

In this section, we present innovative approaches to providing services to ISHCN Enrollees:

Integrated Care Model and Population Health Management Programs

ISHCN Enrollees and their families/guardians, and caregivers are at the center of our integrated care model, which supports their varied and often complex needs. To better serve our Medicaid Enrollees and subpopulations, we continually enhance our integrated care model and population health management programs. Our Kentucky-specific outcomes data and ISCHN Enrollee feedback tell us that they benefit from our fully integrated, person-centered, community-based approach to Care Coordination and Care Management. Our high-touch, in-home approach integrated care model has proven its value in increasing Medicaid Enrollee satisfaction and improving health outcomes. Relying on Care Managers who are nurses or social workers, field-based Care Management and Care Coordination is fully integrated and tailored to each Enrollee's needs by considering their physical health, behavioral health, pharmacy, and social resource needs. This is particularly important for the ISHCN population.

WellCare defines our population health model as: **Coordinating health care needs through a holistic, evidence-based, proactive approach centered on larger, socially grouped medical and behavioral needs and prevention efforts while reducing disparity and variation in care delivery. Analytics allow identification of opportunities to create and implement evidence-based, best practice initiatives delivering excellent and innovative care in the most cost-effective ways.**

Our Population Health Management program is an evidence-based, proactive approach centered on larger, socially grouped medical and behavioral needs and prevention efforts. Our program has seven clinical focus areas, or domains, each led by a clinical advisory board to review effectiveness, explore opportunities and innovations, and develop new programs and initiatives. Our domains include:

1. Behavioral Health and Substance Use Disorder (SUD)
2. Maternal and Child Health
3. Community and Long-Term Supports and Services (LTSS)
4. High Acuity and Transitions
5. Medical Conditions
6. Advanced Illness
7. Prevention and Wellness

Each domain improves health outcomes through prevention and promoting healthy behaviors, early identification, and preventing deterioration or complexities. Our population health domains align with DMS' population health condition priorities. All programs emphasize empowering individuals to improve their health and engage in their healthcare. We employ a person-centered approach that addresses medical and non-medical drivers of health while reducing inappropriate utilization and costs.

Care Management and Care Coordination are key components of integrated, whole-person care for ISHCN Enrollees, including our SSI population comprising 10.87% of our total Kentucky Medicaid membership, representing 7.94% SSI adults and 1.95% SSI children. The majority of our SSI-adult and SSI-child populations live in Region 8. Further, 11.8% of our SSI adult population lives in Region 8, in contrast with the statewide average of 7.9% SSI adults living in other DMS regions. Because the SSI population has multiple physical health care, behavioral health, environmental, and social service needs, they can benefit from our Care Management, Care Coordination, and population health management programs. The most prevalent chronic condition in our SSI-child population is one or more psychiatric conditions (57%) -- a higher rate than any other Kentucky Medicaid population we serve. Our SSI-adult population ISHCN Enrollees have the highest rate of hypertension (56%) and cardiovascular (61%) chronic conditions of the populations we serve. The SSI-adult population experiences a high rate of psychiatric conditions (39%). Our SSI population has the highest rate of asthma (13% of SSI adults and 12% of SSI children) than any other population we serve today. Like other ISHCN Enrollees, many ISCHN Enrollees in the SSI population face adverse social risk factors that may affect their health status, such as housing insecurity and homelessness, food insecurity,

inadequate access to transportation, poverty, and low health literacy. The combination of potentially high-risk and high-cost needs of the SSI population underscores the importance of effective Care Management and Care Coordination for SSI adults and children by assessing the full range of their individualized needs; incorporating their needs and individual preferences and goals in person-centered care plans; connecting them to population health management programs targeting chronic conditions; and coordinating and sharing information across all needed medical and non-medical providers and supports, including family, caregivers, and other stakeholders.

To enhance services for all the populations we serve, we are currently building new or next version Population Health Programs, including programs that target the chronic conditions our ISCHN Enrollees experience, including asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birth weight, and behavioral health and substance use. We are exploring remote patient monitoring to receive biometric data and share it with our providers, deploying resources to an Enrollees' home in real time when a potential issue arises (e.g., blood sugar spike for Enrollees with diabetes, oxygen monitor alert for Enrollees with COPD, and more).

We continue to innovate in our social determinants of (SDOH) programs and will be expanding our WellCare works program, which assists with employment opportunities, to reach Enrollees in all 120 counties--this extends to ISHCN Enrollees who have shared with us their training and employment goals. We are proud that within one year we reached Enrollees in 109 Kentucky counties covering 91% of the Commonwealth with our WellCare Works platform. We fully expect by mid-year, Enrollees in all 120 counties will have accessed our innovative solution to getting Enrollees back to work.

Our latest innovation includes data-informed outcome-based contracting with community partners. These community contracts assess impact and connect to enterprise priorities, including quality outcome data, Enrollee retention, and Enrollee and provider satisfaction. Leveraging our local partnerships, Community Connections staff, community engagement partners, work with community-based organizations to assess their capacity for connecting our Enrollees, including ISHCN, to Care Management, their Primary Care Physician, Workforce Innovation Programs, and more. Based on that capacity, we provide payment to community-based organizations for the health outcomes, based in their community contract. Community-level data analysis helps drive decisions around priorities, investment, and innovation opportunities focused on systemic, industry-leading solutions to drive social determinant integration into healthcare. Innovation pilot programs generate the data to evaluate the impact in local communities by improving health outcomes and increasing access to care, reducing avoidable costs by removing social barriers, and evaluating system effectiveness leading to social innovation. This is vital to most of our ISHCN Enrollees who experience a high degree of unmet social resource needs.

COMPREHENSIVE PAYER/PROVIDER ANALYTICS

WellCare recognizes the fact that the amount and type of data available on an Enrollee or population is a very powerful tool in improving health. We have already implemented an integrated system, built specifically for Medicaid. This system, CareCentral, provides our team

and our provider community and 360-degree view of the Enrollees/patients they serve. We will continue to introduce innovations that include the integration of social determinants into our predictive analytics, earlier trend identification to support program development and individualized Enrollee intervention, and an improved risk stratification model that allows us to move even further toward prevention by including community factors in our scoring. We recognize the importance of KHIE data and will begin to integrate that information into our platforms. Our objective is to collaborate with our provider and stakeholder communities, share data transparently, and drive quality improvement, improved outcomes, and increased Enrollee and provider engagement and satisfaction.

IMPROVED ENROLLEE ENGAGEMENT

We recognize that ISHCN Enrollee engagement is critical to improving their health outcomes. We intensified our unable-to-contact program in the Eastern Region of Kentucky when we deployed local community health workers to find Enrollees, many of whom were ISHCN. **This resulted in a 19.6% reduction in Emergency Department care and a 21.4% reduction in overall medical expenses for Kentucky Enrollees engaged.** During our previous and current Kentucky Medicaid contracts, we launched written, verbal, and digital Enrollee education programs and offer incentives to Enrollees who complete preventative and follow up care. While this has made an improvement in the outcomes for engaged ISHCN Enrollees, we must continue to build on our success and broaden our reach. In addition, we will introduce improvements to our Enrollee portal and social media strategy, which will improve communication and engage Enrollees in several different ways. The portal will become more interactive and easy to use, and our multi-faceted social media approach will allow Enrollees to receive information in the way they prefer to receive and consume it. We plan to implement additional tools to measure each Enrollee experience, which will inform our engagement strategy and toolset. By expanding our Enrollee Care Center in Hazard, we can reach and empower more of our ISCHN Enrollees to help them navigate their healthcare, while connecting them to whole-person solutions that improve their overall health.

INCREASED ACCESS AND AVAILABILITY

Introducing telehealth more broadly across Kentucky is a key innovation that will improve access and availability for our ISHCN Enrollees. Based on feedback from our providers, we will look to roll this out generally, but also with an emphasis on targeted programs or conditions, such as stroke care, substance abuse treatment, diabetes care, and increased access to pediatricians, pediatric specialists, and child psychologists. Access-related provisions related to network adequacy and timely access to care apply to Enrollees in all populations. We have a strong focus on the inclusion of pediatric providers for our ISHCN-child and adolescent population. We understand the challenges of provider availability in rural Kentucky and have built a strong network of providers. However, we must begin to introduce more innovation that improves access and addresses not only the limited number of certain providers in these areas, but the social barriers, such as transportation or child care, which prevent our Enrollees from seeing their providers. We will supplement our focus on telehealth with a virtual high-touch model that allows our clinical and support teams to wrap around providers and Enrollees to make sure they receive integrated, whole-person care.

NEXT GENERATION CONTRACTING MODELS

We understand the need to align our payment structures to drive improvements in quality and outcomes for all populations. We will be expanding our value-based contracting models to a broader array of provider types, not simply focused on mainstream providers like Primary Care Providers, hospitals, and specialists. Today, every Primary Care Provider has a value-based payment (VBP) contract, considering they are all eligible for Partnership for Quality (P4Q) program dollars where providers receive bonus payments for closing care needs on key HEDIS performance measures and timely completion of appointment agendas. **Since 2014, approximately 443,000 care needs have been closed and more than $10.1 million in bonus payments have been paid to providers as a result of WellCare of Kentucky's P4Q program.** We have providers who participate in shared savings arrangements and who want to increase their participation in this type of contract. We will examine the opportunity to better align our models with Population Health quality and outcome goals by introducing VBP structures for Population Health issues, such as substance abuse treatment and diabetes--conditions we see in ISHCN Enrollees. For example, the most prevalent chronic conditions in the TANF-adult population, which includes ISHCN Enrollees, are psychiatric conditions (27%). Other chronic conditions include cardiovascular (24%); gastro, hypertension, and depression (20%); and substance use disorder (13%). For providers that achieve quality and improved outcomes, we will look to expand our Gold Card program that removes authorization requirements for those providers, easing their administrative burden and driving improvements in quality, cost, and improved health.

HOW WE USE EVIDENCE-BASED PRACTICES IN THE PROVISION OF SERVICES TO ISHCNS

Effective access to reliable and persuasive evidence in an understandable format is vital to the development of informed and shared decision-making among healthcare providers, Care Managers or Care Coordinators, ISCHN Enrollees, families and caregivers, and other stakeholders, including state agencies. Promoting practice and evidence-based healthcare practices balance scientific knowledge; clinical expertise and experience; the goals, values, beliefs, and experiences of our ISHCN Enrollees and their families and caregivers; and systematically and objectively measured person-centered outcomes to promote data-informed healthcare delivery and decision-making. We promote transparency of treatment protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources used in the provision of optimal care and services for ISCHN Enrollees. Upon request, we share medically necessary guidelines with all Enrollees and their families. Providers have access to clinical practice guidelines on the provider portal. We provide and continually enhance our decision-making aids for Enrollees and providers to help with care planning and the best options for treatment.

As shown in **Table C.25-1**, we support our staff and providers with industry-leading clinical practice guidelines and criteria for standard physical and behavioral health services to promote evidence-based decision-making. We list a summary of clinical practice guidelines and criteria.

Table C.25-1: Evidence-Based Review Guidelines

Guideline Category	Summary of Clinical Practice Guidelines and Criteria
InterQual Review Manager	A nationally recognized decision tool for level of service, length of service, discharge planning readiness, and level of care
ASAM	American Society of Addiction Medicine (ASAM)
Behavioral Health Guidelines	Level of Care Utilization System (LOCUS) & Child and Adolescent Level of Care Utilization System (CALOCUS) for adults & children, respectively. NOTE: When approved by DMS we will also use guidelines from leading organizations (e.g., the American Society of Addiction Medicine, Substance Abuse and Mental Health Services Administration) for behavioral health & substance use disorders
Children and Adolescents	Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII)
Clinical Practice Guidelines	Appraisals and guidance for 200+ procedures and services. For example: • Our Heart Disease Program (coronary artery disease, congestive heart failure, and hypertension) uses evidence-based clinical practice guidelines and guidelines from the American College of Cardiology (ACC), American Heart Association (AHA), the American College of Cardiology Foundation (ACCF), and the Institute for Clinical Systems Improvement (ICSI), with additional direction from National Committee for Quality Assurance (NCQA), United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), and Agency for Healthcare Research and Quality (AHRQ). • Our Diabetes program uses evidence-based clinical practice guidelines and guidelines from the American Diabetes Association (ADA), American Academy of Pediatrics (APA), NCQA, USPSTF, NQS, and AHRQ, and specialty association, colleges, and societies. Range of topics, including durable medical equipment (DME), disposable incontinence products, food and lodging services, oral function therapy for feeding disorders and other benefits.
Hayes, Inc. Online™ (Medical Technology)	Hayes is a subscription-based tool used by Medical Directors to solidify medical necessity and to research new procedures and technologies. This tool will be utilized in Kentucky subject to DMS review and approval.

Guideline Category	Summary of Clinical Practice Guidelines and Criteria
eviCore Guidelines	Advanced radiology (MRI, CT), cardiology (advanced imaging), radiation therapy management, pain management, sleep management, PT/OT/Speech services, and molecular and genetic lab testing
HealthHelp	Medical oncology and radiation guidelines to help providers optimize cancer treatment protocols
Avesis	Dental and vision evidence-based guidelines
CMS Guidelines	Guidelines as defined in the contract National Coverage Determinations (NCD), Local Coverage Determinations (LCD) used in DME reviews

Care Management for high-risk ISHCN Enrollees guided by evidence-based clinical practice guidelines: For ISHCN Enrollees stratified in the high-risk group, Care Managers oversee person-centered care plan development, linkage and referrals, coordination and monitoring of care, arranging transportation, and assuring that medical records and other information flows among various providers in the system of care. Care Managers build care plans in our Care Management system, CareCentral, guided by standard evidence-based guidelines. Care Managers and Care Coordinators recognize ISHCN Enrollees are at the center of care planning activities and that family members are most often the primary caregivers, e.g., for a child with special health care needs. Our staff values and honors the input of family/guardians and caregivers in shared decision-making about an ISHCN Enrollee's health services. Shared decision-making involves and solicits the input of Enrollees and families, caregivers, and others involved in an Enrollee's care when designing and incorporating evidence-based interventions and monitoring progress toward goals. Use of evidence-based clinical guidelines, including InterQual criteria, serve as a framework for clinical decisions and service provision that optimizes Enrollee care. When our Care Managers include providers on multidisciplinary teams, we improve communication among those involved in an ISHCN Enrollee's care and the ISHCN Enrollee experiences better health outcomes. ISHCN Enrollees trust their providers, so they are often the first to know our ISCHN Enrollees have social resource needs. We educate providers about our Community Connections program, how community-based social resources remove barriers to health and have a measurable positive effect on an ISCHN Enrollee's health, and how to refer them to these resources.

Motivational Interviewing: Motivational interviewing is an evidence-based counseling practice and an essential skill for all Enrollee-facing staff, including Care Managers, Care Coordinators, field outreach coordinators, Enrollee Services representatives, and our Enrollee outreach staff who help us locate and engage high-risk Enrollees across the Commonwealth, and in Region 8. We train Enrollee-facing staff on motivational interviewing, which is a collaborative process between the ISCHN Enrollee and clinician. It is evocative to activate an Enrollee's own motivation and resources for change and honors autonomy to accept that ISCHN Enrollees can and do make choices about the course of their lives. Providers often use motivational

interviewing to help their patients adhere to treatment recommendations and to promote behavioral change by helping Enrollees explore and resolve their ambivalence and barriers to achieving health care goals.

Care Management Success Story for ISHCN Enrollee

In December 2016, a Primary Care Provider referred a Kentucky Medicaid Enrollee who lives in western Kentucky to our care management team. The provider determined this ISHCN Enrollee was facing serious health issues. After neglecting to complete well checkups, her diabetes became unmanaged, and now she has diagnoses of COPD and hypertension. Our care manager quickly called the ISHCN Enrollee and set up a time to conduct an in-person Enrollee needs assessment at the ISHCN Enrollee's home. Through motivational interviewing and assessment results, the care manager found out that the Enrollee was doing without her needed diabetic supplies. The care manager called the ISHCN Enrollee's Primary Care Provider, and they agreed the care manager should order a glucometer, strips, and lancets for this ISHCN Enrollee in alignment with clinical care guidelines. The care manager educated the Enrollee and her family on keeping logs to track blood pressure and blood sugar. She also educated her about the signs her condition(s) are worsening and when to call her Primary Care Provider. During conversations, the ISCHN Enrollee did not express interest in quitting smoking; however, the care manager noticed in the ISHCN Enrollee's record that there had been a prior issue related to a prescription to Chantix. With the ISHCN Enrollee's consent, the care manager successfully resolved the pharmacy order issue.

In addition, the care manager identified socioeconomic conditions having an impact on the ISCHN Enrollee's health. The ISCHN's husband was disabled, unable to work, and their only income was his limited SSI benefit. Their SNAP benefits had been reduced, and food was scarce. The care manager used the Health Connections Referral Tracker to refer the ISCHN Enrollee to a local food bank for assistance. The care manager removed the ISHCN's transportation barrier to health by making a referral to the medical transportation provider in the area, so the ISHCN Enrollee can easily access her Primary Care Provider appointments. Because of our field-based, individualized, integrated care management intervention, the ISHCN Enrollee feels empowered after receiving education about her conditions, self-care, and the importance of self-managing her hypertension, COPD, and diabetes. She subsequently received her Chantix and says she is serious about quitting smoking. Through the connection with the local food bank, the ISHCN and her husband are eating a more balanced diet and saving money as well. Finally, the ISHCN Enrollee's goal is to make every scheduled doctor's appointment now that she does not have to worry about transportation.

Behavioral Health: A strong focus on evidence-based behavioral health care is an opportunity to improve the quality of mental health and substance use disorder care and services and to empower Enrollees in recovery and their families and caregivers to seek quality care that is person-centered and person-reported, achieving recovery-oriented outcomes. **During our tenure in Kentucky, we have consistently maintained the largest behavioral health network, which today includes more than 2,300 behavioral health specialists.** In addition to the behavioral health clinical practice guidelines listed above, evidence-based practices discussed

by SAMHSA include solutions proposed in our Kentucky SKY response for the foster care, juvenile justice-involved, and adoption assistance population. WellCare of Kentucky identifies providers who are specifically trained and certified in evidence-based practices and can immediately refer any ISHCN Enrollee to a specific provider for a specific evidence-based practice. These evidence-based practices include:

- Child Parent Psychotherapy
- Trauma-Focused Cognitive Behavioral Therapy
- Parent Child Interaction Therapy
- Dialectical Behavior Therapy
- Applied Behavioral Analysis
- Motivational Enhancement Therapy
- Multisystemic Therapy
- Multidimensional Family Therapy
- Assertive Community Treatment
- High Fidelity Wraparound

Sharing of Enrollee care needs: Ensuring ISHCN Enrollees, particularly those in the Prevention and Wellness risk level, get necessary preventive services is foundational to our population health management program. We use multiple modalities to share care needs, including our Appointment Agenda, which tells a Physician in one view, everything the ISCHN Enrollee needs during that visit to be compliant with evidence-based preventive and chronic care clinical guidelines.

Leverage new and emerge technologies for wellness and chronic condition management: As more ISHCN Enrollees, particularly among our younger populations, rely on technology, we are continuing to innovate with web-based and mobile engagement tools. For example, we implemented a mobile phone app, JOOL, for our foster care Enrollees (also ISCHNs) to help them life plan for aging out of the system. We also implemented self-help web tools for wellness and chronic condition management, such as MyStrength, which is an evidence-based digital behavioral health platform empowering Enrollees to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges. It also supports the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care.

Peer support offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people: Peer support is an evidence-based practice. It is generally cost-effective and cost saving. Our population health programs, such as our asthma, heart disease, tobacco use, and infant mortality and low birth weight programs, include peer support as an intervention. Peer support helps ISHCN Enrollees prevent illness, manage chronic illnesses, cope with stress or emotional and psychological challenges, and help us engage ISHCN Enrollees who are difficult to locate and engage in Care Management and Care Coordination. In behavioral health,

community-based peers offer their unique lived experience with mental health conditions to provide support focused on advocacy, education, mentoring, and motivation.

Our Trauma-Informed Approach is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of adverse childhood events and related trauma and to facilitate healing: SAMHSA promotes linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and Enrollee and family engagement, empowerment, and collaboration. We currently train our Enrollee-facing staff and providers on a trauma-informed approach and will enhance and expand this training on the new contract. We promote SAMHSA's Six Key Principles of a Trauma-Informed Approach. This trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles can be applied across multiple types of settings. Principles include:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender Issues

Partnering with providers to deliver evidence-based care and services: One way we verify ISHCN Enrollees receive a high standard of care is by partnering with providers to deliver evidence-based preventive, specialty, and integrated care. We do this through telephonic, online, and in-person education at multidisciplinary team meetings to discuss care for specific ISHCN Enrollees. We deploy clinical practice guidelines on the provider portal and provide administrative support in provider practices. Our utilization management (UM) staff assures high-quality care during prior authorization and concurrent review. Our UM team confirms ISHCN Enrollees receive care consistent with clinical guidelines and do not receive unnecessary services.

We reinforce the importance of preventive care with ISCHN Enrollees and providers through reminders and incentives for closing care needs and completing screenings and activities that support EPSDT and HEDIS measures. Incentivizing providers is one way we can help transform the Kentucky health care delivery system for quality and value. Through VBP contracts, we partner with providers to drive Enrollee engagement, improve access to care, decrease non-emergent Emergency Department use, avoid inpatient stays, manage high-risk Enrollees, and improve health care quality and outcomes. We align our VBP incentive payment strategy with DMS' goal of improving health outcomes and reducing costs.

SUMMARY OF HOW WELLCARE OF KENTUCKY'S EXPERIENCE IN PROVIDING SERVICES TO ISHCN ENROLLEES INFORMS OUR APPROACHES

We have an eight year history of implementing innovative programs and fostering collaboration to ensure our ISHCN Enrollees have access to and receive the highest quality of care and services in Kentucky. In addition, we serve similar populations in other state program and we were recently awarded a contract to serve Children's Medical Services in Florida. With the support of our affiliated health plans and our national Population Health team, we focus on improved health outcomes and our approach is completely evidence-based. Our goal is to make it easier for our ISHCN Enrollees to get the high quality healthcare they need, when they need it. We provide a broad range of support for ISHCN Enrollees, ranging from life-sustaining medical care, to therapeutic care and caregiver support and respite. Through community-based partnerships and local services, we help our ISHCN Enrollees successfully navigate complex healthcare systems. This is especially important for ISHCN Enrollees who may be involved with many providers, state agencies, and community-based organizations in the system of care.

We evaluate Care Management and Care Coordination interventions to understand which interventions deliver sustainable results for improved health outcomes and which ones are cost effective for our ISHCN population. Our experience and observations show and outcomes data supports the following interventions consistently contribute to ISHCN Enrollee improved health outcomes:

- Field-based, integrated Care Management and Care Coordination in-person Care Management has a strong and positive impact on clinical outcomes. We streamline the facilitation of appropriate services under the direction of our Care Managers and Care Coordinators, which includes licensed or certified Special Health Needs Coordinators.
- Motivational interviewing helps us understand our ISHCN Enrollees' needs and goals as well as their barriers to achieving positive health outcomes.
- Outreach and education is critical to improved health outcomes. Enrollee education is vital to fostering self-management and monitoring. EPSDT stresses health education to children and their caretakers related to early intervention, health and safety risk assessments at every age, referrals for further diagnosis and treatment of problems discovered during exams and ongoing health maintenance. Provider education improves provider satisfaction and contributes to improved ISHCN health outcomes. In Kentucky, **we have been ranked #1 or #2 for both Enrollee and provider satisfaction for the last two years.** We have improved Kentucky Enrollee access to providers, resulting in an increase in Primary Care Provider visits **from 64.5% in 2013 to over 70% in 2018.** Because of our focus on closing care needs and encouraging preventive care, **91% of our HEDIS measures, including all three Well-Child Visit measures, Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits, have improved year-over-year from 2013 to 2019.**
- Population health management programs target conditions prevalent in the ISCHN population, including asthma and diabetes, and demonstrate sustainable improved health outcomes and lower the cost of care.

- Linkage to social resources provided by community-based organizations through our Community Connections social determinants program fills a significant gap in the ISCHN population. **Since launching the Community Connections Program in Kentucky, we have connected 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program, including a 26% reduction in Emergency Department visits and a 53% decrease in inpatient spending (Robert Wood Johnson study of our Community Connections program, 2016).**

b. Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:

The components of our Care Management and Care Coordination program include:

- Assignment of a Care Manager or Care Coordinator to ISHCN Enrollees who are identified as high-risk and those in the ISCHN adult guardianship population
- Completion of a health risk assessment (HRA) and a comprehensive needs assessment along with supplemental assessments, as needed, to drive development of an individualized care plan with personal, measurable goals and outcomes for qualifying ISHCN Enrollees
- Risk stratification of new Enrollees and monthly predictive modeling of all Enrollees using sophisticated, proprietary algorithms to identify care needs and Enrollees who can benefit from Care Management or Care Coordination
- Plans for diversion from or transition from institutional care, as needed
- Solution-oriented follow up and monitoring after an Emergency Department visit or institutional care to identify opportunities for care improvement to prevent re-institutionalization
- Identify care needs, including accessibility issues
- Identification of barriers that affect the ISHCN's social determinants of health and their ability to adhere to treatments or maintain their health
- Identification of service needs to support ISHCN Enrollees to remain in their homes or other community-based setting
- Symptom management, medication management, and emotional and behavioral health support
- Parent/guardian and caregiver training regarding diagnoses, medications, symptoms, and how to use and manage specialized medical equipment used by some ISHCN Enrollees, including a crisis or back-up plan for loss of power
- Arranging transportation to serve an ISHCN Enrollee and family's needs and assistance with scheduling appointments

- Communication with schools and school-based providers on the development of an individual education plan (IEP), 504 plan, or other education plan and other school-related special program services
- Coordination of EPSDT special program services
- Provider education, such as care needs, and ongoing provider training through webinars, online, and in-person contact, on topics relevant to ISHCN Enrollees, including EPSDT
- Communication and information sharing among Primary Care Providers/Pediatricians, pediatric specialists, behavioral health providers, state entity staff, and others involved in an ISHCN Enrollee's care

Our field-based, high touch Care Management and Care Coordination program supports ISHCN. Medical Director, Howard Shaps, MD, MBA, Vice President of Health Services, Terri Flanigan, and Population Health Management Director, Shannon Maggard lead our Care Management and Care Coordination team and our population health management programs. This team comprises Care Management and Care Coordination leadership and a mix of qualified, experienced, and local Care Managers and Care Coordinators with medical, social work, and behavioral health backgrounds. Our approach provides individualized care and integration between medical, behavioral, pharmacy, and social needs, led by a Care Manager or Care Coordinator and delivered through a multidisciplinary team.

i. Approach to identifying Enrollees.

Our approach to identifying begins with our intensive efforts to locate and engage ISHCN Enrollees and families/caregivers in care and services and to take action on the ISHCN Enrollee's health. WellCare of Kentucky has a team of over 300 associates located throughout the Commonwealth in our six regionally based offices, living and serving in the communities that our Enrollees and providers reside and establishing relationships throughout each DMS region. We are the only MCO with Enrollee and provider-facing staff deployed through six regional offices across the Commonwealth, including nurses, social workers, community engagement partners, quality and provider relations staff. In Region 8, we deployed Enrollee outreach coordinators to locate and engage Enrollees, including ISHCN Enrollees, identified as high-risk. This local and integrated approach to our organizational structure, gives us the knowledge and flexibility to connect ISHCN Enrollees to local programs that are effective and meaningful to them and their health outcomes. We established a Care Center located in Hazard, which focuses on helping Enrollees navigate the Medicaid program and healthcare landscape. Our vision for this center is to improve Enrollee education, satisfaction, retention, and outcomes for our ISHCN. Critical to identifying Enrollees in the ISHCN population is developing and maintaining relationships with local providers, community-based organization staff, homeless shelter staff, and state entity staff, including Department, DJJ, and the Office for Children with Special Health Care Needs (OCSHCN) staff. These relationships increase the number of ISHCN Enrollee referrals and our ability to facilitate their access to appropriate care by connecting them to a Care Manager and a multidisciplinary care team.

There is no wrong door for ISHCN populations to access our Care Management and Care Coordination program. To identify ISHCN Enrollees, WellCare of Kentucky uses various sources of information and employs all possible data and identification efforts including health risk assessment (HRA) results, ID/Strat risk score and Care Management referrals to identify ISHCN Enrollees. The following methods help us identify ISHCN Enrollees:

- *834 Eligibility files:* In the 834 files, data element fields may identify an ISHCN Enrollee. Data element fields that assist in identifying individuals include, but are not limited to date of birth (over 65 years), link to other Enrollees (family members previously identified), an indicator of Medicare part A/B, or institutional status. Further, we may be able to identify ISCHN Enrollees who are participating in multiple Commonwealth programs. We perform retrospective review of secondary claims that indicate additional coverage.
- *Self-reporting:* We contact any Enrollee or family/caregiver who self-identifies an Enrollee as having special health care needs. Our outreach includes completion of an HRA to validate their report. Once we identify the Enrollee as qualifying as ISCHN, we engage the ISHCN Enrollee in the appropriate level of Care Management or Care Coordination and assistance.
- *Manual referrals:* Care Managers, Care Coordinators, Enrollee Services representatives, Primary Care Providers, UM staff, concurrent review nurses, 24/7 nurse line and behavioral health crisis line staff, Community Connections Hotline staff, and community partners may identify ISHCN Enrollees, including those at high risk needing Care Management. Our local field-based and telephonic staff are a reliable resource to identify ISHCN Enrollees with special health care needs. For example, they may identify an additional individual in the same family, residence, shelter, or receive referral from an Enrollee or family member engaged in Care Coordination services. Our provider-facing staff, including Quality Practice Advisors, work with providers to close care gaps and improve quality measurements. They have access to medical chart information and data and to local provider office staff. Both present opportunities to identify ISHCN Enrollees and refer them for Care Management or Care Coordination, as needed. Provider Relations representatives offers training to providers to promote their awareness of the resources available to ISHCN Enrollees. We encourage providers to alert us early and quickly when they identify adult or child ISHCN Enrollees and when they refer an EPSDT-eligible Enrollee to EPSDT special services.

Our health plan in Hawaii, 'Ohana, has a collaboration and data-sharing agreement with the local Homeless Management Information System (HMIS) agencies which allows us to capture real-time data of 'Ohana Enrollees and what services they received (e.g., emergency shelter, temporary housing, etc.) through HUD-funded housing network.

- *The Office for Children with Special Health Care Needs (OCSHCN):* Formerly the Commission for Children with Special Health Care Needs, this state entity provides comprehensive care to children and youth with special health care needs who are Kentucky residents, younger than age 21, meet medical eligibility, and meet financial eligibility. We have an established and collaborative relationship with OCSHCN staff who refer ISHCN Enrollees to us for Care

Management and Care Coordination of care services. We work in collaboration with them and our 44 medically complex foster care ISHCN Enrollees, meeting no less than twice a year and communicating at least monthly on these needs of these special Enrollees.

- *Claims submissions:* System flags attach to specific ICD-10 codes and serve as a stop-gap measure in identifying individuals with chronic conditions, those receiving EPSDT services, those with a location code indicating an institutional setting or code Z59.0 indicating an ISHCN Enrollee experiencing homelessness or likelihood of homelessness.
- *Community Connection Hotline (CCHL):* Our open-access toll-free CCHL call center provides Enrollees, families, and the public connectivity to free resources to help with social determinants of care. CCHL staff occasionally identify our own Enrollees who self-identify with special health care needs when calling the CCHL.
- *Event triggers, discharge management, and transitional Care Management resources:* Individuals involved in discharge planning and the coordination of care for Enrollees who are transitioning from one care setting to another often refer to WellCare of Kentucky individuals who have special health care needs. Relevant data to facilitate ISHCN Enrollees includes inpatient authorizations, and claims data, including length of stay, admission acuity, comorbid conditions, and Emergency Department use during the last six months. Predictive modeling includes our modified readmission prediction tool improved from the nationally recognized LACE score to identify individuals at risk of inpatient readmission.
- *Authorization for services:* A request for authorization may serve as an identifier of an ISHCN Enrollees. This includes a request for inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol/drug use treatment center, and NICUs.
- *Unified Family Court:* With matters involving a family being addressed by a single judge, there is an opportunity to identify and engage WellCare of Kentucky justice-involved Enrollees after domestic violence, dependency, termination of parental rights, and status offenses (runaways, truancy, and beyond control). Recognizing the impact of conflict on health outcomes, we identify Enrollees involved in the family court system as having the potential to be an ISHCN Enrollee.
- *KY-HMIS:* The system collects and reports information on homelessness, which may assist us in identifying individuals experiencing homelessness, which is a Department-specified ISHCN category. This cutting-edge research and data collection demonstrates our commitment to address the housing crisis while documenting the correlations and root causes between homelessness and health outcomes. Eventually this robust data collection could serve as a foundation for predictive modeling tools.
- *Reach program and HRA:* Our staff uses a combination of systematic telephonic outreach at different times on different days and community-based, in-person outreach to locate and engage hard-to-reach Enrollees to increase completion of the HRA and to engage Enrollees identified as having high risk through predictive modeling.

USING DATA ANALYTICS TO IDENTIFY ENROLLEES WITH HIGH NEEDS

Our effective risk scoring and stratification process, depicted in **Figure C.25-1**, ensures ISHCN Enrollees who need services and supports receive them quickly. We use a well-defined and documented process to identify high-needs Enrollees in priority populations who could benefit from Care Management. Our Identification and Stratification (ID/Strat) process is a proprietary multichannel approach that analyzes data sources from our integrated platform to identify priority populations, such as those with emerging risk factors or high-risk needs like high risk pregnancy or individuals with a substance use disorder (SUD). The model accepts varying frequency of inputs and uses a proprietary predictive algorithm that takes all variables (e.g., readmission risk, HRA results, chronic diagnosis classifications, claims and pharmacy data, pharmacy adherence, zip codes, and race and ethnicity) into consideration to identify ISHCN Enrollees at risk early and direct them, using our assignment logic to the appropriate intensity of care and the most appropriate Care Manager or other support person based on their hierarchy of condition and their specific needs. Our Care Manager performs a comprehensive assessment to confirm risk level and holistic care needs through a care plan

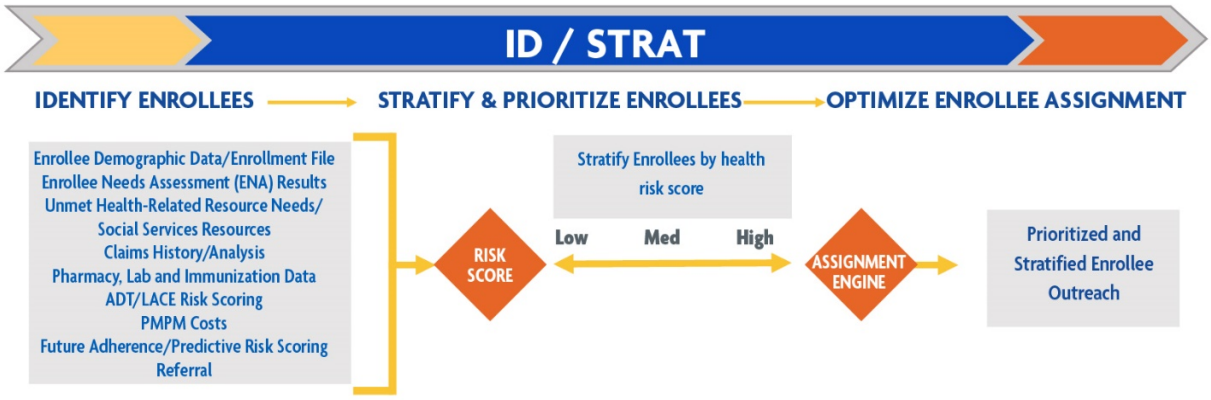


Figure C.25-1 ID/STRAT

After first launching the tool, WellCare identified 20 percent more Enrollees previously masked by claims-only based identification tools and half of those had a BH diagnosis.

Key to the success of our program is how we adapt tools to meet the specific needs of the populations we serve and how we leverage these tools in a fully integrated manner. For example, while all health plans have a risk stratification system as required, WellCare designed our stratification process with predictive analytics specific to the Medicaid population, which allows us to better identify emerging risks as well as behavioral health and substance use risks that are often masked in traditional cost-based stratification models. Our Opioid risk identification and stratification process, for example, can identify, after the first opioid prescription is written, who is at risk for misusing that drug. We assign all Enrollees that fill their first opioid prescription a Risk of Unsafe Use Score™, which identifies Enrollees at risk of unsafe use of prescription opioids and predicts the likelihood that an opioid user will be diagnosed with unsafe opioid use in the next one-year period. This allows us to intervene early with specially trained Care Managers to prevent Opioid misuse. Generally, our risk stratification methodology allows us to determine the risk of our overall population and identify Enrollee risk

levels. Our stratification methodology uses integrated data sources to identify Enrollee needs for services and is run as continuous intervals to ensure new and emerging risks are identified.

ii. Process for screening and assessing individual Enrollee needs

We begin with an assessment and discovery process to better understand the needs of an ISHCN Enrollee and their family/caregivers. Our Care Management and Care Coordination program is rooted in evidence-based strategies for successful coordination of ISHCN Enrollees with complex conditions to assure delivery of accessible, safe, well-coordinated, cost-effective, high-quality care. This includes incorporating population health management program interventions and social services into an individualized care plan. The vulnerable nature of the ISHCN population requires us to place a high priority on Care Coordination activities longitudinally and during care transitions and unplanned acute episodic care. ISHCN Enrollees can move between population health management programs and tiered Care Coordination, depending on the ISHCN's identified needs and preferences.

Our process for screening and assessing individual Enrollee needs includes:

Health Risk Assessment. The HRA is a standardized tool, as designated by DMS, is one way we identify urgent needs to assign ISHCN Enrollees to one of our population health management programs or to Care Management or Care Coordination. We include the HRA in our new Enrollee welcome packet and reach out by phone multiple times at different times to encourage Enrollees to complete the screening within the first 30 days of enrollment and annually thereafter to identify any new needs. With historically low rates of HRA completion across Medicaid populations for all MCOs, WellCare of Kentucky continues to evaluate the best approach to encourage Enrollee completion, such as incentives and different modality options (e.g., mobile). Our Kentucky unable-to-reach in-person contact strategy (REACH) boosted HRA completion rates in Kentucky in Region 8.

Enrollee Needs Assessment. We conduct a comprehensive Enrollee Needs Assessment for individuals identified as potentially needing a higher level of Care Coordination program services. This assesses their immediate, current and past healthcare, mental health, and SUD needs; psychosocial, functional, and cognitive needs; social determinants of health, including employment and housing; ongoing conditions or needs that require treatment or care monitoring; current care being received; current medications; and their support network. The goal of the Enrollee Needs Assessment is to gain a whole-person understanding of the individual's goals, strengths, needs, preferences, abilities, functional needs, and physical and behavioral health status. Within 30 days of an ISHCN Enrollee's referral to Care Management, a local WellCare of Kentucky conducts an Enrollee Needs Assessment in a location and manner that meet their needs to validate which level of Care Management is required for the individual and, if so, the individual's needs.

COMPONENTS OF THE ENROLLEE ASSESSMENT TOOL

Care Managers contact ISHCN or potentially ISHCN Enrollees and/or their families to schedule an in-person Enrollee Needs Assessment at a time and in a place convenient for the Enrollee. The contents includes at least the following elements:

- Immediate care needs
- Current services
- Care and service preferences
- Personal goals (Enrollee and family)
- Demographics
- Clinical Screenings
- Supplemental Assessments
- State or local services currently used
- Physical, intellectual, development disabilities
- Physical health Conditions
- Failure to Thrive
- Developmental Milestone Checklist
- Mental health history (current)
- Substance use history (current)
- Community supports received
- Non-covered benefits received
- Medication list (prescribed and taken)
- DME/Medical Supplies
- Natural supports available
- Functional status (ADLs/IADLs)
- Pain assessment
- Diet/weight
- Safety issues/Falls
- Unmet health-related needs
- Transportation needs
- Housing or shelter needs
- Clothing and hygiene resources
- Employment and education
- DME needs
- Food insecurities
- Domestic violence risks
- Family conflict
- Financial limitations

Our CareCentral clinical IT platform includes a dynamic, configurable comprehensive Enrollee Needs Assessment module that allows us to drill down to specific Enrollee needs. We maintain methodologies and tools for conducting comprehensive Enrollee Needs Assessments for differing demographics and needs while respecting individual choice. Care Managers also use supplemental assessments for individuals in priority populations. We share the results of the Enrollee Needs Assessment with the Enrollee and their PCP within 14 days of completion to inform care planning and treatment planning, as consented to by the Enrollee to the extent required by law.

Supplemental Assessments: Variation in the comprehensive Enrollee Needs Assessment tool relies on branching logic. This means Care Managers are prompted to ask additional questions based on trigger questions, Enrollee responses, and an individual's unique situation. Branching logic streamlines the Enrollee experience and avoids unnecessary questions, which supports completion of the assessment. Supplemental assessments target particular health conditions like diabetes, asthma, depression, or social determinants of health, as well as different priority

population needs, such as asking different questions of a woman with a high-risk pregnancy than those asked of a parent with a child under age five with complex needs.

For all Enrollees, as indicated by certain answers, Care Managers can use validated supplemental screening tools:

- CAGE (Drug and alcohol use screening tool for individuals 16+)
- CRAFFT (Screens for high-risk alcohol and other drug disorders for people ages 12 to 21)
- PHQ-9 (Depression screening tool for individuals age 13+)
- AUDIT-C (Alcohol Use Disorders Identification Test) to screen adults for alcohol use
- Edinburgh Postnatal Depression Scale, a screening tool for postpartum depression

In addition, experience in managing individuals with chronic pain has led us to include screening for opioid use disorder. Care Managers can use the Opioid Risk Tool (ORT), which is a brief, validated screening tool to use to monitor the risk for opioid addiction among adults prescribed certain medications. **Table C.25-2** shows other tools to support identifying and stratifying Enrollees to support services.

Table C.25-2 Additional Support Tools

Additional Tools to Identify and Stratify Enrollees and To Support Services	
Supplemental Tool	**Description**
Smart Care Management Assignment	We generate a daily census report of Enrollees, by risk level, who may benefit from varying levels of PHM intervention. We subsequently segment Enrollees based on risk score and population, such as ISHCN, SMI, SED, Disease Management, Behavioral Health, Transplant, Foster Care, etc. to allow for timely referral to the appropriate resource in the field or telephonically within our clinical teams.
Standard care planning tools	Our care plans are built in CareCentral and guided by standard evidence-based guidelines.
Social Service Needs Assessment, Database and Call Center	Through our database of social service resources, we can track the needs of the population and intervene at the Enrollee, organization, and systemic level to support Care Coordination services.
Holistic view of Enrollee needs	Our Member 360 view helps quickly identify ISHCN Enrollee needs and supports services provided to them by showing any Enrollee-facing staff a holistic view
Provider Portal and Data Exchange Process	Our provider portal is connected to CareCentral, which allows us to share the outcomes of health screens, EPSDT screening and special program services, social determinants of health obstacles, Enrollee assessments, care plans, and multidisciplinary team contacts with providers. Providers can view open

Additional Tools to Identify and Stratify Enrollees and To Support Services	
	and pending care needs through the portal and notify us when those care needs are closed through encounters, claims, EMR interchange, or submission of supplemental medical record information.
Mobile and web Prevention and Wellness education	Through digital platforms, which comply with Federal Section 508 standards and web content accessibility guidelines, Enrollees learn about benefits and services, how to access care, learn about preventive care, how to self-enroll in our health and wellness programs, and how to order a new ID card. Engaging ISHCN Enrollees through their mobile devices and helping them to take even small steps, such as downloading our MyWellCare mobile app, is a step toward empowering them to be active participants in their health and health care.

iii. Approach to provide education to Enrollees and caregivers

WellCare of Kentucky demonstrates ISHCN Enrollees are our priority by putting our Enrollees first so they can get the care and services they need to stay healthy. We maintain a strong focus on early prevention and treatment. We help Enrollees and their caregivers effectively use the resources available through special program services and our population health programs. We offer a wide range of educational materials and use numerous and innovative methods to inform Enrollees, caregivers, and providers about the availability of special program services and to maximize the benefit of our targeted population health programs. We consistently refer ISHCN Enrollees to and coordinate with other providers that provide special program services, such as EPSDT screening and special program services, dental services, and transportation, and to our population health programs that target chronic conditions prevalent in the ISHCN population.

EDUCATING ISHCN ENROLLEES AND CAREGIVERS

Enrollees and their families or guardians want to know what benefits and services are covered. We empower ISHCN Enrollees and their caregivers to take action on their health by providing access to education and resources chronic condition. We meet Enrollees where they are by offering a multi-modal communication and outreach approach that includes specialty-service program descriptions and condition-specific education via easily understood written and online materials; verbal explanations from WellCare of Kentucky staff, providers, and community-based organizations; digital communications; face-to-face interactions; and home visits when appropriate. In all Commonwealth regions, Enrollees and community residents who participate in community events and activities can talk to our staff face-to-face and meet with our community partners to learn about improving health and wellness and the features and benefits of our special program services like EPSDT and our population health programs.

Parents and guardians have both a responsibility and desire to ensure their children get needed health services, but many need education and support to understand and access EPSDT screening and other special program services like dental services and transportation. We coordinate access to other child-oriented special program services like pediatric sexual abuse

examinations. In this case, WellCare of Kentucky staff informs parents and caregivers that we have providers in our network who have the capacity to perform a forensic pediatric sexual abuse examination, and upon receiving a request from DCBS, we coordinate this service. We have an established relationship with DCBS and our staff works closely and collaboratively with DCBS staff to coordinate services for our Enrollees.

METHODS TO EDUCATE ISHCN ENROLLEES AND CAREGIVERS ABOUT BENEFITS AND SERVICES

Our experience tells us that Enrollees and their families/guardians have different preferences in how they learn about covered benefits and services. We meet Enrollees where they are and use a variety of methods to continually educate Enrollees and families/guardians about special program services:

- *New Enrollee Welcome Call and Welcome Packet:* We offer a combination of automated and live new Enrollee Welcome Calls, which includes calls to action like asking all Enrollees to confirm receipt of new Enrollee onboarding materials, including the Welcome Packet and ID card and reminding them to schedule primary care appointments. In addition to the Welcome letter and other informational items, our Welcome Packet includes information related to special program services and population health management programs, including but not limited to:
    - Message encouraging all ISHCN and/or their guardians to schedule well checkups
    - Information on the appropriate use of the Emergency Department
    - Healthy rewards incentive program brochure, a program that rewards Enrollees who complete specific preventive health, EPSDT, wellness, and engagement milestones
    - We include other tools in the initial welcome packet and in subsequent Enrollee communications. This includes prenatal care materials and important phone numbers, including nurse advice line and our Community Connections Help Line (CCHL) for assistance with social resource needs. We direct all Enrollees to call our Enrollee Services toll-free line to obtain written materials, receive assistance with the Enrollee portal, or to receive assistance on any other matter like help finding a doctor or dentist. All material included in the Welcome Packet is also available on the Enrollee portal.
- *Welcome Video:* Our captioned, dynamic welcome video is a recent innovation to engage our Enrollees through a multi-media version of the written Quick Start Guide, included in the Welcome Packet. Enrollees and caregivers access the video through a link on a new Enrollee welcome text (SMS) message. The four-minute video on WellCare Health Plans, Inc.’s (WellCare's) YouTube channel explains in English, with captioning in Spanish. It educates viewers about resources where an Enrollee can learn about benefits and services, including special services like EPSDT and dental services, the role of a Primary Care Provider with a prompt to schedule an appointment, the purpose of the nurse advice line, availability of population health programs, and how to reach our CCHL for live assistance with social needs.
- *Enrollee Services Call Center:* WellCare of Kentucky Enrollees can reach our Enrollee Services call center staff at 1-877-389-9457. Enrollee Services representatives are often an Enrollee’s first contact with us. When an Enrollee initiates an inbound call and it is their first contact,

the Enrollee Services representative helps the Enrollee complete the onboarding process, including completing their initial health risk assessment. They help Enrollees and caregivers understand benefits and services and answer questions about how to access services; help Enrollees find a doctor or other providers and schedule appointments; and help Enrollees connect to other health care services like dental services or voluntary family planning services. Depending on an Enrollee's needs, an Enrollee Services representative may help an Enrollee connect to the Kentucky Transportation Cabinet, Office of Transportation Delivery for nonemergency transportation services or connect them to a Care Manager for medical or behavioral health concerns.

- *Public Website:* WellCare of Kentucky has a mobile-responsive public website. In 2018, the top three most visited sections of the Kentucky Medicaid website included the Welcome page, the Healthy Rewards Program page, and the Benefits page. Our Healthy Rewards Program provides gift card rewards for Enrollees completing wellness visits and preventive care.
- *Enrollee Portal:* Enrollees can access the portal from the internet or from mobile devices. It provides Enrollees a secure, personalized health care experience and 24/7 access to self-service functions. Within the portal, Enrollees can change Primary Care Providers or check on the status of service authorizations. Enrollee portal features banners, which we can use to call attention to special program services. Our Enrollee portal offers Enrollees and families/guardians the following information:
    - Enrollee-specific care needs and how to close those gaps
    - Electronic versions of Enrollee newsletters, which include articles about the availability of special services programs
    - Find-A-Provider search tool
    - Enrollee rights and responsibilities
- *Enrollee Handbook:* Our Kentucky Enrollee Handbook contains information to help Enrollees connect to the care and services they need. Enrollees and families can access the Enrollee Handbook on our secure Enrollee portal at wellcare.com/Kentucky. Through simple navigation and two clicks, Kentucky Enrollees can download the Enrollee Handbook, learn about preventive care, and find FAQs in the New Enrollee Quick Tips section. The Find-A-Provider resource is an intuitively designed query tool recently redesigned according to health literacy principles to help Enrollees find physicians using words, such as pediatrician or obstetrician. Enrollees filter and compare search results by languages, gender, accessibility considerations, specialty, and distance from a user-chosen location, such as home, work, or current location. The Enrollee Handbook highlights special services program descriptions, including but not limited to:
    - Covered Services, immunizations, pregnancy services, and hospital services
    - WellCare of Kentucky's extra benefits like our Healthy Rewards Program Enrollee incentive program and other value-added services, such as over-the-counter items - $10/month per household and free sports physical, maternity care special program services along with our population health management WellCare Baby Steps maternal and child health program

- Emergency care, including nurse advice line and out-of-area emergency care; urgent care; and post stabilization care services
- Dental services
- Non-Emergency Medical Transportation (NEMT)
- EPSDT
- Lock-In Program

- *Digital Engagement:* An effective means of Enrollee engagement, we direct our Enrollees to our digital platforms and demonstrate how to navigate managed care as a convenient way for Enrollees to obtain information or perform self-service functions. Through digital platforms, which comply with Federal Section 508 standards and web content accessibility guidelines, Enrollees learn about benefits and services, how to access care, learn about preventive care, how to self-enroll in our health and wellness programs, and how to order a new ID card. For Medicaid Enrollees with frequent address changes, mailed materials sometimes do not reach them but digital communication are often an effective means of communication. Engaging Enrollees through their mobile devices and helping them to take even small steps, such as downloading our mobile app, is a step toward empowering them to be active participants in their health and health care.

- *MyWellCare mobile app:* Our mobile app makes getting and staying healthier easy. WellCare actively uses our mobile app to communicate important information to our Enrollees and provides easy access to services. In 2018, as a result of **our proactive approach and updated functionality, WellCare of Kentucky experienced a YoY increase of 476% in downloads of the mobile app for Kentucky Medicaid Enrollees from 2017-2018. The top app features used in 2018 were Find A Provider, Messages, and ID card.**

  The MyWellCare mobile app is free and is compatible with Apple and Android devices. This digital engagement tool enables Enrollees to assume more responsibility for their health through familiar tech capabilities and functions. Enrollees can call the Enrollee Services number on the back of their ID cards if they have questions about the mobile app or need assistance downloading it.

  Using the app, Enrollees can view open care needs displayed together with their provider's phone number, which they can tap to call and schedule appointments. They can email their Mobile ID card to providers. We continually add functionalities to our digital applications to keep pace with our Enrollees' increasing utilization and feedback regarding their online experience. **Figure C.25-2** shows the MyWellCare mobile app features.

Figure C.25-2 Using the MyWellCare mobile app, users can use a smart phone or tablet to pull up their ID card, find a provider, and more.

We align monthly health messaging with general, non-PHI messages, or push notifications that mirror the inbound IVR route messaging and the public website.

- *WellCare's mobile app promotes the health and wellness of new mothers in an interactive and modern way by providing immediate, cutting-edge support for new moms at the touch of a button.* The app is a live video chat service, available 24/7 through smartphones. It provides new mothers immediate access to certified providers including lactation consultants and nutritionists. Mothers can receive breastfeeding support as well as guidance related to any health issues their babies may be experiencing, such as colic, digestion, transitioning to solid foods and more. We are piloting this mobile app on our Arizona Medicaid program. The app features push notifications that appear regularly on the mobile devices of registered Enrollees. These helpful alerts include health and safety tips that are beneficial to mothers and their babies.
- *JOOL:* JOOL is a digital life coach mobile application customized for WellCare's foster care ISHCN Enrollees to prepare them for transitioning from the foster care program. Twelve months before aging out of the program, we provide mobile devices with the JOOL app for Enrollees to create a private account and complete an initial screening about their physical/behavioral health and transition goals. JOOL then creates a personalized, step action plan featuring daily check-ins with a chatbot for ISHCN Enrollees to report on their goals progress as well as stress levels and sleeping habits. Powered by machine learning, the chatbot responds to the Enrollee's daily check-ins with short messages, called daily JOOL, which become progressively more attuned to the ISHCN Enrollee's progress or challenges. For example, if an Enrollee reports a lack of sleep, the chatbot recalls that a previous sleep deprivation episode resulted in the Enrollee skipping meds and missing a medical appointment. The chatbot's daily JOOL would correspondingly urge the ISHCN Enrollee to go to bed earlier. Combined with WellCare of Kentucky's supportive, Care Managers who are trained in trauma-informed care, JOOL is a breakthrough app helping ISHCN Enrollees stay on track with their care plans and learn self-care.
- *MyStrength:* As an evidence-based digital behavioral health platform, MyStrength provides our ISHCN Enrollees with interactive clinical programs empowering them to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges, while also supporting the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care.
- *Inbound caller IVR route messaging increase health and wellness awareness:* We create IVR route messaging that inbound callers hear as their calls transfer to our staff. Route messages rotate from month to month and focus on specific health and wellness topics. For example, in 2019:
    - **March:** Dental health for you or your child is important. Ask your customer advocate about your dental benefits. He or she can help set up a visit with your dentist. WellCare of Kentucky is your partner in preventive health!
    - **April:** April 22 to April 26 is Every Kid Healthy Week. Help your kids eat healthy and stay active all year long. Do you want to learn about nutrition and healthy habits? Ask your

customer advocate to set up a visit for you and your doctor! WellCare of Kentucky is your partner in preventive health!

- *Outbound calls regarding Enrollee care needs:* WellCare of Kentucky quality staff, Field Outreach Coordinators, and Care Managers make outbound calls to Enrollees and families or guardians to close gaps in care, including overdue EPSDT screenings or immunizations. Our staff provides reinforcement and support, such as assistance with scheduling appointments for needed services like well-child visits, immunizations, or blood lead screening as well as for annual adolescent and dental screenings. As an example, our quality staff initiated an Enrollee outreach campaign from October 2017 to December 2017 to increase well-child and dental visits. *Quality staff called 10,573 Enrollees. Of those calls, we successfully reached 3,226 Enrollees and closed 681 additional care gaps.* This had an impact on the following quality measures: our Adolescent Well Care measure improved by 31.57%, our Well Child visit measure for children 3-6 years old improved by 25.96%, and the Annual Dental Visits measure improved by 11.59%. In addition, Adolescent Immunizations, Combo 2 improved by 5.67%.
- *Mailings in the form of annual/seasonal prevention written reminders and newsletters:* We send to Enrollees and caregivers an EPSDT guide and birthday cards (shown in **Figure C.25.3**) to remind EPSDT Enrollees about the screenings and preventive services they should receive during the year. Birthday cards encourage Enrollees to reach out to their Primary Care Provider to schedule a check-up and receive screenings and/or preventive services. We send targeted reminders, e.g., reminding Enrollees that February is Oral Health Month to encourage Enrollees to use dental services. Enrollee newsletters (mailed and electronic on the Enrollee portal) contain benefit updates and details, highlight new services, communicate outreach events in specific communities, and present fitness and health education.

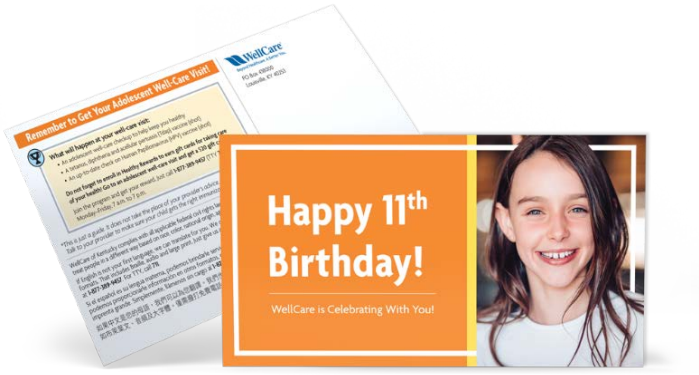


Figure C.25-3. Birthday cards remind Enrollees about screenings and preventive services.

- *Outreaching and Educating Enrollees at Community Events:* We share a common goal with our community partners to improve the lives of the people in Kentucky communities. We engage with Enrollees and caregivers in their own neighborhoods through our Community Connections Program and our comprehensive Enrollee and Community Education and Outreach Program**. In Kentucky in 2019, WellCare of Kentucky staff completed 1,409 community activities, reaching 37,509 stakeholders.** Our Community Education and Outreach Program includes creative collaborations with various entities, including schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations,

and more. WellCare of Kentucky staff continually seek new opportunities to partner with organizations that share our commitment to helping to build healthier communities. We leverage these partnerships to hold fun and informative health-related events; support women's health; and educate children and youth about how to develop healthy habits related to fitness and nutrition.

Community events are activities where WellCare of Kentucky staff dedicate time to connect with community agencies or sponsor/host events for the community. Activities include attending interagency council meetings, specific health and social service-focused coalitions, as well as hosting community activities targeted at specific health or social issues. We have a strong commitment to participate in or sponsor local street fairs, health fairs, county fairs, Kentucky State Fair, festivals, and other scheduled and health-related events like community baby showers, which increase Enrollee compliance with and education about the EPSDT program. When our community relations team identifies an ISHCN Enrollee, they refer them to a Care Manager for follow up. WellCare of Kentucky's community relations team participates in community events that align with special program services and our Population Health Management program focus areas, including:

- *Health Education* -- Obesity: WellCare attended the YMCA Kids Day community event in Henderson County to promote healthy eating and living with kids. Asthma: Community health fairs in numerous counties across Kentucky
- *Maternity Care* -- Low Birth Weight and Pre-term Birth: Community baby shower events; Oh Baby Expectant Parent Fair; Parent Empowerment Workshop
- *Transportation* -- Mental health and substance use/misuse: Third Annual West KY Wellness Summit Community Mental Health and Breaking the Stigma! Mental health was the theme of the 2018 summit. WellCare partnered with the Chrysalis House for the past three years, filling transportation gaps that their women in recovery encounter through taxi vouchers, bus passes, and gas for Chrysalis House's on-site van.

- *Kentucky quality staff and Care Management staff:* Care Management staff conduct educational activities that inform Enrollees about special program services and help them access those services. For high-risk ISHCN Enrollees, Care Managers conduct a comprehensive needs assessment that identifies care needs. When identified, they educate the Enrollee about availability and importance of accessing these services, list referrals to special program services in the care plan, and coordinate access to the services. The Care Manager conducts ongoing monitoring and additional education, as needed, to support appropriate access.
- *Triggering events:* Certain events trigger engagement of ISHCN Enrollees with over or under-utilization of services; Emergency Department over-utilization; discharge planning needs; behavioral health crisis intake; pregnancy; opioid or other controlled substance overdose, etc. Care Managers conduct in-person or telephonic outreach, education about appropriate utilization, assessment, and referrals to special program services, as necessary.
- *Providers and community partners assist us in educating Enrollees:* We educate providers to engage their assistance in educating Enrollees when a provider identifies a need for special program services. Our Community Connections team educates our community partners

about special program services so that they can reinforce our efforts to increase Enrollee awareness of special program services and population health program services and the benefit of using these services to improve health outcomes.

- *Creative efforts to target outreach and education efforts to Enrollees in harder-to-reach populations (e.g., Hispanic, African American, LGBT community, young adult, and veterans):* Partnering with faith-based and other community organizations, including food banks and homeless shelters, serving specific populations helps us connect with Enrollees in hard-to-reach or hard to engage populations, including the ISHCN population. Individuals in the community trust these organizations. Developing customized outreach materials and resources helps us engage targeted populations in special program services. In Kentucky, our community engagement staff participate in a number of community events that target harder-to-reach populations. This includes events sponsored by Volunteers of America for veterans who may be homeless, resource fairs for grandparents raising grandchildren, and Healthy Start 502 Fathers baby shower for Jefferson County fathers in the African American community.

  Our staff participated in the World Refugee Day Celebration in Bowling Green, celebrating diversity and cultures of newcomers who arrived through the Refugee Resettlement program. This event highlighted different cultures and provided educational opportunities for attendees to learn about helpful services and programs in the community, including healthcare services. Our staff sat on the committee for a Language Access Forum, an educational event for healthcare staff to learn how to communicate effectively with their patients who have limited English language proficiency. We attended the Americana World Festival hosted by the Americana Community Center of South Louisville and educated Enrollees about healthcare services. Our staff sat on a committee in Perry County for the LGBTQ ALLYance, founded at Hazard Community and Technical College to train organizations how to become a safe space for LGBTQ-identifying individuals, with the hope these individuals will feel safe seeking needed services

APPROACH TO PROVIDING TRANSITION SUPPORT SERVICES

Enrollee outcomes data shows us that specific, timely interventions are effective in successfully supporting individuals as they discharge from hospitals or facilities and move between settings. Care transitions are widely recognized as periods of heightened health risk, which can result in health complications and costly readmissions. Our formal discharge-planning program includes a comprehensive evaluation of an ISHCN Enrollee's physical and behavioral health and social service needs. This is in addition to the identification of services and supports needed to transition into the most clinically appropriate, least restrictive setting possible following an ISHCN Enrollee's discharge from an acute setting, institutional clinical setting or residential placement, or a transition between levels of care. WellCare of Kentucky has experience with discharge management at the Commonwealth's four hospitals, including Western State Hospital (WSH), Eastern State Hospital (ESH), Central State Hospital (CSH), and Appalachian Regional Hospital (ARH). During 2019, 271 of our Medicaid Enrollees were discharged from

these four hospitals. Approximately 40% of these Enrollees agreed to engage with our Care Coordinator in discharge planning and Care Coordination activities.

WellCare of Kentucky uses transparent UM processes and takes steps to quickly approve services needed post discharge to maintain an ISHCN Enrollee in the least restrictive setting possible. **Our Care Coordinator outreach efforts continue to have a positive impact on reducing hospital readmissions in Kentucky. In 2018, WellCare of Kentucky's readmission rate for the number of Enrollees readmitted to an acute hospital or facility within 30 days of a discharge was down 3% from 2016.**

Our current experience serving the ISHCN population in the Kentucky Medicaid program informs our approach to meeting the Commonwealth's expectations and requirements for discharge management and transitional Care Management for ISHCN Enrollees and their families. On the current contract, WellCare of Kentucky leadership staff meet with providers and with hospital and facility staff serving large groups of ISHCN Enrollees, including our foster care and adoption assistance population, e.g., Our Lady of Peace; Children's Alliance and PRTFs, to enhance discharge-planning processes, improve information sharing, and expand educational opportunities, such as pharmacy utilization of psychotropic medications and telehealth to increase access to specialists.

DISCHARGE PLANNING NEEDS OF ISHCN ENROLLEES

We collaborate with hospitals and other acute care facilities, PRTFs, residential providers, physical and behavioral health providers, the Children's Review Program, DMS, DCBS, the DJJ Placement Services Division, and others on discharge planning needs of ISHCN Enrollees across all levels of care. Today, we coordinate care for our ISHCN Enrollees across a full continuum of care. Our current Care Coordination team works hand in hand with our Utilization Management team to make sure we share and incorporate into the discharge planning process all clinical information and social determinants for health information. We encourage Care Coordination team planning with providers to assure discharge planning consistency and ensure referrals for the next level of care are in process. To plan for discharge, clinical services need to be identified and appropriate placement and levels of supervision needed must be identified. Often, a hold up to identifying an appropriate discharge plan is due to the ISHCN Enrollee's level of supervision need. Once the appropriate placement is identified, finding the correct level of clinical intervention can then be planned. Discharge planning also involves ensuring that social determinants of health and community resources are identified and planned. WellCare of Kentucky maintains written policies and procedures in place for discharge planning focused on strengths-based, culturally competent, and medically appropriate treatment designed to meet Enrollee needs, including those identified with emotional and behavioral issues.

Notification of admission or discharge facilitates timely Enrollee engagement: WellCare of Kentucky uses predictive analytic ID/Strat results, admission, discharge, and transfer (ADT) feeds, direct facility EMR access, electronic prior authorization requests in 278 format, faxes, and HIE to identify ISHCN Enrollees with an inpatient admission and who are experiencing a care transition. In addition to having hospital-based staff onsite in larger Kentucky hospitals and facilities, we require WellCare of Kentucky network hospitals to alert us when Enrollees have an inpatient stay or come to the Emergency Department with physical or behavioral health issues.

In-person staff in large hospitals and enhances our engagement with Enrollees: To engage Enrollees quickly, we embed onsite inpatient Care Managers in high-volume hospitals and facilities and telephonic concurrent review nurses at low-volume hospitals and facilities to identify ISHCN Enrollees experiencing an inpatient stay. Onsite inpatient Care Managers, concurrent review nurses, and our integrated Care Coordination system, CareCentral, enhance a Care Coordinator's ability to quickly engage ISHCN Enrollees. Our approach to Care Management ensures each ISHCN Enrollee needing discharge management and transitional Care Management has a single point of contact who follows-up with the ISHCN Enrollee, family, network providers, and state staff, if involved. Embedded onsite inpatient Care Managers and concurrent review nurses review inpatient hospital and facility stays for medical necessity. They review an ISHCN Enrollee's status to assure the severity of presenting symptoms and the intensity of services provided support the ongoing need for an inpatient level of service. A Care Coordinator completes medication reconciliation telephonically with the WellCare of Kentucky pharmacist.

Advanced analytics identify Enrollees at high risk of readmission: WellCare conducts predictive modeling and risk stratification to identify ISHCN Enrollees at moderate or high risk of readmission, including the LACE+ index, at admission when discharge planning begins. Our LACE Index Scoring Tool for Risk Assessment of Hospital Readmission system alerts our Care Coordination staff about an ISHCN Enrollee's condition. Activated at the time of ADT or other notification, this proprietary algorithm helps Care Coordinators prioritize care needs. It assigns a daily readmission risk score using length of stay, acuity, comorbidities, and ED use to predict the likelihood of readmission. **Use of the LACE tool, combined with WellCare's added analytics, increased the accuracy of the tool's predictive power by more than 60%.** The LACE+ score guides the level of transitional Care Management and the type (in-home or telephonic) and duration of support and interventions. In Kentucky, we stratify all Enrollees into risk levels.

The following information informs ID/STRAT risk stratification includes:

- A weekly assessment risk score using weighted questions to stratify Enrollees and identify those with statistically significant predictors for multiple readmissions.
- A monthly claims-based risk score using claims related to chronic conditions and enrollment data, e.g., considers aid category separately, a diagnostic classification algorithm, PMPM dollar thresholds, utilization requests, and impactable condition flags.
- A monthly pharmacy adherence score using claims, clinical, and intervention data to show Enrollee compliance with medication regimens based on claims history. It predicts an Enrollee's risk of specific medication outcomes, quantifies the financial value of better medication use, and assesses an Enrollee's receptivity to intervention.
- A monthly predictive risk score using admission, readmission, Emergency Department, and disease progression predictions to create a holistic risk profile.

DISCHARGE PLANNING FROM HOSPITALS AND OTHER ACUTE CARE FACILITIES

Effective discharge planning requires a team approach. Our discharge planning activities prioritize collaboration with hospital or facility staff, network providers, state staff, community advocates and others to create a person-centered discharge plan and facilitate an ISHCN Enrollee's proactive and successful transition to a lower level of care. Rapid responses often require same-day or next-day outreach for high-need ISHCN Enrollees who are admitted to a hospital or facility. Onsite inpatient Care Managers, concurrent review nurses, and Care Coordinators add new ISHCN information related to the hospital or facility admission in the Enrollee's record CareCentral.

Our Care Coordinator makes sure ISHCN Enrollees have voice and choice during the discharge planning process and that an ISHCN Enrollee's family has the training and support they need to keep an ISHCN Enrollee safe and well. For foster care Enrollees, an ISHCN Enrollee's discharge plan and transition care plan align with the DCBS case plan and our care plan in CareCentral. The transition care plan includes safe discharge into the most appropriate, least restrictive setting possible, access to the full range of services needed including behavioral health services.

Our Care Coordinator oversees discharge planning and care transitions, including:

- Provide timely, in-person and/or telephonic follow-up post discharge, scheduling Primary Care Provider post-discharge appointments (48 hours to 7 days), and referrals to specialists, appointment scheduling assistance, transportation, and social needs, follow up to confirm completed appointments, and referral management
- Conduct and update needed assessments
- Coordinate comprehensive medication management, medication reconciliation, and medication self-management, engaging a pharmacist
- Conduct ISHCN Enrollee and parent or caregiver condition-specific education; how to recognize the red flags the Enrollee’s condition is worsening; self-management support; use of a personal health record; alternatives to using the Emergency Department; and wellness/prevention education
- Provide specialized training and education for parents and caregivers when an ISHCN Enrollee has a medically fragile condition that requires special procedures or use of special equipment post discharge
- Create an individualized care plan with interventions, including Primary Care Provider, specialist, and behavioral health visit follow-up appointments, durable medical equipment (DME), in-home supports, and connection to peer support, as appropriate
- Connect ISHCN Enrollees to community resources for health-related social needs using the resources of our Community Connections program. We have extensive engagement and strong partnerships with community-based organizations that support the people of Kentucky with their social needs, including the Community Farm Alliance, Orphan Care Alliance, SOAR, Kentucky Home Place, Operation UNITE, and more

- Connect ISHCN Enrollees to value-added benefits. Many of our value-added services are particularly valuable for ISHCN Enrollees post hospital or facility discharge. For example, home-delivered meals for Enrollees discharged from an inpatient stay hospital, rehabilitation or skilled nursing facility; meal program for Enrollees discharged from a behavioral health facility; respite services for caregivers; and over-the-counter items - $10/month per ISHCN Enrollee or family.
- Convene multidisciplinary team meetings of clinical and non-clinical representatives and strengthen collaboration with hospital and facility discharge planning staff, providers, pharmacies, and ISCHN Enrollees, (for foster care ISHCNs, we include foster parents, adoptive parents, fictive kin, caregivers, and Department, DCBS, and DJJ staff) to coordinate a broad spectrum community-based physical, behavioral, pharmacy, and social services post discharge across all levels of care.
- Facilitate collaboration and oversees information sharing between multidisciplinary team members and state entity staff, if the ISHCN Enrollee is involved in other programs
- Coordinate linkage to community services through our Community Connections program and follow up on referrals to community-based services to see if an ISHCN Enrollee's and family's needs have been met
- Conduct timely in-home, high-touch engagement and follow-up with ISHCN Enrollees with complex care needs. A high-touch, high-intensity home visit from a Care Manager after hospital discharge substantially reduces 30-day readmission rates for individuals with multiple chronic conditions. For individuals with complex chronic conditions, home visits reduce the likelihood of a 30-day readmission by almost 50 percent compared to less intensive forms of transitional care.

Our goal for discharge planning is to provide a proactive and well-coordinated plan for transitioning an Enrollee from an acute setting or inpatient facility or PRTF to the most appropriate level of care while focusing on quality, safety, and ISHCN Enrollee and family satisfaction. Another important goal is to engage ISHCN Enrollees in person-centered services, supports, and resources that wrap around the ISHCN Enrollee to minimize his or her risk for readmission. Assuring timely post-discharge follow-up physician and behavioral health specialist appointments is a key strategy to reducing readmissions.

CARE COORDINATION FOR ISHCN ENROLLEES DISCHARGED FROM RESIDENTIAL CARE

We coordinate inpatient behavioral health discharges, e.g., from Our Lady of Peace or The Ridge, and work with the hospital clinical team to engage with PRTF staff for admission to the Care Coordination program. Our clinical leadership team meets with PRTF leaders to establish and maintain relationships, points of contact, etc. to facilitate smooth behavioral health discharges. Discharge planning is often the first step to an ISHCN Enrollee's recovery. Therefore, we begin planning as close to the point of a behavioral health admission as possible. Within the first 30 days, our Care Coordinator outreaches to the PRTF to discuss initial thoughts of discharge placement and needs. For foster care ISHCN Enrollees, the Children's Review program

or DJJ Placement Services Division must be involved in the discussion to assist with placement identification and referral.

Well-Coordinated Discharge Plan

When our Kentucky foster care Enrollee, Ethan, age 8, was hospitalized during a crisis precipitated by his medical and behavioral health needs, his care coordinator facilitated a consultation call between our Medical Director, Ethan's providers, and his adoptive mother to decide next steps to stabilize him. When psychological testing recommended Applied Behavior Analysis, a service typically only provided to Enrollees with an autism diagnosis, the care coordinator worked with our UM staff to obtain authorization. Today, Ethan is stable, out of the hospital, and living at Home of the Innocents. The family's long-term goal plan is for Ethan to return to a less restrictive setting at home with his adoptive mother.

Prior to discharge, our Care Coordinator works with the PRTF discharge planner to get copies of documents related to our ISHCN Enrollee's care in their facility so we can coordinate getting this information into the Enrollee's record and share this ISHCN Enrollee-specific information with the mental health provider who will be providing the ISHCN Enrollee's aftercare. Essential information includes:

- Medical needs including allergies
- Medication; dosage; clinical rationale; prescriber
- Discharge diagnosis
- Prevention plan to address symptoms of harm to self or others
- Any other essential recommendations
- Appointments with after discharge service providers-date, time, place
- Contact information for internal providers
- Contact information for PRTF discharge planners or liaisons

For any ISHCN Enrollee in a PRTF who is receiving or who has received psychotropic medication during their stay, we expect the clinical rational for each medication to be clearly documented on their psychiatric discharge summary or final evaluation. The reason for discharge should also appear on the PRTF's discharge summary.

Providing an appropriate continuum of behavioral health services and social supports is crucial to achieving a successful transition to home or a community setting and the best possible outcomes for children and youth discharged from residential care. Many ISHCN Enrollees are individuals who have diagnoses of co-occurring mental health and substance youth disorders. In addition, family courts or the juvenile justice system may have had a key role in the placement of the individual in residential care, mandating a residential care placement as part of the disposition process. Our experience shows this population benefits from integrated Care Coordination, family-driven care, community-based support, collaboration between residential

and community-based providers and government entities, and provider adoption of evidence-based and effective practices.

We use a high-fidelity model and strengths-based, culturally and linguistically competent approach that recognizes the importance of the family, school, and community and addresses an ISHCN Enrollee's whole person needs. ISHCN Enrollees discharged from residential care have a Care Coordinator who works collaboratively with residential and community-based providers and others involved in an ISHCN Enrollee's care. The Care Coordinator facilitates shared decision-making with physical and behavioral health providers, pharmacists, ISHCN Enrollees, families, and any involved state entity staff so they work together to make decisions and select treatments and care plans based on clinical evidence that balances risks and expected outcomes with ISHCN Enrollee and family preferences and values.

The Care Coordinator seeks active engagement of the ISHCN Enrollee and his or her family or support system to plan for and coordinate follow-up community-based care and services that become part of the ISHCN Enrollee's care plan. This plan lists traditional steps toward recovery and management of co-occurring physical health conditions as well as a crisis and safety plan. Service planning, service delivery, and post discharge Care Coordination may include but is not limited to:

- An in-home evaluation of the family or living situation
- Coordinating with state entities, as necessary
- Coordinating with educational institutions
- Connecting ISHCN Enrollees to peer support groups
- Arranging housing
- Engaging a peer support specialist to accompany an ISHCN Enrollee to outpatient or other community services
- Connecting a ISHCN Enrollee to educational or vocational opportunities

WellCare of Kentucky employs a peer support specialist who is a young adult with lived experience in the mental health system and who is a former foster care youth. The peer specialist serves as a mentor, navigator, and recovery support for our foster care youth ISHCNs in crisis. This peer support specialist can help an adolescent understand treatment options, understand what groups, social and recreational activities are available in the community, and serve as someone to talk to when the ISHCN Enrollee is confused or feeling unsure about where to go for help.

OTHER KEY COMPONENTS OF DISCHARGE MANAGEMENT AND CARE TRANSITIONS

In addition, the following discharge management and transitional Care Management includes the following key components:

Advanced technology helps us address an Enrollee's whole person needs: We maintain a single and centralized Enrollee record in CareCentral, our Care Management system. CareCentral houses all behavioral health and medical UM and authorizations into a single ISHCN Enrollee view. Fully integrated with our claims systems, CareCentral shows users an ISHCN Enrollee's integrated health record, health history, diagnosis and treatment, outreach efforts, information received from providers, assistance with scheduling appointments, assessment data, medication history, health-related social resource needs, claims history, authorizations, and care plans. Authorized WellCare of Kentucky staff and providers have access to a complete picture of an ISHCN Enrollee's needs across the entire spectrum of care when considering authorization decisions and utilization trends.

CareCentral offers automated notifications and workflows related to care transitions. It supports transitional Care Management activities by generating alerts based on ADT feeds, electronic and faxed prior authorization requests, predictive modeling, and other sources. It helps the Care Coordinator bring together an ISHCN Enrollee's entire multidisciplinary care team (e.g., providers, behavioral health specialists, pharmacists, Enrollee, family, and state staff, if involved). CareCentral's intuitive transitional Care Management workflows and alerts automate a Care Coordinator's activities like appointment scheduling, which improves Care Coordinator efficiency in directing the right transitional care to the right ISHCN Enrollees at the right time.

Integrated leadership and staff and joint rounds improve health outcomes: Local leadership represents physical, behavior health, pharmacy, and social services expertise. This is integral to implementing cohesive population health strategies and programs to improve health outcomes and enhance Care Coordination and Enrollee satisfaction. Our Kentucky physical and behavioral health Medical Directors conduct joint rounds and consult on cases with comorbidity. We conduct multidisciplinary rounds on a weekly basis to collaborate on the coordination of care for inpatient ISHCN Enrollees. This approach provides an opportunity for a team review of the clinical reasons for an ISHCN Enrollee's admission to determine the appropriate path to discharge and remove any barriers that exist to an effective care transition. Through this approach, we review outpatient service requests and consider the ISHCN Enrollee's entire history in the context of a requested service. We devote significant attention to investigating the nuances of integrated service delivery, soliciting perspectives from an array of providers and community advocates. Our staff operates under a single set of fully integrated policies aimed at whole-person care, operational integration across internal departments, and collaboration with external entities.

Compliance assessments and ongoing audits assure consistency: Throughout the year, an independent internal clinical service compliance unit performs compliance assessments and ongoing audits to ensure that application of criteria is accurate and consistent. WellCare conducts online inter-rater reliability (IRR) testing using a commercially available IRR product for all clinical review staff involved in assessments, care and service plan development, and utilization decisions. This audit process assures a consistent Enrollee outcome and experience by evaluating all important elements of the record, including the comprehensive care needs assessment, discharge planning, Enrollee and foster family engagement, biological family engagement as appropriate, Care Coordination, and monitoring and follow-up for goal

achievement. UM teams responsible for identifying opportunities for improvement and taking action receive summary reports, including staff training and coaching. Clinical leadership reviews daily management reports displaying patterns of decisions by health plan and by team to look for over and underutilization (e.g., the percentage of reviews that an RN sends to a physician).

We mirror these quality oversight practices with our pharmacy team. Our quality audit specialists conduct a daily review of prior authorizations to assure all processes, (e.g., turnaround times, process steps, and notice of decision) meet or exceed Commonwealth Contract expectations and statutory requirements. Each month, quality auditors randomly sample ten cases per UM associate, reviewing the chart for adherence to our rigorous review steps, clinical standards and program expectations, and for consistency in clinical decision-making.

Joint Operating Committee (JOC) meetings facilitate process improvement: We will continue to hold JOC meetings where we jointly meet with providers to review performance monitoring results; chart audit results (1:40 or more charts); IRR scores; health outcome and operating metrics; monthly, quarterly, and annual reporting; and agree to implement process improvements. As an example of a process improvement in Kentucky, one of our network providers, The Ridge, said they wanted access to concurrent reviews beyond normal business hours. Our staff brought his issue to the JOC meeting for discussion. The JOC-recommended solution was to extend the concurrent review process to 24 hours a day, 7 days a week for The Ridge. After implementing this solution, we expanded it to include Baptist Hospital.

26. Program Integrity

C.26. PROGRAM INTEGRITY

a. Provide a detailed summary of Contractor's proposed Program Integrity plan, including a discussion of the following:

i. The Contractor's fraud and abuse detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

ii. An overview of the Regulatory Compliance Committee.

iii. The proposed appeals process.

iv. Proposed innovations for reporting data in the Program Integrity area. Provide examples of successful innovations implemented in Kentucky or other states.

b. Describe the Contractor's proposed approach to prepayment reviews.

C.26. PROGRAM INTEGRITY

a. Provide a Detailed Summary of Contractor's Proposed Program Integrity Plan:

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 36, Program Integrity and Appendix M, Program Integrity Requirements of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Our Program Integrity Plan addresses WellCare's efforts to detect, deter and prevent overpayments, abuse, and fraud regarding the provision of and payment for Medicaid services. For additional detail, we are providing **Attachment C.26.a.i WHICKY Anti-Fraud Plan** electronically which will be submitted to the Kentucky Department of Insurance (DOI) as required by KRS 304.47-080 and 806 KAR 47:030. Our approach to meeting the Commonwealth's expectations and requirements is rooted in confidence gained across more than 30 years of experience monitoring Program Integrity in Medicaid healthcare delivery across the nation, safeguarding public funds and overall financial stability to protect every dollar spent on Enrollees' services. With eight years of direct experience as the largest managed care partner in Kentucky, we take our role as responsible stewards of Kentucky Medicaid dollars seriously.

OVERVIEW OF INVESTIGATIVE FUNCTIONS

WellCare's Chief Compliance Officer (CCO), oversees and directs the Corporate Compliance Program throughout the WellCare organization and is responsible for ensuring that the Program's goals are achieved. The CCO reports to the Company's Chief Executive Officer (CEO), and to the Board of Directors (BOD). The CCO has unrestricted access to the BOD. The CCO also chairs the Corporate Compliance Committee, which serves as a resource to the CCO, and to the Regulatory Compliance Committee of the BOD. Finally, the CCO also serves as a point of contact for Company associates regarding compliance concerns. Our Program Integrity Plan is overseen ultimately by the CCO and in the Kentucky market by the Compliance Director, Aubrey Harmon.

WellCare has established a special investigations unit (SIU) as part of a comprehensive anti-fraud program designed to prevent, detect, investigate, resolve, correct and report incidents of suspected fraud, waste and abuse (FWA). WellCare utilizes a multi-faceted collaborative approach to detect, deter, prevent and remedy FWA. The WellCare business units that collaborate in this process include, but are not limited to:

- Claims Department
- Legal Department
- Pharmacy Department
- Quality Department
- Recovery Department
- Enrollment Department
- Grievance Department
- Regulatory Affairs Department

However, the SIU is the business unit primarily responsible for identifying, investigating and reporting possible FWA. To preserve total independence and objectivity, our SIU is part of our compliance department reporting directly to the compliance leadership structure of WellCare Health Plans. The SIU is a component of the Compliance Department, headed by our Senior Director, Lori Peters, who reports to the Vice President, Corporate Compliance Investigations, who in turn reports to the CCO.

Our SIU team is a company-wide interdisciplinary team of 50 knowledgeable professionals. The investigators, including dedicated behavioral health clinicians, work closely with certified professional medical coders, coding auditors, nurses, and various analysts who are also a part of our SIU team.

Specifically for WellCare of Kentucky, our SIU employs two investigators located within the Louisville office, Sr. Investigator David Blackford and Investigator Carlye Philbin. These locally based investigators meet the requirements set forth in Section 36, Part H of the Draft Contract. David and Carlye have a combined 13 years of SIU experience in Kentucky and 35 years combined Healthcare experience.

This team, along with Kentucky Behavioral Health Investigator Blanton Halliday, and Manager Jennifer Jarke, participates in monthly meetings with all other Kentucky MCOs as well as representatives from DMS' Program Integrity team to discuss current schemes and providers of interest. Our Kentucky-based investigators are also active participants in these discussions as we realize the importance of collaboration to combat FWA. This team also participates in quarterly meetings attended by the Medicaid Fraud Control Unit (MFCU) and collaborates with various FWA entities within the state to develop strategies and providing updates on active investigation to further combat FWA. In the process of attending these regular meetings, we share our findings with other parties and receive information regarding trends and potential FWA schemes that are occurring in the Commonwealth. We take this shared information and

use it to data mine for potential cases for providers that are in our network. On occasion, we have opened cases on some, especially when the providers have multiple locations.

In addition to the Kentucky-dedicated SIU staff, medical directors and other subject matter experts throughout the WellCare organization are available for consultation on investigations. Moreover, WellCare's Regulatory Affairs team, led locally by Rebecca Randall, works collaboratively with the SIU to fulfill anti-fraud regulatory and contractual requirements, including reporting referrals to the Commonwealth.

PROCEDURES FOR DETECTING AND INVESTIGATING POSSIBLE ACTS OF FWA

The SIU's mission is to identify, investigate and correct FWA committed by *anyone*, against the Plan and its stakeholders, including, providers, facilities, employees, and Enrollees. Our internally managed and operated SIU leads our Program Integrity activities. WellCare's SIU employs a multi-faceted approach to combat suspected or potential FWA. This includes a combination of mining data to spot inconsistencies, application of various levels of pre- and post-pay edits, leveraging of clinical expertise to identify and confirm unusual trends, follow-up on internal and external referrals, use of a broad set of investigative tools and skills, and the deployment of education and awareness training programs to maximize referrals. Our SIU prioritizes work so that those cases that have multi-state impact, potential high dollar overpayment, patient harm, or potential for an increase in fraud or abuse are given the highest priority.

As described in more detail below, among other things, the SIU:

- Identifies, and remedies fraudulent claims;
- Identifies and remedies provider overutilization;
- Collaborates with Provider Relations and Legal to terminate providers who have defrauded or abused the system;
- Refers for regulatory inquiry and criminal prosecution those who defraud the system;
- Works with our pharmacy benefits manager to identify and remedy pharmacy fraud; and
- Supports efforts to provide fraud awareness training to WellCare employees, vendors and providers.

This list is expanded and updated as new fraud schemes and trends are identified.

Our SIU has increased efforts to conduct additional provider onsite visits. **Our local investigators, David and Carlye conducted 12 provider onsite visits in 2018 and 13 provider onsites in 2019.** This frequency is in compliance with the requirements in Section 36, Part B of the Draft Contract to conduct at least three onsite visits per quarter. In accordance with DMS guidelines, our SIU seeks permission to perform provider onsite visits from the Kentucky Department for Medicaid Services. The majority of our provider onsite visits are unannounced unless otherwise required by the provider's contract. Onsite visits allow a unique perspective and insight into provider's practices and behaviors and how our providers are interacting with our Enrollees allowing us to gain further insight to their experiences in the provider's office. Our

SIU team also has three behavioral health (BH) investigators who are licensed clinicians that perform targeted reviews of FWA activities for BH providers. One of these investigators is dedicated, but not solely, to Kentucky; however, 62% of her cases are in Kentucky. **In 2018, these specialized investigators accounted for $1,137,781.43 in recoveries and $144,711.64 in cost avoidance. In 2019, this team has accounted for $826,636.16 in recoveries and $108,993.40 in cost avoidance dollars related to BH providers.** Following are some specific examples of these provider onsite visits.

Louisville Psychotherapy Services

An internal referral was received in the SIU concerning billing for psychotherapy services. Our SIU conducted on onsite audit of this provider and reviewed claims for 59 unique Enrollees. A review of the records submitted by the provider revealed numerous instances of improper billing and all claims were denied. The result of the investigation was an identified overpayment in the amount of $255,035.02. This case has been referred to Kentucky DMS DPI to request permission to pursue the identified overpayment. Currently we are awaiting Kentucky DMS approval to issue the initial overpayment notice to the provider.

Jeffersonville, IN Border State Provider

Our SIU received a tip from a Kentucky Medical Director who noted a series of daily progress notes appeared to have been cloned. Our SIU conducted on onsite audit of this provider and reviewed claims for 46 Enrollees. A review of the records submitted by the provider revealed the record documentation was insufficient and did not meet documentation guidelines due to missing time, date, and late or missing authenticating signature of the provider of service. The result of the medical record audit was an identified overpayment of over $80,000. The Kentucky DMS referral is in process to request permission to pursue the overpayment.

In 2018, our SIU opened 4,096 cases for review. 20% of these cases were driven from proactive data analysis, which yielded $4.3 million in recovered dollars and a cost avoidance of $32.2 million. In 2019, our SIU opened 5,433 cases for review of which 26% of cases were driven from proactive data analysis, recovered $7.4 million and are responsible for a cost avoidance of $38,053,788.29. **In 2018, of the $4.3 million recovered, $56,462 was attributed to Kentucky Medicaid claims and of the $32.2 million in cost avoidance, $2.8 million was attributed to Kentucky Medicaid claims. From January to May of 2019, for the $2.5 million recovered, $305,205 is attributed to Kentucky Medicaid claims and are responsible for a cost avoidance of $502,542 in Kentucky.**

COLLABORATION WITH DMS

WellCare is committed to partnering and exchanging information and ideas with DMS in a shared effort to fight FWA. As such, we have a physical presence at all quarterly meetings with several members of our local and national SIU, compliance and regulatory affairs teams in

attendance to discuss areas of interest regarding investigations of FWA and overpayment in the Medicaid Program.

WellCare recently partnered with Jennifer Mayes-Laracuente from DMS to schedule WellCare of Kentucky hosting the December 2019 Program Integrity Quarterly Meeting. We routinely communicate with David McAnally and Jade Bullen, both with the Kentucky Audit and Compliance Branch, Division of Program Integrity, Department of Medicaid Services, regarding referrals and other FWA related matters.

Additionally, WellCare attended the HFPP meeting held in Louisville during April 2019 and attends the United States Attorneys' Statewide Health Care Fraud Task Force meeting which is held quarterly in Frankfort. At the HFPP meeting, WellCare of Kentucky was recognized as being well prepared to share providers of interest in the breakout sessions.

Our Program Integrity Plan is further defined specifically by our FWA Program, described below.

i. The Contractor's fraud and abuse detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

FWA PROGRAM

Our extensive experience identifying, preventing, and remediating FWA has and will continue to serve DMS well. The graphic below summarizes our sophisticated three-step process to **Prevent, Detect, and Rectify (Report, Follow-up, Monitor),** in **Figure C.26-1**, FWA and further describes the key elements of our FWA program in Kentucky.

Figure C.26-1 Prevent, Detect, and Rectify

Prevent and Detect

Providers/Caregivers Prevention

WellCare of Kentucky uses a combination of tools to spot inconsistencies including: mining data, application of various levels of pre-and post-claim edits. We also use these tools to leverage clinical expertise to identify and confirm unusual trends, follow-up on internal and external referrals, and use of a broad set of investigative tools and skills. As part of our efforts to root out FWA, WellCare has developed a broad range of technology and predictive analysis tools to validate that services billed and paid for were actually provided. Provider credentialing is a significant aspect of our approach to prevent contracting with providers or entities previously found guilty of FWA. We validate the credentials of network providers as part of

initial contacting and we re-credential in accordance with NCQA criteria, and Commonwealth and federal regulations. A thorough analysis is done based on the information collected about the providers from a variety of sources (e.g. National Practitioners Data Bank, OIG list of excluded individuals or entities, and applicable state professional licensure boards). Some of the reports used for screening include OIG LEIE (screened monthly), State Medicaid Exclusion Reports (screened monthly), State Medical/Professional Boards screened monthly, and Medicare Opt Out (screened quarterly). Within WellCare, when FWA is suspected, we generate detailed reports allowing investigators to view the entire billing and claims history for the provider.

In addition, WellCare conducts pharmacy related FWA inquiries focused on identifying, preventing and remedying FWA related to pharmacy services. We derive investigative leads from multiple internal and external sources. For example, our SIU and pharmacy department have monthly workgroup meetings to coordinate appropriate FWA referrals, exchange information, and discuss systemic FWA related issues. Pharmacy claims are administered primarily through our Pharmacy Benefits Manager (PBM). Our PBM's administration of the program includes conducting audits and utilizing data analytics, and EOBs to detect billing issues. WellCare's other subcontractors, such as dental, vision, hearing, and transportation, also identify FWA and make referrals to our SIU for investigation or for reporting to DMS.

Fraud, Waste, and Abuse Prevention and Detection
Proactive Home Health Investigation in Owensboro

WellCare's data mining tool (STARS) identified that a provider may be misrepresenting home health care services/billing. The provider was paid a significant amount higher than other home health care facilities in Kentucky providing similar services. WellCare SIU reviewed a twelve month sample of the provider's claims from 2016-2017. A review of the Enrollees medical records, submitted by the provider, revealed missing and insufficient documentation, improper therapeutic goal plans and all claims were denied. The result of the investigation was an identified overpayment in the amount of $361,329.47. The case has been referred to the Commonwealth and WellCare has been asked to stand down as this has been referred to law enforcement.

Enrollee Prevention

Verification of services

As part of our efforts to detect and eliminate FWA, WellCare has developed a broad range of tools including a Verification of Services (VOS) process to validate that services billed and paid for were actually provided. This process includes partnering with Enrollees or their Caregivers to determine if specific services were received.

Our VOS program consist of sending a letter resembling a REOMB notice containing billed claim information specific to the recipient Enrollee. The letters are sent to a random sample of Enrollees on a quarterly basis. Once comprehensive Enrollee data to generate REOMB is complete, WellCare processes delivery. To initiate Enrollee delivery by mail, a PDF is sent to the WellCare print vendor for creation of a monthly paper copy. Specifically, generation of WellCare's Medicaid REOMB process starts with our Electronic Information Management team,

and is based on monthly claims activity from which an REOMB data extract is created; WellCare sends the extract to our Variable Data Printing system, a data rendering solution that produces PDFs of each Enrollee REOMB.

WellCare uses a sampling methodology based on claims per month to determine the letter recipients. We stratify the sample group to ensure that all Provider types (or specialties), and all claim types are proportionally represented in the sample pool and that the sample group includes the entire range of services available under the contract.

The letter explains that we are asking Enrollees or their designated Caregiver to tell us whether they received all the services for which the plan has been billed for the dates of service included in the letter. It also informs them that they should contact our 24-hour anonymous Fraud Hotline (1-866-678-8355) with questions or in the event the services identified were not actually received. Should an Enrollee or Caregiver indicate that services were not received, a member of our SIU will conduct a review to determine if the allegation of potential fraud or abuse is credible.

WellCare's internet site contains detailed information to inform members and anyone who visits the site how to report potential FWA. FWA can be reported anonymously and confidentially by anyone through multiple channels, including:

- Referral mailbox: SIU@wellcare.com
- SIU Fraud Hotline: 866-678-8355 (Hotline staffed 24 hours per day/7 days per week.)
- iCare Hotline: 866-364-1350 (Hotline staffed 24 hours per day/7 days per week.)
- Direct contact to Chief Compliance Officer

We include examples and Kentucky specific FWA reporting guidelines for our Enrollees within our WellCare of Kentucky Enrollee Handbook. Each Enrollee receives a copy of their handbook at least once a year (more often if requested) and we also post it to our WellCare of Kentucky website: https://www.wellcare.com/en/Kentucky/Members/Medicaid-Plans/WellCare-of-Kentucky. We also provide a Kentucky specific form (also referenced in the Enrollee Handbook, in which Enrollees or their Caregiver can report FWA via our website at https://www.wellcare.com/Kentucky/Report-Fraud-and-Abuse.

Leitchfield Behavioral Health Provider - Stand Down

One recent investigation originating from WellCare's SIU Hotline from a WellCare of Kentucky Enrollee who indicated her child's card information may have been compromised as she did not receive targeted case management services. A claim review was conducted during affected timeframe. After receiving denial letters from several different Enrollees the case was expanded and a medical records request was sent. WellCare's SIU conducted a line by line review of claims for 58 unique Enrollees. After review of the records submitted by the provider, it was determined that the claims were neither billed nor documented correctly which resulted in the denial of all claims. Further, our SIU identified an overpayment of $85,170.00. The provider appealed with additional documentation and the appeal review resulted in a slight reduction of the overpayment with a final determination amount of $84,502.00. At the request of Kentucky DMS, our SIU was asked to stand down as the case was being turned over to law enforcement.

WellCare Associate Prevention

By establishing clear lines of communication with employees, business associates and downstream entities, the Compliance Department promotes the immediate reporting of compliance concerns and suspected incidents of FWA. WellCare's Code of Conduct and Business Ethics (Code of Conduct) requires employees to immediately report any potential FWA concerns to the Compliance Department.

All associates receive mandatory initial and periodic training for detecting and reporting any suspected FWA. WellCare promotes a corporate culture of ethical conduct which seeks to deter FWA. This effort begins with hiring persons committed to ethical business conduct, and ensuring that new associates have successfully passed a background check, which verifies that an associate does not have a criminal history related to healthcare. This culture is reinforced by, among other things, training, and periodic communications informing staff regarding their FWA detection, prevention and reporting responsibilities.

WellCare provides mandatory compliance training, including FWA training, to all associates, Officers and Directors. This training must be completed within 30 days of hire, and annually thereafter. Associates in reimbursement-related functions also receive supplemental FWA specific training, which must be completed within 30 days of hire and annually. The SIU helps develop and maintain the Company's FWA training materials. The Company's FWA training is designed to create awareness of FWA, and to convey a full understanding of associates' rights and responsibilities when encountering or identifying potential FWA. Among other things, the training identifies red flags which may be indicative of FWA, including the following examples excerpted from the training:

Training excerpt: provider related abuse red flags

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's treatment appropriate for the Enrollee's health condition (medically necessary)?

- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the Enrollee?
- Does the provider bill the sponsor for services not provided?

Our SIU oversees the development and ongoing maintenance of WellCare's FWA training materials – and our CCO ultimately approves the content of the training. The curriculum of compliance training programs are also periodically reviewed and revised as needed to ensure continued compliance with federal and state laws, regulations and guidance. Our associate training program is discussed in greater detail in Section B.03 Staffing.

DETECTION AND PREVENTION OF FWA FOR ASSOCIATES THROUGH OUR COMPLIANCE PROGRAM

WellCare's corporate compliance program 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 and standards by Directors, Associates and business partners through:

- A Chief Compliance Officer who reports directly to WellCare's Chief Executive Officer (CEO) and to the Finance and Audit Regulatory Compliance Committee of the Board of Directors.
- 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.
- Compliance training programs, conducted to ensure that policies, procedures and related compliance concerns are clearly understood and followed by all WellCare Officers, Associates and Directors;
- Open lines of communication for WellCare Associates, Enrollees, Caregivers and others to easily and confidentially ask questions or report suspected violations of company 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;
- Periodic audits and routine monitoring 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.

WellCare's compliance team is made up of approximately 180 experienced associates responsible for the oversight and monitoring of compliance with government programs, including Medicaid program requirements, compliance training and education, privacy and data security compliance, and the detection and prevention of FWA by Enrollees, Caregivers, Providers and other business partners. WellCare also has a Market Compliance Director, Aubrey Harmon, who is physically located in Kentucky and reports up to WellCare's CCO. Aubrey is responsible for all compliance and detection activities related to FWA in Kentucky and tailors WellCare's compliance plan to meet the unique needs of the Kentucky market.

In addition to our Kentucky-based associates, all WellCare associates, subcontractors, vendors, and providers are held to WellCare's Code of Conduct which outlines ethical principles to ensure that all business is conducted with an unwavering allegiance to ethics and compliance. Our compliance program requires that all associates know and understand their individual responsibility to report all suspected incidences of inappropriate conduct. Associates have easy access to numerous corporate compliance resources, including trainings, policies and procedures, our anti-fraud plan, our compliance plan and our Code of Conduct.

To further engage associates in WellCare's culture of compliance, there are communications and activities throughout the year that provide associates with reminders and additional information on how they can continue to combat FWA. Our monthly associate newsletter, the Bluegrass Bulletin, is distributed electronically to associates, and includes a "Compliance Corner" section that highlights various compliance topics including FWA. The Kentucky Market Compliance Officer also hosts quarterly educational workshops that provide targeted training on compliance topics such as FWA. Compliance also posts information throughout our offices with reminders of how to report concerns and how to secure protected information.

Annually, WellCare's Compliance team hosts "Compliance Week" to further promote compliance throughout our organization. Throughout the week there are a series of informative emails sent out to associates with quizzes and drawings for prizes for those who participate in the quizzes. It also includes office events that provide opportunities for our associates to interact in-person with members of our compliance organization beyond our Market Compliance Officer, including compliance team members in areas such as SIU, Compliance Investigations, Policy and Compliance Analytics. Office events include interactive games and quizzes and distribution of key compliance materials such as our Code of Conduct.

Additionally, to increase transparency and collaboration, the SIU coordinates quarterly discussions focused on our investigations (including findings, outcomes, dollars recovered and costs avoided), key initiatives, and industry trends. WellCare of Kentucky's CEO and executive leadership team, as well as members of our compliance, regulatory affairs, pharmacy, provider relations, network management, and health services (medical and behavioral) teams are included in these discussions. On an ongoing basis, our SIU receives input from the network and provider relations teams regarding providers currently under investigation or identified through proactive data analysis.

Technological Investigative Strategies

In addition to our proactive training program and investigating referrals, the SIU uses a variety of proactive investigative measures to identify and pursue potential FWA. **Table C.26-1** below lists our technologies and strategies for FWA prevention and detection.

Table C.26-1 WellCare's Technologies and Strategies for FWA Prevention and Detection

Strategy	Description
Fraud and Abuse Hotline	Our compliance department actively promotes timely reporting of suspected incidents of FWA by maintaining lines of communication to enable employees, providers, Enrollees, Caregivers, business associates and downstream entities to report FWA anonymously and confidentially to the compliance department via the referral mailbox or by calling the SIU anti-fraud hotline at 1-866-678-8355. Our website and manuals also contain information for Enrollees, Caregivers, providers, and the general public on how to report suspected or known FWA.
Data Mining	The SIU uses data mining technologies to proactively identify potential FWA: • The SIU employs a team of data analysts, coding auditors and nurses to conduct targeted claims queries, leveraging the Statistical Analysis System® data network to identify Enrollees and providers with suspicious activity or unusual patterns of behavior that might indicate FWA. Our SIU also uses COGNOS reporting to detect FWA. An example of our COGNOS reporting is our Physician Trend Report by specialty, which enables us to identify spikes or other aberrant trends. Results of such queries include the identification of up-coding, unbundling, misuse of modifiers, unusual CPT codes, double billing, and unreasonable service time billed in a day based on excessive service counts. If this analysis identifies a provider with suspicious activity, a more detailed set of reports is generated, allowing investigators to view the entire billing and claims history for that provider. These efforts allow our SIU to identify suspicious activity, which may lead to an expanded investigation with multiple lines of inquiry. • The SIU employs a statistician to generate Statistically Valid Random Samples (SVRS) and Audits on a routine basis. These audits identify and detect inappropriate claims and potential FWA billing. • We use a FWA analytics library to produce ad hoc reports for the identification and investigation of FWA. These reports include but are not limited to visit trend analysis, provider up-code checker, and hospital stay with no professional services, bell curve analysis and abnormal provider utilization. • The SIU uses the Cotiviti STARSSolutions as a FWA Analytical Tool that provides predictive models and algorithms that identify aberrant patterns and outliers. The Cotiviti STARSSolutions FWA tool provides robust capabilities to identify outlier providers, Enrollees and pharmacies. It provides predictive analytics algorithms applied to pharmacy and medical claims data each month. The scoring, which prioritizes providers and Enrollees for investigation, is based on the most current six months of paid claims, with up to three years of

Strategy	Description
	claims data being available for reference. The results of the scoring once prioritized, are forwarded to a workgroup of investigators, coding auditors and nurse reviewers with the outcome of increased identification of FWA and recoveries for our SIU. To illustrate the importance of STARSSolutions and other FWA analytics techniques, over 20% of all our cases of suspected FWA are identified via STARSSolutions or other data mining tools.
Provider Services and Quality Improvement Personnel	Provider services and quality improvement personnel are trained to be aware of possible and questionable indicators of FWA so that issues can be identified during routine office visits or medical record reviews. These employees report suspected FWA activities to our SIU for review and further action.
Provider Credentialing	Provider credentialing prevents contracting with providers previously found guilty of FWA. We validate the credentials of network providers as part of initial contacting and we re-credential in accordance with NCQA criteria, and state and federal regulations. As part of this process, we collect and evaluate information about providers on a monthly basis from a variety of sources (e.g., OIG list of Excluded Individuals or Entities, state Medicaid exclusion Lists and applicable state professional licensure boards). Providers found to have Medicare or Medicaid Exclusions are terminated immediately WellCare will not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act.
Medical Management Activities	Medical Management activities (e.g., prior authorization, concurrent review, discharge planning, retrospective review and provider profiling) include: 1) verifying Enrollee eligibility; 2) reviewing the medical necessity of the service; 3) determining the appropriateness of the service being authorized; 4) verifying that the service is covered; and 5) referring Enrollees to appropriate providers. When the prior authorization process identifies FWA, the prior authorization will be denied, a notice of action will be sent to the Enrollee or designated Caregiver and provider, and a report will be sent to the SIU. Our SIU reviews, trends, and reports findings to regulators as necessary. In addition, medical management reports allow the SIU department to have multiple points of data to review and verify unusual patterns that may indicate potential fraud and abuse. Any unusual incident is documented and reported as outlined by WellCare policies and procedures.
Statistically Valid Random Samples (SVRS) and Audits	WellCare's SIU conducts SVRS and Audits on a routine basis. These audits identify and detect inappropriate claims and potential FWA billing.

Strategy	Description
SIRIS	As a member of the National Health Care Anti-Fraud Association® (NHCAA), WellCare has access to SIRIS, the NHCAA information-sharing website that includes regular postings of information about potential provider FWA activities by more than 100 insurance companies nationwide. SIU investigators use SIRIS as part of the due diligence they perform in their investigations.
Thomson Reuters CLEAR	Thomson Reuters CLEAR is a powerful online investigation software SIU investigators can use throughout the different phases of an investigation. CLEAR has a vast collection of public and proprietary records that enable SIU investigators to uncover hard-to-find data. CLEAR can be used to analyze billions of records from all different sources that are constantly being updated with current information.

Rectify

Once we detect a potential case of FWA, either through a referral or through the various array of analytical tools deployed, WellCare's SIU pursues investigative actions. The SIU pursues reactive and proactive investigations to either corroborate the allegations or determine them unfounded. The investigator develops an action plan to investigate the allegations applying the steps outlined in **Table C.26-2**:

Table C.26.-2 WellCare's FWA Investigative Action Plan Steps

Strategy	Description
Intake	When we receive a referral, staff enter the referral record into our secure Compliance 360© enterprise compliance management system. The intake team completes a preliminarily assessment to confirm that the matter concerns potential FWA.
Request for Approval to Proceed	If that assessment confirms possible FWA, we request permission to proceed with an investigation from the DMS Program Integrity Division. When permission is granted, a manager assigns the case to an investigator for further inquiry.
Investigation	The investigator may pull and review any of the following records: Provider top CPT/ICD-9 codes; Payment records; NHCAA SIRIS search and reporting; Provider/Vendor/Enrollee IDs, contact information, eligibility; copy of provider's Commonwealth license and disciplinary actions; provider and vendor contracts. The investigator may also conduct any of the following actions to either corroborate the allegations or determine them unfounded: Data analysis; clinical record reviews; interviews; provider on-site audits; public record reviews

Strategy	Description
Case Prioritization	Our SIU prioritizes work so that those cases that have multi-state impact, potential high dollar overpayment, patient harm, or potential for an increase in Fraud or Abuse are given the highest priority.
Determination	Based on the findings of the review, the investigator makes a determination of whether or not the target party engaged in FWA.
Remedial Action	When an investigator determines that the target party engaged in FWA, the SIU pursues remedial action. The type of remedial action depends on the misconduct identified by the investigation. For example, if the FWA concerns an Enrollee's drug abuse or doctor shopping/pharmacy shopping, the Enrollee may be placed in our Pharmacy Lock-In Program, and the Enrollee's access to narcotics will be closely regulated. For a provider who engages in FWA, remedial actions may include recovery of an overpayment, termination of the provider, and/or referral to law enforcement for prosecution.

As previously described, our SIU's comprehensive approach to combatting FWA includes a combination of analytic tools, clinical expertise, investigative knowledge, and internal and external referrals, as well as an education, training and awareness program.

Reporting, Follow-up, and Continuous Monitoring of Compliance

WellCare maintains its SIU internally including all facets of regulatory reporting and does not subcontract these requirements. Our internal process and policies ensure compliance to all Kentucky contractual requirements. WellCare partners closely with our specialty vendors to assist with the more granular aspects of FWA prevention, detection and rectification.

Our SIU submits ongoing referrals to Kentucky Division of Medicaid Services (DMS) Department of Program Integrity (DPI) and law enforcement for further investigation and prosecution. WellCare of Kentucky submits a standardized Provider or Enrollee Investigative Report directly to David McAnally within the DMS DPI for review. The following process is utilized to make an initial disclosure to regarding a new allegation of FWA. The requisite steps include:

- The MCO Provider or Enrollee Investigative Report is completed by our SIU investigator and submitted to their manager for review.
- Once all pertinent information is confirmed, our manager or senior investigator submits the investigative report referral via the MOVEit Transfer Plus portal. Should our SIU wish to also report the matter to the Office of Attorney General (OAG), our investigator will transfer the required case files to Direct Drop.
- Our manager or senior investigator then logs the approval and submission information into the comments section of the C360 case tracking system and notifies the investigator the information has been "submitted, referred and approved."

- Updated investigative report referrals are sent as need to Kentucky DMS Program Integrity Division via the same process with additional case findings and information when applicable to include requesting approval prior to pursuing overpayments over $500 and approval to close the case.

From 2017 to 2018, our referrals to Kentucky DMS increased from 77 to 152 and in 2019, we sent 199 referrals..

WellCare also reports on a monthly basis all provider internal referrals (tips) and the disposition of the prior months' internal referrals, SIU investigator staffing specific to WellCare of Kentucky, and provider on-site visits via the Kentucky Current Tips and Reconciliation Report which is submitted on the last business day of the reporting month. This report is prepared and reviewed for quality by our SIU and submitted via the MOVEit Transfer Plus Portal to Jade Bullen, Kimberly Shannon, and David McAnally within the DMS Program Integrity Division.

Also on a monthly basis, WellCare submits three reports: #72 – Medicaid Program Violation Letters and Collections, Kentucky Report #73 - Explanation of Enrollee Benefits (EOMB), and Kentucky Report #75 – SUR Algorithms, Kentucky Report. These reports are prepared and validated by our SIU and submitted to our WellCare of Kentucky Regulatory Affairs team who submits the reports to DMS by the 15th day of the month following the reporting period.

Quarterly, WellCare submits three reports: Kentucky Overpayment and Prepayment Report, Kentucky Report #76 - Provider Fraud, Waste, and Abuse, and the Kentucky Report #77 - Enrollee Fraud, Waste and Abuse. These reports are prepared and quality checked by our SIU department. The Kentucky Overpayment and Prepayment Report is submitted via the MOVEit Transfer Plus Portal directly to Jade Bullen, Kimberly Shannon and David McAnally at the Kentucky Department for Medicaid Services. Reports 76 and 77 are prepared and quality checked by our SIU and submitted to our WellCare of Kentucky Regulatory Affairs team who submits to the Kentucky Department for Medicaid Services by the 30th day of the month following the reporting period.

Our Payment Integrity Team focuses on identifying cost savings opportunities though cost avoidance, correct coding requirements, medical payment policy, claims payment quality, and overpayment recovery. This team reviews claims to identify potential outliers for closer review. High dollar claim areas such as NICU, implants, pediatric, surgical, transplants, or other identified outliers are examples of scenarios where additional review could be warranted to identify potential unbundled services or overpayments. These reviews are applicable to how the individual claim is billed, not to a particular provider. The intent is strictly to ensure that we are paying the claims correctly and to educate providers when there are billing errors. If our payment integrity team identifies any questionable billing patterns and/or trends, they promptly refer them to our SIU for investigation.

SIU personnel engage in continuing professional education and training throughout the year, including attendance at formal training and bi-monthly webinar programs sponsored by the National Health Care Anti-Fraud Association (NHCAA), of which WellCare is a corporate member, and the American Association of Professional Coders. As a member of the NHCAA, WellCare has access to the Special Investigation Resource and Intelligence System (SIRIS), the

NHCAA information-sharing website that includes regular postings of information about potential provider FWA activities by more than 100 insurance companies nationwide. SIU investigators use SIRIS as part of the due diligence they perform in their investigations.

These numbers are reported externally to DMS and distributed internally as part of our commitment to promote and maintain a culture of compliance and to provide awareness of the impact of FWA. While the SIU is primarily responsible for anti-fraud activities, all associates, officers and directors are trained to look for unusual or suspicious activity and to report such activity through our compliance program.

Partnerships to Enhance FWA Prevention and Detection

WellCare's many partnerships with both state and federal agencies enhance our FWA prevention and detection capability. In **Table C.26-3** below we highlight some of our key state and Federal partnerships.

Table C.26-3 WellCare's State and Federal Partnerships for FWA Prevention and Detection

Partnership	Description
National Health Care Anti-Fraud Association (NHCAA)	As a member of the National Health Care Anti-Fraud Association (NHCAA), the SIU has access to their information sharing website, SIRIS, which includes input from over 100 insurance companies, and the regular posting of current activities nationwide, ranging from indictments to Provider convictions. The SIU also participates in other NHCAA information-sharing activities. These activities enable the SIU to proactively target and remedy FWA.
Healthcare Fraud Prevention Partnership (HFPP)	As a member of the Healthcare Fraud Prevention Partnership (HFPP), WellCare joins a Partnership of private and government payers and anti-fraud
National Association of Medicaid Program Integrity	WellCare's Vice President of Compliance Investigations, Chris Horan, is an active member of the National Association of Medicaid Program Integrity and attends meetings regularly.
SIU/WellCare of Kentucky Collaboration Meetings	Collaboration meetings between SIU and key Kentucky market stakeholders to encompass FWA prevention through the full spectrum of WellCare's operations.

DME Provider in Ashland

WellCare received a referral from the Kentucky OIG that a provider was possibly engaging in fraudulent activities, including but not limited to forging patient and physician signatures, falsifying documents, and fraud involving power wheelchairs. WellCare SIU reviewed a 10 month sample of the provider's claims. The purpose of the audit was to determine if the services billed were supported by the documentation. The medical records provided for the selected claims were reviewed and the review revealed improper documentation for DME services. An overpayment of $31,847.29 was identified and upheld after the provider appealed the audit findings. The provider did not send in the overpayment and WellCare SIU is currently in the process of offsetting. To date, the SIU has recovered $19,907.34. We are continually updating the Department with our findings.

TRAINING AND EDUCATION OF ENROLLEES, PROVIDERS/CAREGIVERS, ASSOCIATES, AND SUBCONTRACTORS

Training and education is another important way of preventing FWA. WellCare maintains comprehensive training programs to ensure our WellCare associates, Enrollees and/or Caregivers, providers and subcontractors understand the policies, procedures and related compliance concerns of the company and conduct special trainings on FWA identified billing and overpayment concerns.

Associate Training: WellCare's corporate culture of ethical conduct which seeks to deter FWA begins with hiring persons committed to ethical business conduct, and ensuring that new associates have successfully passed a background check, which verifies that an associate does not have a criminal history related to healthcare. This culture is reinforced by, among other things, training, and periodic communications informing staff regarding their FWA detection, prevention and reporting responsibilities. WellCare provides mandatory compliance training, including FWA training, to all associates, officers and directors. This training must be completed within 30 days of hire, and annually thereafter. New associates receive a minimum of five hours of compliance training and, depending on the nature of their roles, may receive up to an additional three hours of compliance training within the first 30 days of hire and on an annual basis. Associates who fail to timely complete such mandatory training are subject to disciplinary action. Our FWA training is designed to create awareness of FWA, and to convey a full understanding of associates' rights and responsibilities when encountering or identifying potential FWA. The training identifies red flags which may be indicative of FWA. The SIU helps develop and maintain the Company's FWA training materials. The CCO ultimately approves the content of the Company's FWA training.

Subcontractor: As part of our onboarding process for new Subcontractors, we provide compliance and FWA training. WellCare's Delegation Oversight department conducts a pre-delegation assessment of all potential Subcontractors before the Subcontractor is formally engaged. This assessment includes an assessment regarding the entities FWA compliance protocols. Delegation Oversight requests all pertinent FWA related policies and procedures and training documents. Where a Subcontractor's FWA training does not adequately match

WellCare's FWA training, first tier, downstream and related Subcontractors must complete WellCare's FWA training module. First tier, downstream, and related Subcontractors who satisfy FWA certification requirements through Medicare Program enrollment, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS), are deemed by federal regulation to satisfy the training and educational requirements for FWA compliance. The assessment process is repeated during an annual review.

Enrollee Awareness of FWA: To ensure Enrollee awareness of FWA, we provide ongoing education through our Enrollee handbook, community outreach, quarterly newsletters and online Enrollee portal. Our handbook defines FWA and provides examples that our Enrollees or their designated Caregiver can more closely relate to, identify, and understand. Enrollees can call our toll-free 24-hour fraud hotline or report through our website as previously discussed in section titled Enrollee Prevention.

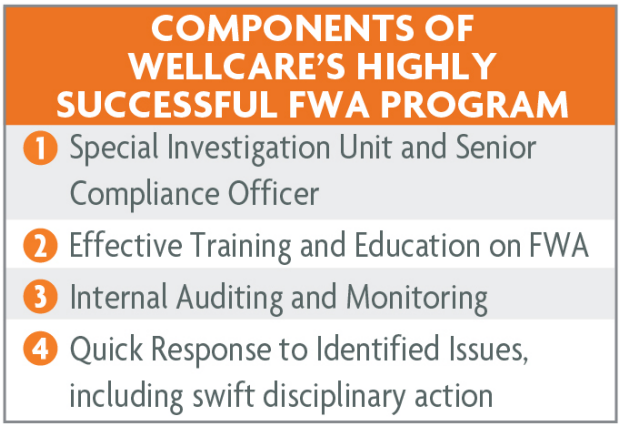


Figure C.26-2 FWA Program

Provider and Caregiver Training: WellCare's compliance and FWA program is communicated to providers through several avenues including provider orientation visits, which take place within 30 days of the provider's contract effective date, the Provider Handbook, the provider's contract, and online through our provider portal. The provider can elect to complete the training module at the time of the initial onboarding visit with their local provider relation's representative or they can complete it online through our provider portal. However, regardless of the option selected, the provider must attest to the completion of the training. **In 2018, WellCare's provider relations representatives completed approximately 357 new provider orientation visits. In 2019, WellCare's provider relations representatives completed approximately 586 orientations visits including new provider orientations, provider manual orientations, and company overview presentations..**

Training is only one of the components of our FWA program, see **Figure C.26-2**, above.

ii. An overview of the Regulatory Compliance Committee

The Audit, Finance, and Regulatory Compliance Committee (AFRCC) of the Board of Directors assists the Board in the oversight of WellCare's compliance with legal, financial and regulatory requirements, and compliance with WellCare's code of conduct and business ethics and related policies by employees, officers, directors and other agents of, and those providing services for, WellCare and its affiliates. The AFRCC provides oversight of the structure, operation and efficacy of the compliance program, including, but not limited to (i) establishing and periodically reviewing procedures for the receipt, retention, and treatment of complaints received by WellCare regarding accounting, internal accounting controls, or auditing matters, and the confidential, anonymous submission by employees providing services for WellCare or its affiliates of concerns regarding questionable accounting or auditing matters; (ii) compliance

efforts with respect to its code of conduct and business ethics and relevant federal and state laws, regulations or other legal standards; (iii) the adequacy, efficacy and implementation of WellCare's annual compliance audit plan developed by the Chief Compliance Officer; (iv) the adequacy of the organization, responsibilities, plans, results, budget, membership, staffing and operations of the corporate compliance committee and compliance department; (v) the adequacy and efficacy of WellCare's compliance policies and procedures; (vi) regularly review compliance audits, or summaries of such audits, corrective action plans and the results of such plans; (vii) review WellCare's code of conduct and business ethics not less than annually and make recommendations to the Board regarding proposed revisions to the code of conduct and business ethics; (ix) receive and review periodic reports from the CCO; not less than annually, such reports include a compliance program report incorporating each of the elements of an effective compliance program identified by CMS.

WellCare also maintains a Market Compliance Oversight Committee (MCOC) that meets quarterly and advises, reports to, and supports the CCO and the corporate compliance committee to assist the compliance department in identifying risks and issues to be reported to the AFRCC. The MCOC supports and facilitates the identification, evaluation and assessment, oversight, and communication of market compliance matters including risks, issues, and mitigation and oversight activities. MCOC responsibilities include (i) identifying key compliance risks, issues, or concerns related to market-based legislative, regulatory, or contractual requirements; (ii) evaluating and assessing known or potential noncompliance and assuring business owner assignment and accountability of remediation and oversight activities; (iii) providing guidance and support to business owners regarding market compliance risks to ensure appropriate oversight activities and the prevention or detection and, if applicable, remediation of compliance issues.

iii. The proposed appeals process.

When an investigator determines that the target party has engaged in FWA, the SIU pursues remedial actions. The type of remedial action depends on the misconduct identified by the investigation. For a provider who engages in FWA, remedial actions may include recovery of an overpayment, termination of the provider, and/or referral to law enforcement for prosecution. The SIU, as part of remedial actions, may choose to educate the provider should the findings not rise to the level of FWA and place that provider on a monitoring list for re-review to ensure the provider has corrected their billing practices.

Should our SIU receive permission from DMS to pursue the recovery of the identified initial overpayment, the provider, in accordance with their contract language, is offered the opportunity to request an appeal and submit additional documentation, such as medical records, for review. The request for an appeal may be mailed, faxed, or submitted through a secure portal to the SIU for review - see **Attachment C.26.a.iii Initial Overpayment Letter Example** for a sample of our Initial Overpayment Letter.

The provider will have 60 calendar days from the original notice of adverse action to file an appeal. Appeals submitted after that time may not be considered for review. Should the

provider feel they submitted an appeal timely, they may submit documentation showing proof of timely filing.

Upon receipt of all required documentation, WellCare has 30 calendar days to review the appeal and to render a decision to reverse or uphold the original findings. Our SIU reviews all additional documentation provided and if necessary, will engage clinical staff should the appeal involve clinical issues including whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate.

Our SIU notifies the provider of WellCare's final decision in writing. Should the provider still have concerns, our SIU collaborates with the provider to discuss the findings, determine any necessary repayment plan, and/or negotiate a settlement agreement. If we are unable to come to an agreement, depending on the terms of the provider's contract, arbitration would be an option. If the provider doesn't pursue arbitration, the SIU may pursue claims offset. **Figure C.26-3** below provides the specific steps in our SIU overpayment appeals process.

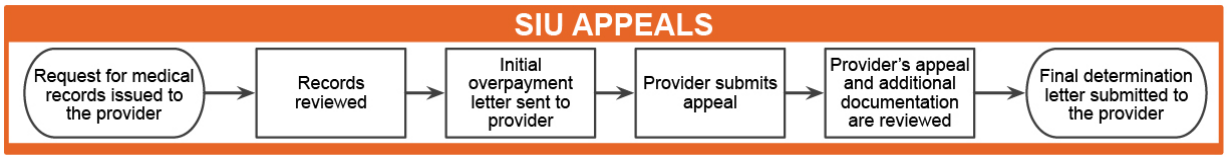


Figure C.26-3 SIU Appeals

iv. Proposed innovations for reporting data in the Program Integrity area. Provide examples of successful innovations implemented in Kentucky or other states.

WellCare strives to be the industry leader in government healthcare programs and has an established history of innovation and collaboration within the Commonewealth. To continue this precedent, WellCare's SIU team has chosen the following proposed innovations to move our Kentucky FWA program forward as a national best in class program:

PROACTIVE DATA MINING - 2019 DATA PLAN

To ensure WellCare of Kentucky's SIU is investigating the current industry fraud and abuse trends, our SIU team utilizes the US DHHS OIG Annual Work Plan to drive data analytics within multiple Medicaid markets that we serve. Our annual data plan is created by our SIU Data Analytics team which is overseen by a Senior Data Analytics Manager. This team monitors our claims data closely to identify the current trends and aberrancies. Through the use of our FWA Tool they can identify the top scheme and/or rule violations. They conduct additional analysis of that data such as identifying the top violating providers in a particular state. This information is used regularly for proactive case generation. With our unit goal of having a minimum of 25% of our cases being proactively generated, this process and tool is instrumental in assuring we are identifying and pursuing quality cases instead of just working reactive cases. Our proactive case initiatives can also result in more global approaches where the FWA issue is addressed as an SIU Project. Through the use of an Annual Data Plan we remain vigilant in our pursuit of potential FWA and take a collaborative approach with participation and input from multiple levels. If new schemes and trends are identified throughout the year, the data plan can easily be adjusted to incorporate "hot topics."

SIU 2019 Kentucky Strategic Plan

Specifically for Kentucky, we have taken the global 2019 Data Plan and combined it with our proven experience, trends, and themes to drive our KY Strategic Plan. Using our SIU annual data plan, we asked the KY Investigators to conduct a deep dive on the SIU activities in Kentucky, compile the data and success, then develop a Strategic Plan consisting of areas of focus. The Strategic Plan was presented to the Kentucky Market Management Team to collaborate and solicit the market's assistance in identifying ideas/concerns they recommended be included. The 2019 Strategic Plan listed specific provider specialties/schemes to initiate proactive cases, the plan to increase on-site audits, collaboration efforts, etc. The plan also listed the 2018 accomplishments and best practices. The successes shown in the Kentucky plan demonstrated a year over year dashboard of cases opened and closed, recoveries, cost avoidance, onsite visits, RFIs, etc. Additionally, process improvements implemented in Kentucky were listed which included a Recovery Process enhancement, established timeframes to offset overpayments, and specific timeframes for medical record requests to keep investigations moving forward.

This innovative approach to monitoring potential fraud, waste and abuse activities in the Kentucky Medicaid market allows us to be nimble and flexible. When collaborating and sharing case reviews with other plans and DMS, OIG, OAG, and MFCU at monthly and quarterly meetings and we become aware of new schemes or trends, both the data and strategic plans can be modified to ensure we are current with what is affecting Kentucky Medicaid.

SIU Proactive Project Strategy

Our experience when speaking with other health plans has yielded that other SIU departments do not place as much emphasis on collaboration as our Kentucky staff. Our SIU in Kentucky is considered innovative because our proactive project strategy consists of data mining to initiate multiple proactive investigations based on global FWA trends. The cases that result from these investigations are initiated simultaneously for the same/similar allegation but tailored in accordance with Kentucky specific guidelines and regulations. These cases are worked as a group instead of individual investigators working solo on smaller cases, and they progress together.

As these cases are developed based on global FWA trends, they are given the highest priority so we can provide the Commonwealth with investigative reports on current trends affecting Kentucky Medicaid. Multiple cases are opened, based on highest priority, and assigned to different investigators so cases are researched and investigated. All letters and documents are tailored to the specific FWA trend/and scheme for the investigator to use as templates. Newer investigators learn how to build better cases and they develop case management skills. Any case issues or concerns are discussed and addressed as a team. The proactive project cases enhance teamwork within the unit and across the enterprise.

Proactive projects previously completed for Kentucky include emergency department up coding and advanced life support ambulance. Kentucky provider project investigations currently in progress include genetic testing and allergy testing.

Kentucky Opioid Concerns

Utilizing our approach to data mining, several cases identifying outlier laboratories were opened to review their billings for urine drug screening. A recent example of a successful innovation based on this data mining is in regards to urine drug screening. Given the scope of the opioid epidemic in Kentucky, WellCare undertook a significant effort to control wasteful spending related to inappropriate use of these drugs. WellCare noticed a dramatic increase in the use of urine drug screening (UDS) by some of our providers, especially our laboratory providers. Our clinical policy team worked collaboratively with our payment integrity team to identify key laboratory codes that showed a significant trend of abuse and waste. As a result of this internal collaboration, we created a drug testing clinical edit guideline that our providers can reference. This edit explains in detail the evidence-based guideline related to this claims edit. Secondary to this effort, we have seen more appropriate utilization of these services and ensured compliance with medical necessity standards. We know from collaborating with other MCOs, controlling wasteful spending of UDS is a best practice and the savings benefits both the Commonwealth and tax payers.

WellCare understands DMS' recent instructions to incumbent MCO's to remove all UDS edits and guidelines for UDS effective July 1, 2019, in anticipation of a universal policy that DMS announced in October 2019. WellCare successfully implemented the DMS UDT policy effective January 1, 2020.

SIU Investigators with Behavioral Health Credentials

Over the last several years, due to DMS' expansion of behavioral health services available to Enrollees, there has been a substantial increase in the number of behavioral health claim submissions and subsequent opportunities for increased FWA. To address this, the SIU expanded its investigative expertise by hiring three BH clinical investigators and a BH coding auditor. The BH SIU team is tasked with investigating BH services including psychosocial services and targeted case management. One of these specialized investigators currently devotes over 60% of her time solely to Kentucky. **In 2019, specific to KY Medicaid, this team has identified over $1,773,966 in overpayments and recovered over $387,360.**

Low Priority SIU Case Process

WellCare of Kentucky's SIU developed an innovate process to be used as a best practice for KY Medicaid cases as well as our other lines of business to screen and identify low priority SIU cases. This low priority methodology was implemented to ensure that cases which could have an adverse effect on our members are moved to a higher priority, while at the same time identifying the truly low priority cases. Our goal is to utilize our investigative resources in the most practical and productive manner for the Commonwealth.

Cases are prioritized as defined below. A case can start high, move to medium, then back to high or move to a low priority. In addition, cases may start out as a low priority and not move up to another priority level.

- *High* – Cases/allegations having the greatest program impact which would include: patient abuse or harm, multi-state fraud, high dollar impact of potential overpayment, likelihood

for an increase in the amount of fraud or enlargement of a pattern, cases with an active payment suspension, etc.

- *Medium* – Cases/allegations not at the level of a high priority, may be a case in Coder review, overpayment letter sent, multiple complaints against subject, etc.
- *Low* – Cases/allegations not at the level of a high or medium priority, may be a case active with law enforcement or regulatory agency and SIU told to stand down, cases in recovery status, etc. All cases being prepared for closure should be a low priority

The SIU screening process to identify and close the low priority cases ensures the Investigators are working cases with the highest impact. Cases are screened and prioritized as follows:

- Determine how many prior complaints/matters/cases have been received involving the subject
- Identify the dollar amount in controversy/potential loss based on allegation
- Determine if any adverse effect would come to our member if the matter was not pursued.
- No findings identified from the due diligence research
- If no harm will come to the patient, three or fewer complaints have been received in the past 6 months, the potential loss is low dollars (i.e., less than $500.00), and no aberrancies identified from the due diligence, the provider will be placed on a monitoring list to be evaluated in six months and the case closed

Notice of Adverse Provider Actions (NAPA)

The WellCare of Kentucky SIU, in collaboration with our compliance and regulatory teams, recently developed a process to track adverse provider actions. This process is known as our Notice of Adverse Provider Actions (NAPA) process and is used to track adverse provider actions received from the Kentucky Division of Program Integrity. Trackable actions include:

- Payment suspensions
- Involuntary termination
- Denied provider applications
- Release of payment suspension
- Recession of provider termination
- Settlement agreements

The process utilizes a workflow within Compliance 360 to track communications with DMS as well as various internal teams to ensure appropriate actions are taken. The workflow depicted in **Figure C.26-4** below details this process:

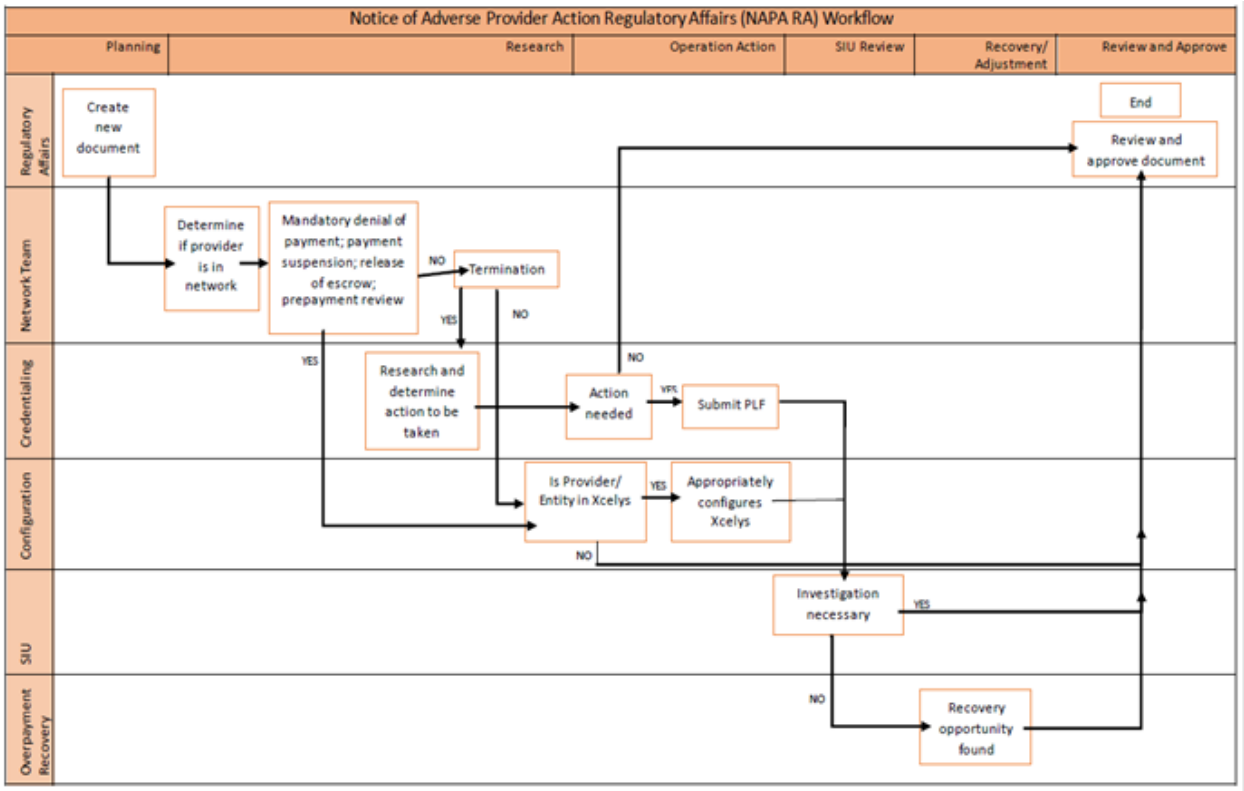


Figure C.26-4 NAPA Process Workflow

The NAPA workflow is initiated when DMS submits notification of an adverse action to our local Kentucky Regulatory Affairs (RA) Team. The RA team "announces" the action within C360 and it then flows through our local Network, Credentialing, Configuration, SIU and the Overpayment Recovery Teams. The Network and Credentialing Teams determine if the provider is an active provider within our network. If the provider is active in our network, they will "announce" to our configuration team who will initiate action based on the request, i.e., place future claims billed in an escrow status. Once the Configuration Team has completed their step, the SIU Team will review the circumstances of the announcement to determine if an investigation should be initiated. SIU and the Overpayment Recovery Team both ensure that any identified overpayments resulting from the adverse action are pursued for recovery. Reports can also be pulled from C360 to show the status of actions requested by DMS and when the actions were implemented by WellCare.

Recommended Reporting Innovation for Kentucky's Program Integrity Division

WellCare's SIU can provide meaningful dashboards to the Kentucky Division of Program Integrity which is used in other markets. For example, the screenshot shown below in **Figure C.26-5** shows a sample dashboard developed for use in other WellCare Medicaid markets and includes activities regarding recoveries, cost avoidance, workload, referrals, etc. by quarter. WellCare's SIU team led the charge to develop a universal reporting and would like to propose that we work collaboratively with the Kentucky Division of Program Integrity to do the same. This dashboard can be customized so that MCOs can share the results of their investigations and other FWA activities at the monthly and quarterly collaborative meetings. This universal

platform will assist in furthering the plans' ability collaborate and share information regarding Kentucky Medicaid providers and current and potential FWA trends and allow DMS greater transparency into plans' FWA activities.

WellCare has implemented similar initiatives in South Carolina, Florida, and Nebraska and has been received well by the respective Medicaid agencies.

Program Integrity Quarterly:										
	Q1 Final Recoveries		Q2 Final Recoveries		Q3 Final Recoveries		Q4 Final Recoveries		YTD Final Recoveries	
Recoveries	Final Identified $	Final Recovered $	Final Identified $	Final Recovered $	Final Identified $	Final Recovered $	Final Identified $	Final Recovered $	Final Identified $	Final Recovered $
SIU FA Recoveries										
Non-SIU Waste Recoveries (and unsolicited refunds)	N/A		N/A	$	N/A	$	N/A	$	N/A	$
Total	$	$	$	$	$	$	$	$	$	$
Cost Avoidance	Q1 Cost Avoidance		Q2 Cost Avoidance		Q3 Cost Avoidance		Q4 Cost Avoidance		YTD Cost Avoidance	
SIU FWA Cost Avoidance	$		$		$		$		$	
SIU FWA Pre-Pay	$		$		$		$		$	
Other Cost Avoidance (i.e. COB/TPL; Subrogation; Other)	$		$		$		$		$	
Total	$		$		$		$		$	
Type	Q1 Summary Information		Q2 Summary Information		Q3 Summary Information		Q4 Summary Information		YTD Summary Information	
SIU FWA Cases Opened			#		#		#		#	
SIU FWA Cases Active (includes Opened)			#		#		#		Not Applicable	
SIU Referrals to State			#		#		#		#	
SIU Provider Education			#		#		#		#	
MCO Providers Termed for Cause			#		#		#		#	

Figure C.26-5 Sample Dashboard

b. Describe the Contractor's proposed approach to prepayment reviews.

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 36.2, Prepayment Review of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix.**

WellCare of Kentucky contracts with established pre-payment medical code editing vendors to improve claims payment accuracy and reduce costs through prospective claim editing. In claim editing, we perform automatic claims reviews to catch errors, omissions and questionable coding by comparing data against expansive databases containing millions of government and industry rules, regulations and policies governing health care claims. **In 2018, these activities resulted in $40.7 million in avoided overpayments across our Kentucky Medicaid Plan.**

In conjunction with our business associate, Equian LLC (Equian), WellCare has been performing reviews of high dollar inpatient hospital claims submitted for adjudication since November 19, 2013. This process has reviewed over 1,300 claims, or less than 1% of our more than 150,000 inpatient claims adjudicated during that same period. Despite the very low volume of targeted claims, nearly $81M in billed charges have been called into question on those claims. WellCare's review demonstrates a fiscally responsible, provider friendly approach by targeting fewer than 24 claims per month on average while addressing highest cost claims which are most likely to have challenges with accuracy and compliance given the high volume of billing entries and coding complexities.

Prepayment Process Overview

The adjudication process, procedures involved in accurately, and timely compensating providers for their services have evolved as reimbursement methodologies and complexities have increased. Historically, claim adjudication has only focused on ensuring eligibility and conducting basic administrative and code editing on the information provided in the claim submission data. In order to proactively identify potentially abusive billing practices, WellCare has enhanced its adjudication process and extends claim adjudication to also include an analysis of the claim as a whole and/or individual detail for the specific charges in comparison with the medical records. Through this process, WellCare has identified numerous provider billing errors and billing methodologies that, on their face, are inconsistent with sound fiscal, business, or medical practices, and that would have otherwise resulted in unnecessary cost to the Kentucky Medical Program.

Resolution and Appeal Process

WellCare's review begins when a claim is identified as a contradictory to industry standard billing practices and peer comparison. When a review identifies questionable billing, a claim or specified line item is denied, and the additional documentation and/or information necessary to clarify/support the charges at issue is requested. Providers are afforded a minimum of 45 days to submit the medical documentation requested. Clarifying information may include but is not limited to provider billing policies, explanations and/or medical record excerpts pertaining to the issue(s) affecting the claim in question. If a provider does not respond to the request for information within the specified timeframe, the claim remains denied. If a provider complies with the request and submits the medical documentation within the specified timeframe, WellCare performs a detailed review for compliance with applicable billing guidelines and issues a report with our findings within 30 days. Both the CMS and DMS guidance is clear regarding our fiduciary responsibilities with claims accuracy by defining fraud, waste and abuse to include everything from mistakes (i.e. unbundling), inefficiencies, bending the rules (upcoding), and intentional deception.

Should the provider not agree with the findings of our review, the notice also advises the provider of their formal appeal rights and procedures for filing. Consistent with the MCO contract, WellCare will review and issue a written response to any formal provider appeal within 30 days of receipt. If the appeal decision is upheld by WellCare, the provider may pursue Independent External Review in accordance with DMS guidelines.

WellCare believes that prepayment review is an important component of our overall payment integrity program and a critical element of our overall fiscal duty to identify potential fraud, waste and abuse. Under the new contract, we propose to expand our pre-pay review process by partnering with our vendor, Optum, to introduce a robust program that uses predictive analytics and provider scoring to target additional potential FWA claims for medical record comparison. Partnering with Optum will provide us with medical payment policy advisory services based on, but not limited to, generally accepted principles and practices of CMS, American Medical Association (AMA) coding Kentucky guidelines, specialty academy organizations, applicable guidelines, and other processes and rules approved by WellCare and DMS to achieve prospective payment accuracy across all claim types.

This process was launched in both our Georgia and Florida Medicaid markets and has yielded a combined savings of approximately $3.9 million since July 2018. Using the same concepts in Kentucky for the same time period, WellCare is able to project that this initiative would have yielded approximately $1.7M in cost avoidance.

Through this implementation, WellCare will continue to comply with Section 36.2 of the Draft Contract including, but not limited to, the following provisions:

- We do not use Prepayment Review to hold claims for an indefinite period of time
- Providers are given 45 days to submit documents in support of claims under prepayment review
- Documentation is reviewed in a reasonable time not to exceed 30 days
- Claims under Prepayment Review are not subject to prompt payment or timely filing requirements

Edit effectiveness is not based exclusively on claim approvals, but we evaluate effectiveness based on denial rate and dollar return, as well as risk to our members. We revise and replace ineffective edits. Any provider that has undergone additional education on prepayment medical review for six months or longer that has not corrected their billing patterns is escalated for further actions. For providers who demonstrate sustained a 90% error free claims submission rate for 45 days, we will request express permission to continue Prepayment Review from DMS' Director of Program Integrity (or designee) and the Director of Program Quality and Outcomes (or designee).

C.26 Program Integrity

- Attachment C.26.a.i WHICKY Anti-Fraud Plan (Provided Electronically)
- Attachment C.26.a.iii Initial Overpayment Letter Example

WellCare
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Special Investigations Unit

January 18, 2020

Provider Name
Attention: Legal Department
Provider Address
City, State Zip

RE: Proposed Action – Findings for Medicaid Case #12345

Thank you for your patience and cooperation while WellCare's Special Investigations Unit (SIU) completed its medical records review. Based on this review, the SIU has determined that a $X,XXX.XX overpayment was made to Provider Name. Please refer to the analysis below for additional information regarding how the overpayment amount was calculated.

Reason for the Review

WellCare's SIU attempted to conduct an audit to validate the services being provided to WellCare members. The audit was to ensure Provider Name is complying with the rules and regulations listed in the Kentucky Medicaid Provider General Handbook.

Summary of Findings

WellCare's Special Investigation Unit (SIU) Coding Auditor reviewed ## claim lines representing ## unique members. ## CPT/HCPCS codes were reviewed. The dates of service for the claims were between insert date range.

Primary Denial Reason(s):

- 12 claim lines were disallowed because the documentation does not meet Local Coverage Article requirements for Therapeutic Shoes for Persons with Diabetes.
- 5 claim lines were disallowed because the documentation does not meet Local Coverage Article requirements for Ankle-Foot/Knee-Ankle-Foot Orthoses.
- 4 claim lines were disallowed because the signature on the records does not meet CMS criteria.
- 2 claim lines were disallowed because the documentation does not meet Local Coverage Article criteria for surgical dressings.
- 1 claim line was disallowed because no records were submitted to support the billed services.

Additional Denial Reason(s):

- 4 claim lines were also disallowed because the documentation does not meet Local Coverage Article requirements for Therapeutic Shoes for Persons with Diabetes.
- 1 claim line was also disallowed because there was conflicting/inconsistent documentation in the medical records.

References

- Social Security Act, Title XVIII, Section 1833(e)
  https://www.ssa.gov/OP_Home/ssact/title18/1833.htm

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- Code of Federal Regulations, Title 42, Section 424.5 (a) (6) https://www.gpo.gov/fdsys/pkg/CFR-2005-title42-vol1/content-detail.html
- WellCare Kentucky Medicaid Provider Manual, Page 45. https://www.wellcare.com/Kentucky/Providers/Medicaid
- MLN Matters Number SE1237 https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1237.pdf
- WellCare Kentucky Medicaid Provider Manual, Page 45. https://www.wellcare.com/Kentucky/Providers/Medicaid
- Article for Therapeutic Shoes for Persons with Diabetes - Policy Article (A52501) https://localcoverage.cms.gov/mcd_archive/view/article.aspx?articleInfo=52501:14
- Local Coverage Article: Surgical Dressings - Policy Article (A54563) https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=54563&ver=16&LCDId=33831&Date=05%2f02%2f2018&DocID=L33831&SearchType=Advanced&bc=KAAAABABAAAA&
- Local Coverage Determination for Ankle-Foot/Knee-Ankle-Foot Orthosis L33686 https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33686&ver=15&Date=12%2f04%2f2017&DocID=L33686&SearchType=Advanced&bc=KAAAABAAAAAA&

Resolution

REMIT OVERPAYMENT
If you agree with the determination, please submit a draft in the amount of $X,XXX.XX within sixty (60) days from the date of this letter to:

WellCare Health Plans, Inc.
Attention: SIU-Director Lori Peters
PO Box 31407
Tampa, FL 33631-3407

Please ensure to place the case number (#12345) in the memo section.

You may contact Investigator Name, at (502) 555-1212 to discuss repayment options.

ADMINISTRATIVE REVIEW
If you do not agree with this proposed determination, you may request an Administrative Review by submitting your request in writing within sixty (60) days of the date of this letter. Your request should detail why you disagree with these findings and must include any supporting evidence/documentation you believe is pertinent to your position. In the event of an appeal, any additional and previously submitted documentation will be included in a more comprehensive review to include (but not limited to) medical necessity, all applicable local, state, and federal rules, as well as any applicable regulatory policies and guidelines.

WellCare
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Special Investigations Unit

Additional documentation should be sent to:

WellCare Health Plans, Inc.
Attn: SIU Records Custodian
8735 Henderson Road
Building 2, Floor 2
Tampa, FL 33634

A Final Determination will be rendered within thirty (30) days of the date of receipt of the additional information submitted with your administrative review request.

CLAIM OFFSET

If no refund is received within sixty (60) days from the date of this letter, the TOTAL REFUND AMOUNT will be reduced from future claim payments, per *WELLCARE 2019 KENTUCKY MEDICAID PROVIDER HANDBOOK; SECTION 5: CLAIMS; PAGES 81-82 OVERPAYMENT RECOVERY*: "WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will adhere to Kentucky Regulatory Statute KRS 304.17A-708 and limit its notice of retroactive denial to twenty-four (24) months from the payment receipt date. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, required by,or initiated at the request of, a self-insured plan, or required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or Members In all cases, WellCare or its designee will provide a written notice to the Provider identifying the specific claims, overpayment reason and amount, contact information and instructions on how to send the refund. If the retroactive denial of reimbursement results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address WellCare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides sixty (60) days for the Provider to send in the refund, request further information or dispute the retroactive denial. Failure of the Provider to respond within the above time frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted by WellCare, or its designee, to arrange payment."

Any final resolution in this matter between the provider and WellCare Health Plans, Inc. in no way binds nor precludes the State or any other regulatory agency from taking further action for the circumstances that were addressed in this letter.

Thank you in advance for your prompt attention to this matter.

Regards,
Investigator Name
Investigator Contact Information

27. Contractor Reporting Requirements

C.27. CONTRACTOR REPORTING REQUIREMENTS

a. As indicated in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," the Department would like to leverage the contracted MCOs existing technologies and reporting capabilities to develop a comprehensive reporting package through a collaborative process. Understanding that ultimately the Department will define the reporting package, describe the Contractor's willingness to participate in such a collaboration, including a discussion of the following:

i. Proposed reports and report templates that will result in a comprehensive, Department-accepted reporting package.

ii. Proposed ideas for collaborating across MCOs to ensure consistent and comparable reporting using the same data definitions and specification can be achieved.

iii. Requirement of Subcontractors to participate and or comply with this process.

b. Provide a detailed description of the Contractor's capability to produce reports required under this Contract, including an overview of the Contractor's reporting systems and capability to configure such systems to capture data according to reporting definitions and specifications as required by the Department.

c. Describe the Contractor's processes to review report accuracy and completeness prior to submission to the Department.

d. Provide examples of the Contractor's proposed:

i. Processes for conducting comparative data analyses, interpreting trends, and summarizing findings in a manner that is easily interpreted by the Department.

ii. Use of dashboard reporting to monitor, track, and evaluate performance metrics, including dashboard level data the Contractor proposes to submit to the Department. Provide a sample dashboard report.

iii. Use of findings from reports to make program improvements and to identify corrective action.

e. Describe the Contractor's processes for monitoring, tracking, and validating data from Subcontractors.

f. Describe the Contractor's proposed process for the receipt, generation, interpretation, and provision of ad hoc reports requested by the Department.

C.27. CONTRACTOR REPORTING REQUIREMENTS

OUR EXPERIENCE IN REPORT SUBMISSION

WellCare of Kentucky will comply with the Department of Medicaid Services' expectations and requirements as specified in Section 37 Contractor Reporting Requirements and Appendix D Reporting Requirements and Reporting Deliverables and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare of Kentucky has a long history of ensuring timely submission, accuracy and completeness of all regulatory reports and compliance requests with our government partners. Our compliance and regulatory oversight teams, tools and processes are specifically designed to meet the unique needs of government constituencies. Our highly responsive well recognized local Regulatory Affairs and Compliance team is led by Chief Compliance Officer Rebecca Randall. Working together, alongside a dedicated IT Regulatory Reporting team, with an average of over 7.5 years of dedicated regulatory reporting experience meeting the needs of the Department, WellCare of Kentucky has historically demonstrated strong capabilities in fulfilling the Department's reporting requirements. For example, **all 2019 report submissions were delivered timely and in accordance with the Department's required specifications.** This dedicated team will continue to use their well-established processes to provide the Department with timely and accurate reports, for both standard regulatory report submissions and ad-hoc report requests, including the reporting package outlined in Appendix D "Reporting Requirements and Reporting Deliverables" and the additional reports as mentioned in section 37.3 Reporting Requirements for Specific Operational Areas. These processes include cataloguing the request, working with appropriate department owners and subject matter experts to ensure understanding of the request, validating accuracy, tracking completion, analyzing for trends, archiving the report and any supporting documentation, and final submission to the Department.

a. As indicated in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," the Department would like to leverage the contracted MCOs existing technologies and reporting capabilities to develop a comprehensive reporting package through a collaborative process. Understanding that ultimately the Department will define the reporting package, describe the Contractor's willingness to participate in such a collaboration, including a discussion of the following:

COLLABORATIVE APPROACH

WellCare has extensive experience within the Kentucky market as well as, recently in both Georgia and Nebraska, participating in working groups, facilitated or led by the Department, to define common formats for regulatory reporting requirements. We welcome this opportunity to once again collaborate with the Department and our MCO partners to develop a robust and meaningful reporting package for the Department.

In the past WellCare of Kentucky has worked directly with the Department in reviewing, developing and analyzing regulatory reports. **Through this collaboration we were successful in enhancing several reporting packages, specifically related to behavioral health that would have otherwise been very difficult to obtain.**

Our Collaborative Approach with the Department

One example of our collaboration involved the inclusion of Severe Mental Illness (SMI) and Severe Emotional Disorder (SED) enrollee data within our reports. The core of the issue was the Department wanted the MCO's to report on specific outcomes related to SMI and SED enrollees, but the Department did not capture all SMI and SED enrollee indicators and provide to the MCOs via the 834 file process.

WellCare of Kentucky collaborated with the Department to resolve this issue as generating a report without appropriate enrollee indicators was an impossible task. We proactively reached out to the Department for Behavioral Health and Intellectual Disabilities (DBHDID) to determine a solution.

Through the process we learned that as our enrollees were being treated for mental health disorders through the Community Mental Health Centers (CMHCs), the CMHC's provided a monthly enrollee listing to DBHDID with both SMI and SED indicators. We were able to develop a file transfer process with DBHDID to receive a monthly enrollee SMI/SED indicator file from the CMHCs to flag enrollees as SMI or SED in our eligibility system.

Through this collaboration, we are now able to enhance our reporting capability to DMS and ensure that we are providing the most current data available regarding this specific population.

Our past experience has demonstrated that the Department's proactive approach to solicit MCO participation, feedback and suggestions, while ultimately defining the reporting package requirements will allow for streamlined processes and defined outcomes for the Department as well as the MCOs. We have found that this face to face collaboration is most effective in determining Department needs as well as MCO capabilities. WellCare of Kentucky commits to identifying and making resources available immediately upon Contract Execution to participate in the collaborative meetings with the Department and other MCOs to establish a reporting package that provides:

- Detailed specifications and consistent data definitions for all required reports
- Statistical information in a format for which trends can be identified
- Detailed analysis with a summary of identified trends and patterns of change, outliers, successes, risks, and mitigation strategies

Additionally, WellCare of Kentucky, as we have done in the past will draw upon our experience and reporting best practices utilized in our other Medicaid markets that could potentially also be useful for the Department to review.

i. Proposed reports and report templates that will result in a comprehensive, Department-accepted reporting package.

As a willing participant in the collaborative process of developing a comprehensive reporting package, WellCare of Kentucky will leverage ideas and suggestions from our vast experience within the Kentucky market, as well as from other Medicaid markets we currently serve to suggest templates and reporting specifications for the Department to consider. Our locally centered regulatory reporting team has reviewed the proposed reporting requirements within Appendix D and 37.5 of the Contract and worked collaboratively with counterparts in other

WellCare markets to gather sample reports and templates that closely resemble both the new as well as existing reporting requirements and descriptions laid out by the Department.

NEW REPORTS

We have included two sample templates (listed below), as examples of standard reporting templates that are already available, with defined specifications, that WellCare of Kentucky, the Department and other MCOs could collaboratively agree to implement. WellCare already generates these reports for our Florida Medicaid program and they are generally well-received.

- **Attachment C.27.a.i-1 Administrative Subcontractors and Affiliates Report Template**
- **Attachment C.27.a.i-2 Appointment Wait Times Report**

Modified Reports

After further review of the modified reporting descriptions to the existing reports within Appendix D, we have identified the following reports (listed below) that could potentially be modified or combined with another report to increase efficiency and reduce the overall volume of reports. As with the new reporting templates referenced above, WellCare already generates these reports for our Florida Medicaid program.

- **Attachment C.27.a.i-3 Claims Aging Report**
- **Attachment C.27.a.i-4 Denied Suspended Terminated Provider Report,** and
- **Attachment C.27.a.i-5 Enrollee Compliance Grievance Appeal Report** (provided electronically)

Additional Reporting Suggestions

In addition to the review and presentation of specifications and templates for new and modified reports, we would also propose the following:

- Identification of additional subject areas of potential interest that are not currently being reported on, such as the use of Social Services by enrollees
- Identification of reports that could potentially be removed from the existing regulatory reporting package that are redundant or could be combined with another report
- Recommendations to consider establishing the practice of defining all report templates and standards within a Kentucky Medicaid Reporting Guide, that would include a defined Data Dictionary (further outlined in below), and making that information publicly available via the Department's website.
- Internal Operational Dashboards and Reports that are in use in our organization that the Department may wish to access (through our Government Partner Portal, refer to **Figure C.27-1**) or another Department-defined platform.

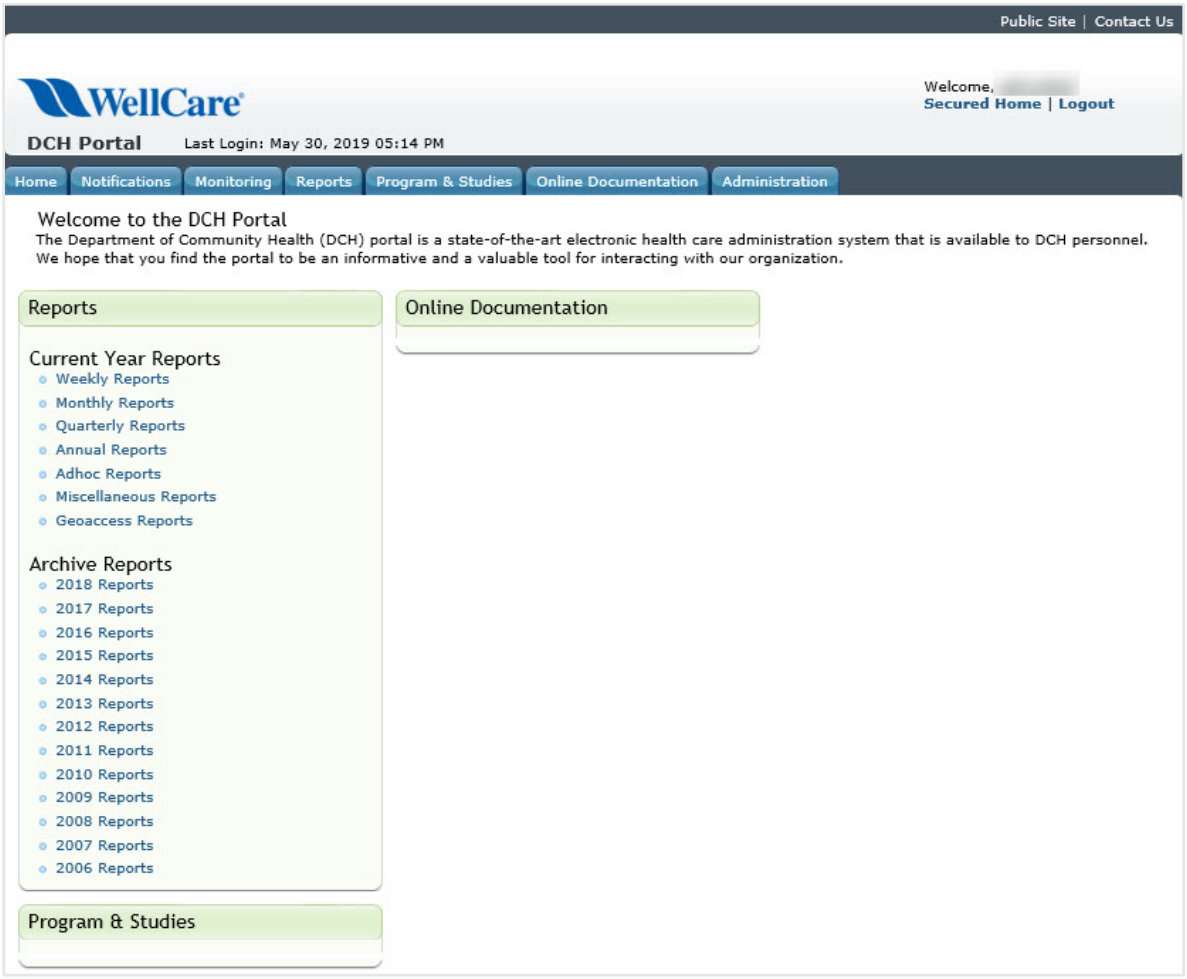

Figure C.27-1: Sample screenshot of Government Partner Portal

We also believe that reporting transparency is an important component of the Department's regulatory reporting package. Once all the MCOs and the Department have agreed upon all templates and specifications of the reporting package, WellCare of Kentucky would recommend that the "Kentucky Medicaid Reporting Guide" be published on the Department's website. This guide would provide the details of all the managed health plans reporting requirements including instructions, specifications and templates. This guide is further discussed in (ii).

We would also propose to the Department that MCOs work collaboratively to implement Quality and Outcome Driven Reports through a dedicated webpage (ideally placed on the Department's website) that would include all of the performance measure indicator descriptions defined in Section 19.4 Kentucky Healthcare Outcomes of the Contract, for e.g., HEDIS. This information would be available to the public and would allow further visibility into the Department's monitoring of the Medicaid health plans' performance. The Medicaid Beneficiaries can also access and use this information to compare health plans and determine the relative value of care offered by managed care health plans. The measures allow the users to understand how well health plans achieve results that matter, such as how effective and accessible is the care being delivered, network adequacy, prevention and treatment quality scores, customer service satisfaction, and % of board certified providers, just to name a few.

WellCare has direct experience working collaboratively with State Medicaid Agency to design a comprehensive reporting package and greatly welcomes the opportunity to partner with Kentucky to do the same.

ii. Proposed ideas for collaborating across MCOs to ensure consistent and comparable reporting using the same data definitions and specification can be achieved.

As a willing participant in the collaborative process of developing a comprehensive reporting package, WellCare of Kentucky will share insights and experiences gained from the development of our own robust reporting solutions. As the Department suggests, the establishment of a common Kentucky Medicaid Reporting Guide is a key step in achieving the desired results. **We have direct experience with this type of collaboration in Kentucky and other Medicaid markets we serve.** In Kentucky, we presented a standard approach for using provider type and specialty fields to distinguish and identify behavioral health services and substance abuse services from non-behavioral health services. This proposal was submitted to both DMS and DBHDID reporting and operational teams in 2018. A sample of the BH logic document report is attached in **Attachment C.27.a.ii Sample BH Logic Report**, provided electronically.

We also have extensive experience in our other Medicaid markets working with our governmental and managed care plan partners to develop a robust, consistent and transparent reporting package. Our experience integrating acquired entities into our operating environment has demonstrated that once the Reporting Guide is established, and independent systems (such as those used by the multiple MCOs) map elements to within the Reporting Guide, data quality, accuracy, and consistency will automatically increase. Further, as we suggested earlier, placing this information on the Department's website, where it can reviewed by Enrollees and other interested parties, increases transparency and allows the people of the Commonwealth the opportunity to see the true value that managed health care brings.

Other key considerations WellCare of Kentucky would recommend to discuss include:

- Reporting Guide definitions of "Reference Data" and values. This can include agreement to utilize specified Code Sets but can also extend to values for common fields such as gender, reason codes (such as disenrollment reason), and other frequently utilized fields
- As Reporting Guide will be the precursor to successful implementation and achievement of the Department's reporting goals, our recommendation would be to establish various sub groups, based on subject matter (e.g. claims, behavioral health, and utilization management). Bi-weekly sessions would be an appropriate frequency.
- WellCare's past experience has shown that both business and technical resources are key to defining a successful Reporting Guide and would include a variety of participants from the Department and WellCare of Kentucky staff in areas such as IT, Regulatory, Claims, Customer Service and other operational areas (depending on the Department's areas of focus) in this process.
- WellCare of Kentucky also recommends collaboratively exploring the opportunity to leverage existing, published Data Dictionaries for the health care industry (e.g. Medicare standards). This approach would reduce the time and effort required to complete the

Reporting Guide yet allow the end product be tailored to the unique needs of the Department.

iii. Requirement of Subcontractors to participate and or comply with this process.

As a contracted MCO, we believe it is our obligation to know, understand, and represent all services and capabilities offered to DMS, whether they are subcontracted or not. If nuances within a specific service type provided by a subcontractor required the need for additional guidance, it would be incumbent upon the MCO to work directly with their vendor to gather that information and bring it back to the work group Further, our experience has demonstrated that competitive, market and other relationship scenarios of subcontractors can create challenges when a single vendor represents multiple MCOs. . However WellCare of Kentucky would recommend that participation by subcontractors in the process not be required, and in most cases limited or not included.

WellCare of Kentucky includes in our contracts with subcontractors, language that requires them to comply with all requirements in our contracts with government partners. We fully expect subcontractors to comply with the final requirements published by DMS. Our Kentucky Subcontractor Oversight Team, led by Ben Orris, is supported by multiple subject matter experts across our company. As part of their negotiating and contracting processes, our National Network Performance Team ensures all required Kentucky-specific contract standards are included in our Kentucky subcontracts, and also aligns these standards with monetary performance incentives and penalties. In addition, our Network Performance Team and our Delegation Oversight team works to ensure our subcontractors are in compliance with the processes and expectations. They also periodically re-procure our subcontracts to ensure we are partnering with the strongest organizations and obtaining the best value for the subcontracted services. Reporting deliverables, complaints and inquiries are tracked within LIONS and C360. In the instance of reports, each month, the Oversight Team generates a report of all deliverables due. If a Subcontractor is responsible for a regulatory report, the Regulatory Affairs team sends a reminder to the Subcontractor contact stating the due date. The report is to be delivered to the plan, with the appropriate attestation to accuracy. The Regulatory Affairs team reviews the data in collaboration with the Subcontractor management team, and submits the report to the Commonwealth. We do not allow our subcontractors to submit reports directly to DMS without appropriate internal review and approval.

If a Subcontractor fails to deliver the report in a timely manner, they are subject to reimburse the plan for any penalties assessed by the Department. The issue is escalated internally to the Subcontractor management team who will determine if further corrective action is warranted. Repeated violations of contractual obligations could be justification of contract termination. In addition to a formal annual audit, WellCare regularly monitors all delegated subcontractors through monthly scorecards. The results of these monitoring and oversight activities are discussed directly with the delegated subcontractors and the Kentucky Regulatory Affairs Team through Joint Operating Committee (JOC) meetings.

Please see **Attachment C. 27.a.iii-1 2019 Delegation Oversight Audit Schedule** and **Attachment C. 27.a.iii-2 Sample Avesis Scorecard**, provided electronically, for examples of some of our monitoring tools.

One suggested participant to include beyond the MCOs would be the KHIE. As an active participant with many common goals and objectives, WellCare of Kentucky believes that KHIE may have an existing Data Dictionary and other assets that would also assist the Department and the MCOs in developing a uniform reporting package.

b. Provide a detailed description of the Contractor's capability to produce reports required under this Contract, including an overview of the Contractor's reporting systems and capability to configure such systems to capture data according to reporting definitions and specifications as required by the Department.

WELLCARE'S REPORTING CAPABILITIES

WellCare of Kentucky has developed the systems and processes necessary to ensure the ability to produce the reports required under this contract. We have historically demonstrated a strong commitment to meeting the reporting expectations of our government partners and have invested heavily in developing systems and processes that support our commitments.

We have a long history of submitting high quality data files and reports in accordance with state standards for accuracy, timeliness, and completeness.

This success is the result of the combination of our proprietary Legal Integrated Online Network Solution (LIONS) submission tracking tool, our Enterprise Information Management (EIM) solution, a formal report development lifecycle, and a formal certification process to produce the reports previously outlined within Appendix K of the MCO Contract. These processes will carry forward to ensure the reporting package in Appendix D "Reporting Requirements and the additional reports outlined in Section 37.3 Reporting Requirements for Specific Operational Areas:

- *LIONS:* formalizes the certification tracking and submission process to ensure individuals validate and complete the review and attestation activities
- *EIM:* provides access to data that is already quality-reviewed, both reducing development time and improving data quality
- *Lifecycle:* our report development lifecycle ensures an accurate understanding of the request (and data elements) is established up front and serves as the basis for independent QA validation prior to production deployment
- *Certification process:* ensures that all participants in the report development process have an understanding of the critical nature of the submission and the appropriate appreciation for the required data quality compliance.

An experienced team of staff currently uses these established tools, processes, and systems to provide the state with timely and accurate data files and reports. These processes include cataloguing the request, distributing the requests to appropriate owners, validating accuracy, tracking completion, analyzing for trends, storage of the completed report, and final submission to the Department.

Our ability to meet the Department's reporting requirements extends not only to the pre-defined contractual reports identified in Appendix D "Reporting Requirements and the

additional reports outlined in Section 37.3, but also to the reporting package that will be developed during the collaborative work team process. It also extends to the ability to support ad hoc reporting requests on short notice, consistent with the Departments expectation that we respond timely to ad hoc requests. We are able to make the commitment to meet these expectations of turnaround times, which can be as short as three days, not only because of our systems and processes, but because we anticipate the need as an expectation of the Department. Consistent with that expectation, WellCare has an assigned, directly allocated Regulatory Reporting team with an average of over 7.5 years developing regulatory reports, to ensure we have staff with the necessary expertise to meet these obligations.

OVERVIEW OF THE REPORTING SYSTEM

WellCare's reporting capabilities, including regulatory and ad hoc report submissions, are based on our Enterprise Information Management (EIM) solution. This is the central repository of all our data, which facilitates data integrity and self-service analytics. The EIM catalogues and collects all available data in a scalable and high performing repository which is built using industry leading technologies. We support development of enhanced data integration and analytics capabilities, and the EIM can provide the Department with the data requested in a timely manner and in accordance with technical requirements. The EIM solution facilitates data integrity and self-service analytics. It leverages innovative solutions and technologies for storage and processing, high performing data exchange and integration tools, data visualization tools for reporting and analytics in conjunction with predictive modeling capabilities to process, analyze and report on very large amounts of data rapidly. In addition, the EIM is also directly integrated into our quality management activities, risk adjustment processes, and fraud waste and abuse functions. The EIM also provides service coordinators with member 360º views and serves as the source for the risk stratification and provider profiling functions. The EIM backs the ongoing initiatives detection to onboard clinical data in industry format from providers for effective population health management initiatives and to reduce gaps in care.

Key functional attributes of this enterprise technical component include:

- *Data Ingestion* which captures and catalogs the raw data from incoming files, internal applications, and outgoing files regardless of the source data structures leveraging Hadoop.
- *Data Refinement* employs a set of validation, cleansing, and aggregation activities to assemble the raw data into standard subject areas in Hadoop.
- *Data Publishing* makes pre-assembled information available for reporting, analytics, and applications, including support for regulatory reports and ad hoc requests using the formats and best-suited database (Oracle, Greenplum and XML).
- *Data Access* tools are supplied to match user needs and experience, including traditional reporting tools (such as Cognos), analytics tools (such as SAS), and visualization tools (such as Tableau®).

All of the data that is pooled into the EIM is available for use in generating regulatory reports, fulfilling ad hoc requests, and meeting operational and analytics needs. Data is collected and incorporated into the Data Marts on a continuous basis. We employ a set of validation,

cleansing, and aggregation activities to make sure all Data Marts are populated with clean, accurate, and useful information. Data Marts include all data types and combine similar data sets from multiple source systems in order to meet the specific needs of the organization as efficiently as possible. The data marts are constructed based on the intended use and can generally be classified as an Application Support, Reporting, or Analytic Data Mart. While WellCare has existing Data Marts and the associated information available to meet our existing reporting obligations in Kentucky, as needed, new Data Marts will be constructed to specifically support the requirements.

Application Data Marts are a key method of integrating data from all sources into our applications. Just as the application data stores (such as claims, enrollment, and provider transactions themselves), these Data Marts are accessed by applications through the data services layers. Reporting and Analysis Data Marts often come from the same sources of data but are structured to be used by our reporting tools (such as Cognos), analytics tools (such as SAS), and visualization tools (such as Tableau®). In turn, these tools make data readily available to our users.

The following **Figure C.27-2** depicts our reporting and analytics sources and integration:

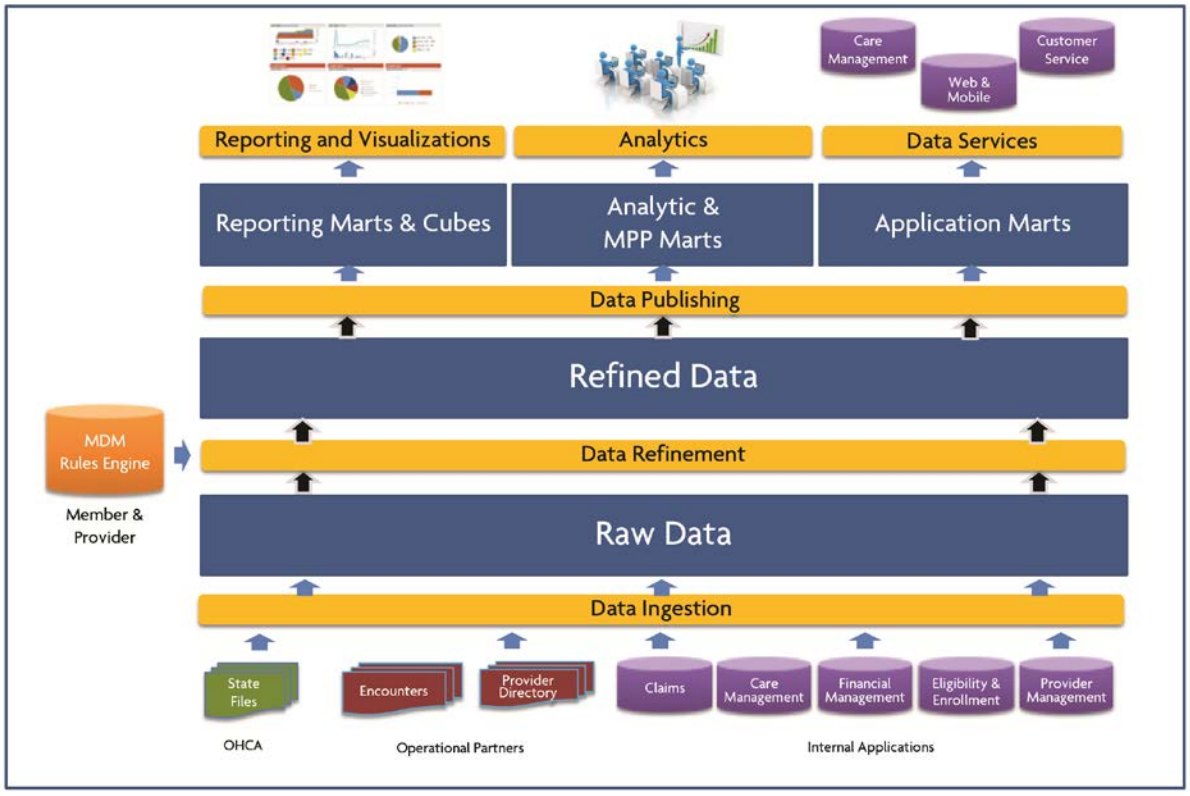

Figure C.27-2: Our reporting and analytics sources and integration

A key distinguishing outcome of our EIM strategy is the ability to ensure the appropriate, validated source of information is available to the appropriate user of the information and delivered according to the appropriate methodology.

ABILITY TO CONFIGURE SYSTEMS TO CAPTURE DATA

WellCare's operational systems are designed to support the data and operational characteristics associated with our contract with the Department. As a result, we have built into our processes the capture of the data elements needed to support our obligations.

Where necessary, WellCare of Kentucky is able to rapidly update and expand these systems and the associated data repositories to support regulatory reporting needs. This includes, in particular, the ability to utilize our Roles and Relationship Data Structure (RRDS) to add new attributes (demographic in nature) and conditions (which are time sensitive) to both the enrollee and provider databases. As an example, WellCare of Kentucky will be able to configure the capture of the provider's participation in KHIE using the RRDS structures, as committed in our response to support participation in KHIE. The reliable capture of this information results in WellCare's ability to identify provider partners that are not actively integrated with KHIE and assemble smart reporting to be shared with our Network and Provider Relations teams. The translation of that data to actionable information can then be used to pursue corrective action or incentivize participation in the KHIE.

A significant advantage of our EIM solution is the flexibility that results from having all of the data received from external sources or generated by internal systems available for reporting and inclusion in the Data Marts available for use in generating regulatory reports, fulfilling ad hoc requests, and meeting operational and analytics needs. This data is collected and incorporated into the Data Marts on a continuous basis. The result is WellCare of Kentucky's ability to rapidly adjust our report content to include new data elements without large scale projects.

Additionally, a built in feature of our dashboard solutions is the opportunity to change filters and drill down into more detail without the development of new reports. WellCare of Kentucky has identified examples of dashboards that may be of interest to the Department but would openly welcome the opportunity to discuss dashboards of interest to the Department.

c. Describe the Contractor's processes to review report accuracy and completeness prior to submission to the Department.

We view accurate and complete data, analytics and reporting as a foundational element of a top-performing health plan. To that end, WellCare of Kentucky has established a compliance process for "Subject Matter Expert" review and Business Owner review of, and attestation to, the accuracy of each report, prior to each submission to the Department. This is referred to as the Internal Certification Process. Attached are the policies and procedures of our certification process **Attachment C.27.c Attestation Policy and Procedure**. The purpose of the Internal Certification Process is to establish procedures for the review and certification of all reports, records, data, and other information that are contractually required to be filed with, or submitted to, state and federal agencies ("Submissions" or "Reports"). Specifically, the Internal Certification Process helps to ensure that:

- Appropriate reviews, validations, certifications, and approvals occur prior to submission to any federal or state agency

- All submissions are accurate, complete, submitted in a timely manner, compliant, and in accordance with all governing contractual provisions and the underlying state and federal laws, requirements and guidelines.
- All retention protocols are satisfied
- Associates receive regular training on their duties and responsibilities under this policy and its associated procedures, and that any questions or issues regarding such duties or the appropriate use of the attestation forms are promptly resolved.

WellCare's Regulatory Reporting department is a team of over 30 resources who are focused and accountable to develop reports for submission to the Department based on contractual requirements. Data-driven reports (e.g. excluding financial statements, corporate filings, and narrative summaries) are developed by this dedicated team. This team is composed of the following positions:

- Software Engineers: skilled in WellCare application development tools and processes and accountable for developing code and extracts to support reporting requirements
- Business System Analysts: familiar with business terminology and processes who are accountable for documenting the business requirements of any individual report or extract request and facilitating data mapping exercises
- Data Engineers: responsible for the analyzing, designing, developing, testing, and documenting information management systems with specific knowledge or data sources
- Data Analysts: primary points of contact for interface between data users and information system teams. They conduct analysis of business and user data needs, documenting requirements, create source-to-target mappings, and revise existing logic, as necessary. They also analyze data needs for users and cross reference to data sources in information technology (IT) systems.

Additionally, for each regulatory report submission, there are the following roles:

- Market Project Manager: dedicated Kentucky Market resource who tracks receipt of each monthly and quarterly report for timely submission, report template completion and assures the sub-certification for each report has been finalized
- Data Source Provider: this individual has direct knowledge of the data used in the data request, and is responsible for specific data and data sources supplied to the request preparer
- IT Preparer: an IT associate who works with the data request preparer, data source provider, and business owner; establishes data request control and requirements documents
- Business Owner: Responsible for collaborating with the State data requestor (e.g., auditor, contractor) to fully understand and document data request specifications and requirements; monitors timeliness of data request delivery

- Data Request Preparer: compiles final data set and certifies it before submission or required sign-off

WellCare of Kentucky maintains a Kentucky-specific reporting policy to submit required reports and submissions timely and in the appropriate format, frequency as prescribed by the Department. This report submission process is overseen and validated by our Regulatory team, led by Rebecca Randall. The sources, processes, and systems above are used to meet the requirements of our other state partners. A significant advantage of our sole focus on government sponsored initiatives is that ability to leverage prior works. We are able to update and modify the format and content of any new or existing report to meet the requirements of the Department.

d. Provide examples of the Contractor's proposed:

i. Processes for conducting comparative data analyses, interpreting trends, and summarizing findings in a manner that is easily interpreted by the Department.

WellCare of Kentucky understands that their responsibility to not only complete that statutory regulatory reporting package, but, more importantly, to demonstrate a commitment to providing the Department with reports, trends, and analyses that are easily interpreted and can be utilized by the Department to drive organizational change. Part of that mission is designed to be fulfilled by our dashboard containing key performance indicators, visualizations, and trends. That dashboard is configurable to meet the Departments needs and can be adapted to new configurations.

It is our intention to take our internal resources and processes for detailed comparative analysis and put them at the disposal of the Department. Specifically, we are proposing that on a quarterly basis WellCare of Kentucky will propose a range of topics that have been identified for analysis through our internal processes. From this list the Department will select a topic for detailed comparative analysis and by quarter end produce a detailed whitepaper on that topic detailing all geographic and demographic trends, outliers, as well as a proposed strategy for addressing the topic at hand, complete with descriptive interpretations. Depending on the breadth and complexity of the topic, these papers could range from 5 - 10 pages on average and provide all of the insights available to WellCare's leadership through internal channels.

The foundation of this reporting will be Kentucky-specific data that addresses the topic, but where appropriate the whitepapers will also include recommendations from our subject matter experts, industry best practices, and comparative analysis between WellCare of Kentucky and other WellCare Medicaid markets.

This process is intended to, first and foremost, meet the Department's needs for actionable information. In the event that the Department identifies areas of concern which were not recommended by WellCare of Kentucky, possibly through CMS initiatives or legislative inquiries, we will be able to provide the same level of quality research into the department preferred topic rather than the proposed set. The attached whitepaper (**Attachment C.27.d-i Sample Dashboard Report,** provided electronically) is a very short demonstration of the types of analysis available through this process. It is only intended to serve as an example.

In addition to the generation of our standard Regulatory Reporting WellCare would welcome opportunities to collaborate with the Department to leverage our AI and Machine learning team to jointly develop and execute advanced analytic exercises. WellCare's dedicated team of experts in this discipline, in collaboration with the appropriate business partners, have been able to leverage these statistical techniques to approach analytics from new and productive perspectives. A key example of the application of the tools, knowledge, and skill sets has been our set of Population Segmentation activities.

Population segmentation and modeling are have proven useful for a variety of applications. Some of these include, but are not limited to: identifying populations for specialized/tailored health interventions, selecting different care and utilization management strategies, factors leading to disenrollment, and the effectiveness of member retention practices.

Prior works on population segmentation at WellCare were primarily based on the use of multiple 'traditional' methods that are usually centered on the identification of naturally occurring clusters (sub-populations) on the basis of observable and directly measurable attributes of a particular population.

ii. Use of dashboard reporting to monitor, track, and evaluate performance metrics, including dashboard level data the Contractor proposes to submit to the Department. Provide a sample dashboard report.

WellCare's dashboards help us monitor, track, and evaluate performance metrics. We routinely begin with a high level analysis and proceed to break that data out:

- By Region
- By Hospital / Provider
- By Diagnosis
- By Age / Gender Cohort
- By Race / Ethnicity / Language
- By Time Period
- By enrollment type
- By urban/rural designation

This more detailed analysis allows us to pinpoint the root cause of positive or negative data observations and create a mitigation or promotion strategy as appropriate.

WellCare of Kentucky is also proposing an additional process to provide comparative analysis, trend analysis, and actionable intelligence for the Department. As a process, our key leaders routinely review dashboards and trend reports to confirm that processes are working as intended, spot outliers, or uncover emerging trends. However, our analysis does not end with these reports. Business leaders throughout the organization, upon viewing such summary reports, have teams of analysts and economists that are able to proceed from general trends and examine the phenomena at a much more granular level.

To ensure our findings are easily interpreted by the Department we adopt a "pyramid" approach that starts with an "Executive Summary" dashboard containing a high-level view of the most important metrics (enabling efficient review) – but also allows the user to easily "drill down" and slice the data into key sub-segments that can reveal meaningful insights. The dashboard allows WellCare users to utilize standard data element definitions and mapping for commonly utilized data elements to ensure consistency in reporting and the use of data across our organization. This tool allows uses to drill-down and "slice" the data into relevant sub-components and make the data available in a digestible format. Dashboard examples are provided in the following section, ii.

Below are screenshots (**Figure C.27-3, Figure C.27-4, and Figure C.27-5**) of our sample dashboard which can be easily interpreted by the Department. *The dashboards (below) and the report attached under ii) is based on mock up data which would give the Department an easily interpreted picture of the report yet maintaining our confidentiality of data.*

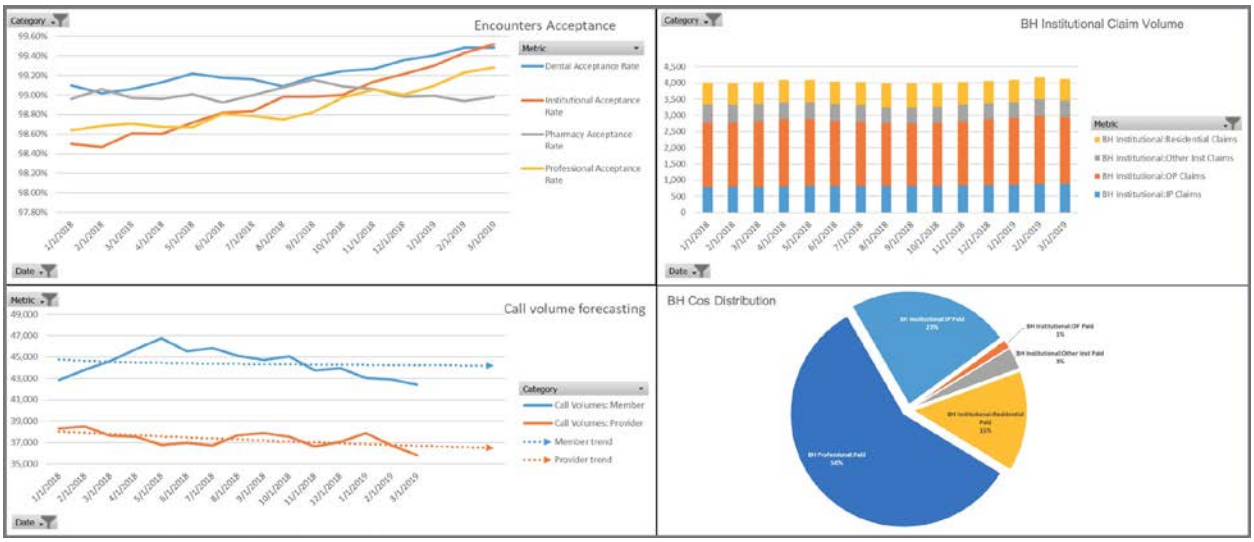

Figure C.27-3: Sample dashboard screenshot

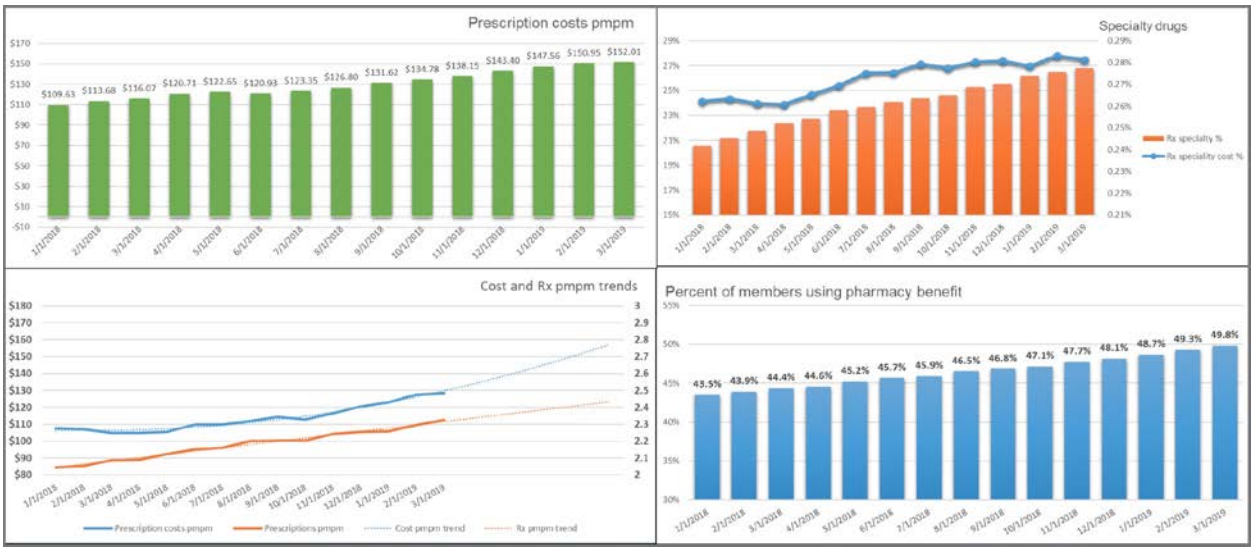

Figure C.27-4: Sample dashboard screenshot (continued)

Figure C.27-5: Sample dashboard screenshot (continued)

iii. Use of findings from reports to make program improvements and to identify corrective action.

EXAMPLE 1: Improving Generic Dispensing Rate

Identifying the trend: In March, 2018, Park DuValle's, a FQHC provider group that is a member of the Kentucky Primary Care Association, had a Generic Dispensing Rate (GDR) of 87.6% and their Per Utilizer Per Month (PUPM) was $87.

Implementing the Solution: Our local pharmacy team under the leadership of Director of Pharmacy Thea Rogers, and Ayonna Tolbert, Pharmacy Manager, worked with the provider to

assist them in increasing their generic dispensing rate. As a corrective action, our pharmacy team organized meetings and went over the reports with them. The provider was provided specialized reports regarding their top prescribed drugs by costs, formulary adherence, and key performance indicators such as ingredient cost per utilizing member per month (PMPM), average cost/Rx, generic dispensing rate, and percentage of controlled substances prescribed. Within these reports, we also provided them with actionable recommendations that include the formulary and/or lower costing alternatives. We also provided the FQHC with an enrollee list that identified which enrollees would be impacted by the recommended change. Our specialized reporting allowed them to observe their performance over time and compare them to other peer (other FQHCs) prescribers in plan. Through our collaborative efforts, we were able to assist the provider with achieving improved cost savings to the program which also resulted in improved quality of care for our enrollees, and concurrently reducing the administrative burden of completing authorization requests by switching to a generic drug that does not require authorization.

Results: In March, 2019, Park DuValle's GDR had improved to 90.4%, while their PPM had significantly declined for the first quarter of 2019 to $71. We have included an example of this report in **Attachment C.27.d.iii Sample Report**.

EXAMPLE #2: Preventing Inpatient Hospital Readmissions

Identifying the trend: It is not unusual for Medicaid utilization trends to be hidden when reviewing information at a high level. WellCare regularly examines information beneath the surface to determine if there are unfavorable trends emerging by line of business, region, facility or age cohort to name a few. In 2018 we experienced a 3.3% year over year increase in our Aged, Blind and Disabled (ABD) inpatient readmission rate which went from 18.0% in 2017 to 18.6% in 2018. Identifying drivers of the adverse trend, we saw a need for ABD Enrollees to be more engaged in their discharge planning and after-care and a greater need for collaboration for discharge services.

Implementing Solutions: In addition to the Enrollee, provider and system level strategies to reduce inappropriate utilization, we implemented targeted initiatives to address this adverse readmission trend, including the following efforts:

- Enhanced Discharge Planning Collaboration: Our care management, UM and provider relations team began collaborating on clinical rounds for Enrollees identified through our predictive discharge algorithm, known as LACE+, as being at the most risk for a readmission. We run the predictive scoring algorithm at the time of admission and throughout the stay to identify risk. Our collaborative team works to identify discharge needs (including behavioral, physical, pharmacy and social needs). We worked closely with the hospitals, including placing care coordinators in certain high-volume hospitals, to collaborate on discharge plans ensuring that needed services such as DME or home health were in place when the Enrollee goes home.
- Care Management Integration: When it becomes clear through our discharge efforts that an Enrollee will need more intensive follow-up, our PHM staff is engaged for follow-up and referral to Chronic Condition Management or Complex Care Management.

- Medical Leadership Engagement: A key strategy for addressing inpatient readmissions includes intense local engagement with individual hospitals. Dr. Shaps worked extensively with hospitals systems throughout the state as we saw the spike and trend (and ongoing) to provide education and discuss methods to prevent avoidable inpatient hospital readmissions. Hospital systems across the state included, but were not limited to, the University of Kentucky, St. Elizabeth Healthcare, Norton Healthcare, KentuckyOne and Baptist Health. Meetings and collaboration with key stakeholders which included hospital or health system leadership, consisted of reviewing historic readmissions data, profiling high-risk patients, providing WellCare resources upon hospital discharge such as connecting discharging members with social gaps in care, and assisting with arranging post-acute care.
- Enhanced Data Exchange: We have used admission, discharge, and transfer data to stay better informed on Enrollee discharge status and to inform our providers when an Enrollee has a change in status so they can be empowered to help prevent an unnecessary readmission.

Results: With the greater awareness and focus on our ABD enrollees through the first 6 months of 2019, our ABD readmission rate has improved by 7% and currently running at 17.3%; the lowest readmission rate we have achieved for the ABD population since inception.

e. *Describe the Contractor's processes for monitoring, tracking, and validating data from Subcontractors.*

WellCare of Kentucky's approach to ensuring the timeliness and validity of data from providers and subcontractors, WellCare's Data Governance and Data Quality programs including external data sources in their scope, and are based on our assumption of responsibility for all data associated with our contract with the Department, whether that data is internally generated or provided by providers or subcontractors. During our regulatory report submission attestation process, if data from subcontractors is included in the report, this fact is recorded and the appropriate internal subcontractor representative is attesting to the accuracy of the data.

WellCare's Data Governance processes identify and define an enterprise Data Dictionary. This process includes business owners as Data Stewards to ensure both technical (data type, data ranges, referential integrity) and business (definition, reasonableness, expected values and uses) are incorporated into the results. This Data Dictionary is used as the basis of our Data Quality edits and validations.

WellCare of Kentucky also ensures that all data from subcontractors is submitted to the appropriate Data Quality validation edits based on the Department's guidelines. As an example, for claims and encounters WellCare of Kentucky applies the Department's encounter SNIP edits and will reject submissions back to the subcontractor for resolution if the edits are not met. Our encounters team actively tracks the quality, timeliness, and volumes of subcontractor's submissions to ensure we are receiving timely, accurate encounter data for inclusion in our submission process.

WellCare implements completeness checks against data received from subcontractors in addition to standard edits, as part of every process. As an example, WellCare requires the submission of a Cash Disbursements journal in addition to Encounters from delegated

adjudication entities. This allows us to ensure the subcontractor has provided all required encounter information.

In similar fashion, WellCare executes Data Quality edits against clinical data submissions and cross reference the closure of care needs data with the clinical and administrative data to ensure data quality and accuracy.

In addition, all data received from subcontractors is included in our Enterprise Information Management (EIM) solution that supports all of our data needs, including application processing, regulatory reporting, and ad hoc reporting. This comprehensive EIM solution ensures that all data sources, including data from subcontractors, are captured and catalogued, fully integrated into and accessible by transactional processing systems, and enables robust reporting capabilities in support of regulatory, operational, and analytic capabilities.

WellCare of Kentucky employs a Data Quality set of validation, cleansing and aggregation activities to make sure all Data Marts are populated with clean, accurate, and useful information, which include not only data type and format, but also data integrity constraints. In cases where data is submitted to us by a subcontractor and it fails to meet the data quality and accuracy requirements or our EIM, the submission is rejected to the subcontractor for remediation and resubmission.

f. Describe the Contractor's proposed process for the receipt, generation, interpretation, and provision of ad hoc reports requested by the Department.

WellCare of Kentucky's Regulatory Affairs (RA) team, led by Rebecca Randall, will serve as the single point of contact for DMS to request all ad hoc reporting requests, simplifying the process of managing these requests for DMS. We currently have a well-structured process of report generation from receipt to delivery, which takes into consideration the unique and urgent nature of the request:

Receipt: The Regulatory Affairs team utilizes a shared email box to receive all requests from DMS and the same holds true for ad hoc reporting. Once a request is received, the request is triaged by RA staff and is assigned to a Regulatory Manager and project analyst. *Adhoc reporting requests are assigned high priority status as we understand that many request are generally time sensitive and needed by DMS to respond to an external inquiry.* The Regulatory manager and project analyst is accountable for ensuring the ad hoc request is treated as high priority and fulfilled in the timeline requested by DMS. All requests will be immediately logged in our tracking application and forwarded to our IT Regulatory Reporting team for discussion and review, and will be fulfilled using our report development lifecycle and artifacts.

Generation: The first step in this review process is for an assigned Business System Analyst and the assigned Data Analyst to review the request, document the requirements in our Data Requirements Document (DRD) (**Attachment C.27.f-1 DRD Template Sample**) and the Source to Target mapping document (**Attachment C.27.f-2 Source to Template Sample,** provided electronically), using our enterprise Data Dictionary as a reference, to ensure that correct data sources, formats, and validations are included in the report. Any questions or requests for clarifications flow through the Regulatory Manager from DMS to ensure streamlined communications. Once the business and data requirements are documented and completed,

the report request is fulfilled by the Engineering team, using a Technical Design Document (TDD) (**Attachment C.27.f-3 TDD Template Sample,** provided electronically) to ensure all details of the report generation process meet the business requirements. Our independent Quality Assurance (QA) process will validate the final report against the lifecycle artifacts to ensure the accuracy of the report before it is sent to the Regulatory Manager for final review and submission.

For each regulatory report submission, including ad hoc requests, WellCare of Kentucky identifies the following roles:

- *Data Source Provider:* this individual has direct knowledge of the data used in the data request, and is responsible for specific data and data sources supplied to the request preparer
- *IT Preparer:* an IT associate who works with the data request preparer, data source provider, and business owner; establishes data request control and requirements documents
- *Business Owner:* Serves as the subject matter expert for the Data Source Provider, the IT Preparer and Data Request Preparer to fully understand and document data request specifications and requirements; monitors timeliness of data request delivery
- *Data Request Preparer:* compiles final data set and certifies it before submission or required sign-off

Interpretation: Once the report is delivered from our Regulatory Reporting team to the Regulatory Manager, a meeting is convened with the Regulatory Affairs and Compliance Director, Rebecca Randall and our COO, Ben Orris, to review the report and ensure that 1) the data accurately meets DMS's request, 2) the report is in the format requested and 3) any trends, issues, caveats, etc. are identified and disclosed. Once the report is vetted and final approval is granted, our COO completes the executive attestation and the report is submitted to DMS.

C.27 Contractor Reporting

- Attachment C.27.a.i-1 Administrative Subcontractors and Affiliates Report Template
- Attachment C.27.a.i-2 Appointment Wait Times Report
- Attachment C.27.a.i-3 Claims Aging Report
- Attachment C.27.a.i-4 Denied Suspended Terminated Provider Report
- Attachment C.27.a.i-5 Enrollee Compliance Grievance Appeal Report (Provided Electronically)
- Attachment C.27.a.ii Sample BH Logic Report (Provided Electronically)
- Attachment C.27.a.iii-1 2019 Delegation Oversight Audit Schedule
- Attachment C.27.a.iii-2 Sample Avesis Scorecard (Provided Electronically)
- Attachment C.27.c Attestation Policy and Procedure
- Attachment C.27.d.i Sample Dashboard Report (Provided Electronically)
- Attachment C.27.d.iii Sample Report
- Attachment C.27.f-1 DRD Template Sample
- Attachment C.27.f-2 Source to Template Sample (Provided Electronically)
- Attachment C.27.f-3 TDD Template Sample (Provided Electronically)

WellCare
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THE AGENCY FOR HEALTH CARE ADMINISTRATION

ADMINISTRATIVE SUBCONTRACTORS AND AFFILIATES REPORT

1.	2.	3.	4.	5.	6.	7.
Managed Care Plan ID	**Managed Care Plan Name**	**Managed Care Plan Medicaid Base ID Provider Number**	**Reporting Year**	**Reportin g Quarter**	**Subcontractor/Affiliate Name**	**Business Entity Type**

Administrative SAAR Template - 05.01.2014

THE AGENCY FOR HEALTH CARE ADMINISTRATION

ADMINISTRATIVE SUBCONTRACTORS AND AFFILIATES REPORT

8.	9a.	9b.	9c.	9d.	9e.	10a.	10b.	10c.	10d.
Tax ID # (SSN/FEIN)	Correspondence Address					Subcontractor/Affiliate Physical Address			
	Street Address / P.O. Box	*City*	*State*	*Zip*	*Country*	*Street Address*	*City*	*State*	*Zip*

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THE AGENCY FOR HEALTH CARE ADMINISTRATION

ADMINISTRATIVE SUBCONTRACTORS AND AFFILIATES REPORT

10e.	11a.	11b.	11c.	12.	13a.
Country	Parent Company Name *(if applicable)*	*State*	*Country*	Service Type(s)	Subcontractor/Affiliate Owner(s) Business Name or Individual's Last Name

THE AGENCY FOR HEALTH CARE ADMINISTRATION

ADMINISTRATIVE SUBCONTRACTORS AND AFFILIATES REPORT

13b.	13c.	14.	14a.	15.			16.			17.
Subcontractor/Affiliate Owner(s) Individual's First Name *(if applicable)*	Percent Ownership	Payment Methodology	Payment Methodology: Other	Subcontract Begin Date			Subcontract End Date			Downstream Delegation of Services
				Month	Day	Year	Month	Day	Year	

THE AGENCY FOR HEALTH CARE ADMINISTRATION

ADMINISTRATIVE SUBCONTRACTORS AND AFFILIATES REPORT

18.
Comments

Administrative SAAR Template - 05.01.2014

APPOINTMENT WAIT TIMES

Managed Care Plan Name:	

Reported Quarter:		January - March		April - June		July - September		October - December

- Pursuant to Attachment B, Exhibit B-1, Section VIII.A.8 (a-b), The Managed Care Plan shall:
  - Ensure that appointments for medical services and behavioral health services are available on a timely basis:
    - ♦ Urgent Appointments
      - Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization
      - Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization
    - ♦ Non-Urgent Appointments
      - Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment
      - Within fourteen (14) days for initial outpatient behavioral health treatment
      - Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition
      - Within thirty (30) days of a request for a primary care appointment
      - Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist
  - Quarterly, review a statistically valid sample of PCP, specialist, and behavioral health offices' average appointment wait times to ensure services are in compliance
- The Managed Care Plan must file the Agency supplied template (and attestation) to the SMMC SFTP Site
- The Managed Care Plan must use the naming convention as described in Chapter 2 of the Report Guide
- The template contains the following spreadsheets: MMA Cover Sheet, MMA Urgent Template and MMA Non-UrgentTemplate

Describe below the Managed Care Plan's methodology used to obtain the statistically valid sample:

Attachment C.27.a.i-2 Appointment Wait Times Report

MMA Urgent Appointment Wait Times

- Must provide methodology on "Cover Sheet" of this report template
- Data entered below must reflect in # of HOURS
- Simply inputting Contract standard wait times is not acceptable

			Actual Wait Time in Number of Hours			
			Do **NOT** Require Prior Authorization		**DO** Require Prior Authorization	
NPI #	NAME (Last Name, First Name)	LOCATION ADDRESS	Medical	Behavioral	Medical	Behavioral

Created by PNOU

Attachment C.27.a.i-2 Appointment Wait Times Report

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MMA Non-Urgent Appointment Wait Times

- Must provide methodology on "Cover Sheet" of this report template
  - Data entered below must reflect in # of DAYS
  - Simply inputting Contract standard wait times is not acceptable

Service Type Actual Wait Times in Number of DAYS:

NPI #	NAME (Last Name, First Name)	LOCATION ADDRESS	BEHAVIORAL HEALTH		ANCILLARY	PCP	SPECIALIST
			Post Inpatient Discharge Follow-up	Initial Outpatient Treatment	Diagnosis/ Treatment	Initial Appt Request	Request for Specialist Appt

Created by PNOU

DENTAL APPOINTMENT WAIT TIMES

Dental Health Plan Name:	

Reported Quarter:	☐	January - March	☐	April - June	☐	July - September	☐	October - December

Pursuant to Attachment B, Section VIII.A.7 (a-d), the Dental Health Plan shall:

- Contract with and maintain a provider network sufficient to comply with timely access standards as specified in the Contract
- Establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply (42 CFR 438.206(c)(1)
- Ensure that PDP services and referrals to participating specialists are available on a timely basis:
  - **Urgent Care Services** - within twenty-four (24) hours for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization
  - **Routine Sick Patient Care** - within seven (7) days
  - **Primary Dental Care** - within thirty (30) days
  - **Follow-up Dental Services** - within thirty (30) days after assessment
- Quarterly, review a statistically valid sample of average appointment wait times to ensure services are in compliance

The Dental Health Plan must file the Agency supplied template (and attestation) to the DENTAL CY18-23 SFTP site.
The Dental Health Plan must use the naming conventions as described in Chapter 2 the Report Guide.
The template contains the following spreadsheets: Dental Cover Sheet, Dental Report Template

Describe below the Dental Health Plan's methodology used to obtain the statistically valid sample:

Attachment C.27.a.i-2 Appointment Wait Times Report

DENTAL APPOINTMENT WAIT TIMES

- Must provide methodology on "Cover Sheet" of this report template
- Data entered must reflect the ACTUAL value (number) for each PDP
- Simply inputting Contract standard wait times is not accceptable

PDP NPI#	Dental Health Plan Name (Last Name, First Name)	PDP Location Street Address	City	Wait Times in Number of Hours/Days				
				Urgent Care Service Within 24hrs (**<u>Do Not</u>** Require Prior Authorization)	Urgent Care Service Within 48hrs (**<u>Do</u>** Require Prior Authoirzation)	Routine Sick Patient Care	Primary Dental Care	Follow-up Dental Service

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Claims Aging Report
Denials

Field Name	Description
Reporting Fiscal Year	State Fiscal Year in YYYY-YY format (ex: 2017-2018)
Reporting Fiscal Quarter	Quarter in State Fiscal Year QQ format (ex: Q1)
Medicaid Health Plan Identifier	Plan's 3 letter identifier assigned by the Agency
Provider Name	Full name of Provider or the Entity being reported (including any known "d/b/a")
Provider Tax ID	Provider's tax ID number
Provider NPI	Provider's National Provider Identifier number
Provider Medicaid ID	Provider's Florida Medicaid ID number
Provider Type	Medicaid provider type
Denial Date	Date the provider is effectively denied from participating in plan's network
Denial Reason	Primary reason for plan's determination to deny provider from participating in plan's network
Participation Suspension Effective Date	Effective date of provider's suspension from participating in plan's network
Participation Suspension End Date	End date of provider's suspension from participating in plan's network
Participation Suspension Reason	Primary reason for plan's determination to suspend provider from continued participation in plan's network
Payment Suspension Effective Date	Effective date of provider's payment suspension from participating in plan's network
Payment Suspension End Date	End date of provider's payment suspension from participating in plan's network
Payment Suspension Reason	Primary reason for plan's determination to suspend payments to provider
Termination Effective Date	Effective date of provider's termination from participating in plan's network
Termination Reason	Primary reason for plan's determination to terminate provider from continued participation in plan's network
Comments	All details plan wishes to include that are not captured elsewhere or that need further explanation

Claims Aging Report
Denials

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Denial Date	Denial Reason	Previously Denied?	Comments

Claims Aging Report
Denials

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Suspension Effective Date	Suspension End Date	Suspension Reason	Comments

Claims Aging Report
Denials

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Payment Suspension Effective Date	Payment Suspension End Date	Payment Suspension Reason	Comments

Attachment C.27.a.i-3 Claims Aging Report

Claims Aging Report
Denials

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Termination Effective Date	Termination Reason	Comments

Line by Line Field Definitions

Field Name	Description
Reporting Fiscal Year	State Fiscal Year in YYYY-YY format (ex: 2017-2018)
Reporting Fiscal Quarter	Quarter in State Fiscal Year QQ format (ex: Q1)
Medicaid Health Plan Identifier	Plan's 3 letter identifier assigned by the Agency
Provider Name	Full name of Provider or the Entity being reported (including any known "d/b/a")
Provider Tax ID	Provider's tax ID number
Provider NPI	Provider's National Provider Identifier number
Provider Medicaid ID	Provider's Florida Medicaid ID number
Provider Type	Medicaid provider type
Denial Date	Date the provider is effectively denied from participating in plan's network
Denial Reason	Primary reason for plan's determination to deny provider from participating in plan's network
Participation Suspension Effective Date	Effective date of provider's suspension from participating in plan's network
Participation Suspension End Date	End date of provider's suspension from participating in plan's network
Participation Suspension Reason	Primary reason for plan's determination to suspend provider from continued participation in plan's network
Payment Suspension Effective Date	Effective date of provider's payment suspension from participating in plan's network
Payment Suspension End Date	End date of provider's payment suspension from participating in plan's network
Payment Suspension Reason	Primary reason for plan's determination to suspend payments to provider
Termination Effective Date	Effective date of provider's termination from participating in plan's network
Termination Reason	Primary reason for plan's determination to terminate provider from continued participation in plan's network
Comments	All details plan wishes to include that are not captured elsewhere or that need further explanation

Denials

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Denial Date	Denial Reason	Previously Denied?	Comments

Participation Suspension

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Suspension Effective Date	Suspension End Date	Suspension Reason	Comments

Payment Suspension

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Payment Suspension Effective Date	Payment Suspension End Date	Payment Suspension Reason	Comments

Terminations

Reporting Fiscal Year	Reporting Fiscal Quarter	Medicaid Health Plan Identifier	Provider Name	Provider Tax ID	Provider NPI	Provider Medicaid ID	Provider Type	Termination Effective Date	Termination Reason	Comments

Kentucky Medicaid 2019 Audit Plan for Subcontracted Entities

Effective Date	Entity	Function	Annual Audit 7.1.18 -6.30.19 - Audit Date	CAP Issued Y/N
2/1/2012	Alere (aka Optum)	OB Risk Assess	8/27/2019	N
6/26/2013	Advanced Medical Review	UM	4/30/2019	Y (Not applicable to KY)
1/1/2013	Avesis	UM, CL, CR, CS, NM, PA	3/15/2019	Y - CR
2/1/2009	Evicore	UM	3/15/2019	Y (Not applicable to KY)
9/1/2005	Carenet Healthcare Services	Nurse Advice Line	6/30/2019	N
1/1/2016	CVS Health	PBM (CL, NM, CR)	8/15/2019	N
10/1/2011	Focus Behavioral Health, Inc.	UM	5/30/2019	N
7/24/2013	Health Integrated, Inc.	Crisis Line	9/2/2018	N
4/3/2017	HealthHelp, LLC	UM	4/15/2019	N
10/1/2016	Progeny Health, Inc.	UM, CM	5/31/2019	N
5/1/2008	Teleperformance_TPUSA	Customer Service	8/15/2018	N
4/1/2019	The Results Companies - Main	Customer Service	8/31/2018	N

WellCare®	Procedure		
Manual Section: Corporate Policy and Procedures, Corporate Compliance Area, General Counsel	**Procedure Name:** Certification of Reports and Submissions to Federal and State Agencies		
Procedure Number: C13-LG-022-PR-001	**Issue Date:** 01/14/2009		**Page:** 1 of 10
Prior Procedure Number(s):	**Related Policy Number:** C13-LG-022		

Applicable to:			**(Check One)**		
☒	ALL	*Area*	**New** (Date procedure was created)	☐	
☒	ALL	*Department*	**Reviewed** (No changes to procedure)	☐	
			Revised (Content changes made to procedure)	☒	4/10/18
☒	ALL	*All Associates*	**Repealed** (Procedure is no longer active)	☐	
☒	ALL	*Lines of Business and Applicable State(s)*	**State Agency Approval Date** (Attach supporting evidence)	(State Abbreviation)	(Date)
			Electronic Approvals are located within the area/department's Procedure SharePoint site.		

Procedures:

WellCare Health Plans, Inc. and its subsidiaries ("WellCare" or the "Company"), and their business activities, are subject to a broad array of state and federal statutes and regulations. WellCare's Code of Conduct and Business Ethics reflects the Company's commitment to the accuracy and completeness of all reports and submissions to state and federal agencies.

The procedures within this document have been developed and adopted pursuant to policy C13LG-022. These procedures are designed to meet the requirements of that policy relating to the review and certification of all contractually required reports, records, data and other information that are filed with, or submitted to, state and federal agencies ("**Submissions**" or "**Reports**").

Procedures used to prepare the report data are documented and retained as part of the report file and related report preparation procedures align with specific reporting instructions provided by the regulator.

Transaction details must be retained for cost related regulatory reports that support monies due to or from regulators.

Definitions

A. The **Business Requirements Document ("BRD")** or **Process Control Document ("PCD")** is a document developed through the collaborative efforts of the BRD/PCD Owner and Data Source Provider that identifies which data must be compiled to satisfy the requirements of a particular Report. The BRD/PCD protects the IT system from changes that would adversely affect the format and accuracy of Report data.

B. The "**BRD/PCD Owner"** is the WellCare associate responsible for the IT system(s) that hosts and provides content data for use in a Report.

C. The "**Certification Forms**" are those forms attached to this procedure as Attachments A, B, C, D and E. Specifically, they are the Report Preparer Certification Form (Attachment A), Data Sub-Certifications Form (Attachment B), Executive Internal Certification of Regulatory Report Form (Attachment C), Data and Records Qualification Disclosure Statement (Attachment D) and Report Attachment Proxy (Attachment E). The Certification Forms document the Company's effort to assure the accuracy of data submitted to its regulators, as well as any issue, concern, qualification or exception the certification process reveals.

D. The "**Data Source Provider**" is an associate, with direct knowledge of the data utilized in a Report and who is responsible for specific data sources and data supplied to the Report Preparer for inclusion in a Report. The Data Source Provider may be a Company associate or the representative of a Delegated Entity.

E. A "**Delegated Entity**" is an external third party that is contracted to provide specific services to WellCare members, and that is responsible for providing accurate and complete data to satisfy particular regulatory requirements.

F. The "**Executive Approver**" is the profit center owner, area leader or business executive who signs the Executive Internal Certification of Regulatory Report Form (Attachment C), if necessary.

G. **"IT"** means information technology,

H. The "**IT Preparer**" is the WellCare associate within the IT Department who works with the BRD/PCD Owner to ensure the IT systems are configured correctly according to the documented processes. The IT Preparer can also serve as the Report Preparer.

I. The "**Regulatory Owner**" is the WellCare associate primarily responsible for defining the specifications for a particular Report and measuring WellCare's compliance based on the applicable regulatory and contractual requirements. The Regulatory Owner is the associate responsible for communicating with the applicable state or federal regulator if clarification of such reporting requirements is necessary. In the case of a Reports required by a Medicaid contract, the Regulatory Owner is the designated Regulatory Affairs contact for that contract's Reports and related issues. In the case of Medicare contracts, the Regulatory Owner is a designated individual from the Medicare Regulatory Compliance group.

J. The **"Report Preparer"** is the WellCare associate who:

1. Is responsible for ensuring the accuracy, completeness, timely submission, and retention of a particular Report to be submitted to a regulatory agency;
2. Compiles the final Report, which may include multiple data sources and inputs;
3. Certifies the final Report prior its submission to the Company's Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other executive for such executive' signature.

In some cases, the Report Preparer may also serve as the IT Preparer and/or the Data Source Provider.

Attestation and Disclosure Process

The Report Preparer shall comply with all reporting and submission requirements established by the regulatory agency to which a Report is to be submitted pursuant to law, regulation or contract. As discussed below, the Report Preparer shall certify all Submissions prepared by him or her. The Report Preparer may require Data Source Provider(s) to sub-certify Report content when appropriate, such as in instances where the Report Preparer does not have personal/direct knowledge of the underlying data. In the event a current BRD/PCD has not been established, the BRD/PCD Owner is responsible for working with the IT and market Regulatory Affairs departments to develop and implement such BRD/PCD. Market review, conducted by either the market Regulatory Affairs department, the market President, or his/her designee, must be documented for all reports for which the Report Preparer is a Shared Services business owner and the report is submitted to a State regulator.

In instances where the data submitted for Reports are provided by a Delegated Entity, the Delegated Entity works with the Report Preparer in attesting to the accuracy and completeness of the data submitted. The Report Preparer must sub-certify the data reflecting the review and approval of the Delegated Entity submission.

The Regulatory owner is responsible for notifying Corporate Compliance of Reports that are no longer required, and for providing supporting documentation from the applicable regulatory agency.

Use of Forms to Certify Reports

Certification Form(s) (see Attachments A, B, C, D and E) shall be used to document the internal review process and include the signature of the Report Preparer and, if necessary, the signatures of any other providers of data or other information contained in the Report, confirming the Report Preparer's reliance on the accuracy and completeness of such data or other information. The Certification Form(s) shall also set forth any issues, concerns, qualifications or exceptions identified by the Report Preparer or other certifiers. The Certification Form(s) attest that, to the best knowledge of the Report Preparer and Data Source Provider(s), all data contained in the Report or underlying the Report and all documents requested by the government regulator have been reviewed to ensure accuracy and adherence to the specific reporting requirements and that no such data or information have been falsified or altered.

WellCare policy requires that any Report provided to a regulatory agency receive executive certification regardless of whether executive certification is required by the receiving agency. Where the recipient agency requires such executive certification, that certification is provided in the format required by the agency. Where it is not required by the recipient agency, the executive certification is documented using the Executive Internal Certification of Regulatory Report Form (Attachment C).

These Certification Forms (which may be completed either in electronic or paper format) are standardized to address the majority of business owners' needs, systems, or processes. Any changes to the forms must be approved by Corporate Compliance in advance of being presented for certification or attestation.

Subject to any issue, concern, qualification or exception regarding the Report that has been reviewed and approved by the Compliance and Regulatory Affairs Departments (see paragraph 2 below), the person(s) signing on behalf of the Company shall attest, based on his/her best knowledge, that all data submitted in conjunction with the Reports and all documents requested by the government regulator are accurate, truthful and complete.

A. **Report Preparer Certification Form (Attachment A)** – Internal form completed by the Report Preparer and/or IT Preparer, used to document completeness and accuracy of information provided.

B. **Data Sub-Certifications Form (Attachment B)** – Internal form completed by the Data Source Provider to certify the source data used to generate the Report.

C. **Executive Internal Certification of Regulatory Report Form (Attachment C)** – Internal form completed by the Vice President or Area Leader of the department submitting the data to report. This form is completed only when executive attestation is NOT required by the regulatory agency receiving the Report. When executive attestation is required by the regulatory agency, it is provided in the format requested by the agency.

D. **Data and Records Qualification Disclosure Statement (Attachment D)** – Internal form completed by the Data Source Provider and/or the Report Preparer to document known issues, concerns, qualifications or exceptions affecting the quality of the data. Compliance and Regulatory Affairs and, in some instances, Legal Services, review and signoff is required for the submission of a Report for which this form has been submitted.

E. **Report Attachment Proxy (Attachment E)** – Internal form completed by the Report Preparer in instances when the actual Report is not being presented for executive attestation due to a large file size or possible confidential data content.

Procedures When There is a Known Issue, Concern , Qualification or Exception with the Accuracy of Data or Reports

All business requirement documents are prepared to support how unresolved warning edits and/or non-reconciling items are deemed not to be errors.

If known issues, concerns, qualifications or exceptions exist regarding the accuracy or completeness of a Report, the Report Preparer and/or Data Source Provider will:

A. Complete a Data and Records Qualification Disclosure Statement ("**Disclosure Statement**") (see Attachment D) documenting the nature of the issue, concern, qualification or exception.

B. Check the appropriate box on the Report Preparer Certification Form (Attachment A) indicating that he or she is aware of an issue, concern, qualification or exception.

C. Submit the Disclosure Statement for review and approval by the appropriate Regulatory Affairs and Compliance leaders and, if directed by the Chief Compliance Officer in his or her discretion, to the Legal Department.

The designated Corporate Compliance and Regulatory Affairs personnel shall jointly:

A. Determine whether the issues, concerns, qualifications or exceptions addressed in the Disclosure Statement require disclosure to the agency that will receive the Report; and

B. Determine the manner in which such issues, concerns, qualifications or exceptions should be disclosed (i.e., as part of the Report, or in correspondence accompanying the Report submission to the government agency).

The Compliance Department shall also ensure that an appropriate corrective action plan has been established to ensure that the issue, concern, qualification or exception is being addressed and, if appropriate, remediated. This procedure should occur prior to the submission of the Report to the regulatory agency.

Attachments:

Attachment A: Report Preparer Certification Form

Attachment B: Data Sub-Certifications Form

Attachment C: Executive Internal Certification of Regulatory Report Form

Attachment D: Data and Records Qualification Disclosure Statement

Attachment E: Report Attachment Proxy

Attachment A

Report Preparer Certification Form

Report Name: **Contract Name:**

Preparer Certification:

All Report Preparers must complete this section:

This report is created in compliance with the policy on Certification of Reports and Submissions to Federal and State Agencies. I have reviewed the documentation and procedures used to compile the enclosed report and signed to certify the following:

Please check one:

☐ To the best of my knowledge, the information contained in this report and the attached supporting documentation is complete and accurate.

☐ The information contained in this report includes issues, concerns, qualifications and exceptions as described in the attached data disclosure form.

Please check one:

☐ There are Business Requirements Documents (BRDs) on file for automated reports, or the equivalent documentation on file for manual reports.

☐ BRDs (or equivalent documentation for manual reports) for this report are missing, outdated or in progress.

Please check one: (Additional fields below to be completed by IT Preparer only)

☐ The automated report ran from our IT production scheduler without error.

☐ There was an error in running the automated report from our IT production scheduler (I have listed these errors and exceptions on the attached Data and Records Qualification Disclosure Statement Form).

Please check "Yes or "No": (To be completed by IT Preparer Only)

This report has been subject to a code change since it was last run.

☐ Yes ☐ No

Name	Signature	Title	Date

I am also sub-certifying the source data used to create this report (If yes, you should also fill out Attachment B. If no, a different sub-certifier should fill out and sign Attachment B):

☐ Yes ☐ No

Attachment B

Data Sub-Certifications Form

Report Name: **Contract Name:**

I am sub-certifying the data and/or supporting information used to compile this report.

By signing below and checking **"Yes",** I certify that, to the best of my knowledge, the information contained in this report and the attached supporting documentation is complete and accurate.

By signing below and checking **"No"**, I certify that the information contained in this report includes issues, concerns, qualifications and exceptions as described in the attached Data and Records Qualification Disclosure Statement Form.

				Report is Complete And Accurate
Type of Report Data: _____ Name	Title	Signature	Date	☐ Yes ☐ No
Type of Report Data: _____ Name	Title	Signature	Date	☐ Yes ☐ No
Type of Report Data: _____ Name	Title	Signature	Date	☐ Yes ☐ No
Type of Report Data: _____ Name	Title	Signature	Date	☐ Yes ☐ No
Type of Report Data: _____ Name	Title	Signature	Date	☐ Yes ☐ No

Attachment C

Executive Internal Certification of Regulatory Report Form*

Report Name: **Contract Name:**

Executive Certification

I have reviewed the Report Preparer and Data Sub-Certifications Form, along with the attached supporting documentation, and have signed to certify the following:

Please check one of the following:

☐ To the best of my knowledge, the information contained in this report and the attached supporting documentation is complete and accurate. Data provided for the report was prepared in accordance with the report instructions and guidance provided by the Report Preparer. Procedures used to prepare the report data have been documented and retained as part of the report file and align with specific reporting instructions provided by the regulator.

☐ The information contained in this report includes issues, concerns, qualifications and/or exceptions as described in the attached Data and Records Qualification Disclosure Statement ("Disclosure Statement"). Accordingly, I will not release the report to our regulators until the Disclosure Statement has been reviewed by the Regulatory Affairs and Compliance departments and, as applicable, the Legal department, and they have determined what kind of disclosure, if any, will be made when the report is submitted to the relevant regulatory agency.

If you checked the second box, there is a completed Disclosure Statement attached to this submission

Please check one of the following:

☐ Market review conducted and documented (required for all reports for which the Report Preparer is a Shared Services business owner and the report is submitted to a State regulator).

☐ Market Review not required

_____	_____	_____	_____
Name	Title	Signature	Date

NOTE: This form should only be used when an external executive attestation is <u>NOT</u> required to be submitted to the regulatory agency.

Attachment D

Data and Records Qualification Disclosure Statement*

Report Name: **Contract Name:**

Preparer Data Qualification Statement

The following known issues, concerns, qualifications or exceptions affecting data quality in this report are disclosed below:

1)

2)

3)

4)

5)

Name	Signature	Title	Date

Regulatory Affairs Review (required)

Name	Title	Signature	Date

Compliance Review (required)

Name	Title	Signature	Date

Legal Review (per Corporate Compliance discretion)

Name	Title	Signature	Date

NOTE: This form is only to be used when known issues, concerns, qualifications or exceptions exist with the submitted data and/or records.

Attachment E

Report Attachment Proxy*

Report Name: _____

Contract Name / Number: _____

Report Submission Date: _____

Actual Submitted Report File(s) Not Attached Here

The report referenced above is not physically attached to this archive record due to either very large file size or possibly confidential data content.

Please contact the Report Preparer or appropriate Regulatory Affairs leader associated with this report submission if access to the actually submitted report is needed. This report file must be archived for a period of ten years, in accordance with the governing Policy & Procedure C13LG-016 Records and Information Management Policy.

Note - This Report Attachment Proxy **MUST be archived in lieu of report files containing protected health information (PHI).*

State Specific Requirement (list requirement and detail procedure)
(If Applicable)

Prescriber Profile Report

WELLCARE KY MEDICAID (Park Duvalle)

Reporting Period: 03/01/2018 - 03/31/2018

NPI ID: ALL **Name:** ALL **Specialty:** ALL

Your Top 20 Prescribed Drugs By Total Ingredient Cost (IC)

Product/Drug Name	FC	Total Rx	Total Util	Avg Qty/Rx	Total ICP	Avg ICP/Rx	Avg DS/Rx	Avg ICP/Days
ABILIFY MAINTENA	ON	4	4	1	$8,368	$2,091.92	27.3	$76.77
LATUDA (Aripiprazole, Quetiapine, Olanzapine, Risperidone)	OFF	3	2	30	$3,755	$1,251.73	30.0	$41.72
JANUVIA	ON	6	6	30	$2,622	$436.94	30.0	$14.56
ONE TOUCH ULTRA TEST STRIP	ON	28	27	73	$2,596	$92.72	27.3	$3.40
BASAGLAR KWIKPEN	ON	7	7	15	$2,330	$332.81	29.3	$11.36
VENTOLIN HFA	ON	35	32	19	$1,963	$56.09	24.1	$2.33
RISPERDAL CONSTA	ON	2	1	2	$1,867	$933.43	28.0	$33.34
ARISTADA	ON	1	1	2	$1,815	$1,814.58	30.0	$60.49
HUMALOG (will be non-preferred effective 5/15)	ON	1	1	60	$1,666	$1,666.33	30.0	$55.54
SYMBICORT	ON	5	5	10	$1,636	$327.15	30.0	$10.90
HUMALOG KWIKPEN (will be non-preferred effective 5/15)	ON	2	2	23	$1,609	$804.35	30.0	$26.81
INVOKANA	ON	3	3	30	$1,418	$472.52	30.0	$15.75
VIVITROL	OFF	1	1	1	$1,323	$1,323.40	28.0	$47.26
DULERA	ON	4	4	13	$1,265	$316.19	28.8	$11.00
ADVAIR DISKUS (generic fluticasone/salmeterol, Dulera, Symbicort)	OFF	2	2	60	$797	$398.27	30.0	$13.28
TOUJEO SOLOSTAR (Basaglar)	OFF	2	1	5	$715	$357.49	31.0	$11.53
HUMALOG MIX 50/50	ON	1	1	20	$576	$575.66	28.0	$20.56
JANUMET XR	ON	1	1	30	$434	$434.33	30.0	$14.48
XARELTO	ON	1	1	30	$424	$423.68	30.0	$14.12
CHANTIX CONTINUING MONTH	ON	1	1	56	$413	$412.98	28.0	$14.75

Rolling 4 Quarters

	2018-Q1	2017-Q4	2017-Q3	2017-Q2
DEMOGRAPHICS				
Total Utilizing Patients	564	527	533	550
Female %	65.60%	64.90%	61.91%	63.27%
Male %	34.40%	35.10%	38.09%	36.73%
Avg. Ptnt Age	46	46	47	47
KPI				
Total Rx	3,824	3,492	3,595	3,484
Total Brand Ingredient Cost	$127,836	$109,066	$123,022	$93,972
Total Generic Ingredient Cost	$20,017	$25,602	$26,372	$26,410
Total Ingredient Cost	$147,853	$134,668	$149,395	$120,382
Ingredient Cost PUPM	$87	$85	$93	$73
Avg. ICP/Rx	$38.66	$38.56	$41.56	$34.55
Avg. DS/Rx	27.25	27.82	27.54	27.38
Avg. Units/Rx	42.41	43.37	43.04	42.99
Gen Disp %	87.6%	86.9%	85.7%	87.3%
Single-Source Brand %	12.26%	12.97%	14.08%	12.63%
Multi-Source Brand %	0.13%	0.11%	0.19%	0.11%
Controlled Substance %	1.94%	1.60%	1.95%	3.01%

Summary Statistics

	Total Rx/Prescriber	Total Util/Prescriber	Avg. Days Supply/Rx	Generic %	Formulary %	DAW %	Male %	Female %	Avg. Ptnt Age
Plan:	66	14	25	89.23%	97.95%	0.1%	39.6%	60.4%	40
KPCA:				89.27%					

Attachment C.27.d.iii Sample Report

WellCare	Last Updated: 1/17/2020
	DRD Version: 1.0

[Project/Intake Name]
[Intake ID]

Data Requirements Document

PREPARED BY

XXXXX

ENTERPRISE INFORMATION MANAGEMENT, WELLCARE HEALTH PLANS, INC.

WellCare	Last Updated: 1/17/2020
	DRD Version: 1.0

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	DRD Version: 1.0

Document History Log

Version	Date	Author	Reason for Change	Section(s) Changed/Added

Peer Review

Name	Title	Confirmation	Date
		<Embed email>	

Document Approvals

The departments identified below have reviewed this document to the best of their ability and agree with the following statements about the functional specifications identified and requested in this document. If approving behalf of any of the below listed roles, please specify.

Role	Name	Title	Approval	Date
Business Owner				
QA Manager				
EIM Manager 1				
EIM Manager 2				

Document Reviewers

Role	Name	Title
Business Reviewer		
EIM Reviewer		
QA Reviewer		
Data Architect Reviewer		
Solution Architect Reviewer		
IT Project Manager		

Document Conventions

- All text in RED font indicates any new additions or changes to the document.
- Any text with a ~~strikethrough~~ means it is being removed.

1 Introduction

1.1 Purpose

1.2 References

Title	Hyperlink/Attachment	Description	Version	Status

1.3 Definitions

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2 Project Scope

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3 Process/Data Flows

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4 Business Requirements Table

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5 Functional Requirements

5.1 Functional Requirements

Functional Req. ID	Functional requirements and Acceptance Criteria	Business Req. ID

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Specifications	Description
Type of Data	
Source Location	
Target Folder Location	
File Format	
File Frequency	

Specifications	Description
Incoming File Name/Layout	
MoveIT Job timing	
Data Extract location	

6 Non-functional Requirements

Non-Functional Req. ID	Non-Functional requirements and Acceptance Criteria	Business Req. ID

7 Appendix

28. Records Maintenance and Audit Rights

C.28. RECORDS MAINTENANCE AND AUDIT RIGHTS

a. **Describe the Contractor's methods to assess performance and compliance to medical record standards of PCPs/PCP sites, high risk/high volume specialist, dental providers and providers of ancillary services to meet the standards identified in Section 38.1 "Records Maintenance and Audit Requirements" of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."**

b. **Describe the Contractor's approach to prevent and identify data breaches.**

c. **Describe the Contractor's approach to conducting Application Vulnerability Assessments as defined in Section 38.6 of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."**

C.28. RECORDS MAINTENANCE AND AUDIT RIGHTS

a. ***Describe the Contractor's methods to assess performance and compliance to medical record standards of PCPs/PCP sites, high risk/high volume specialist, dental providers and providers of ancillary services to meet the standards identified in Section 38.1 "Records Maintenance and Audit Requirements" of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."***

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 38.1 Records Maintenance and Audit Requirements of the Draft Medicaid Managed Care Contract and Appendix Q Cabinet for Health and Family Services Contractor Security Requirements of the Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

We maintain medical records for Enrollees and require both our network Providers and Subcontractors to maintain clinical and medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil, and/or criminal investigations and/or prosecutions. Our Chief Compliance Officer, Rebecca Randall, oversees this process locally in Kentucky.

PROVIDERS

We incorporate all contractual requirements for maintenance of clinical and medical record policies and practices into all our Provider agreements and Provider Manuals (including those of our delegated subcontractor Avesis for dental and vision services), which is distributed to Providers during contracting and orientation to our plan and/or via our Provider website. The standard language in our provider contract templates contain this language and doesn't vary based on specialty including, but not limited to, PCPs/PCP sites, high risk/high volume specialists, dental providers and providers of ancillary services.

Our contracts require Enrollees' medical records to be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to: medical charts, prescription files,

hospital records, Provider specialist reports, consultant and other health care professionals' findings, appointment records (including appointment date and duration), and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services Provider under the Contract. The medical record is signed by the Provider of service.

We will also ensure, through our provider agreement, any Kentucky-specific provisions including the requirement that PCPs forward copies of Enrollees' medical records to new PCPs or Partnerships within 10 days from the receipt of request in accordance with Section 38.1 of the draft managed care contract.

The Enrollee's medical record is the property of the Provider who generates the record. However, each Enrollee or their representative is entitled to one free copy of his/her medical record. Additional copies are made available to Enrollees at a cost. Medical records are preserved and maintained for a minimum of ten years unless Federal or Commonwealth requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person's lifetime).

Each Provider is required to maintain a primary medical record for each Enrollee, which contains sufficient medical information from all Providers involved in the Enrollee's care, to ensure continuity of care. The medical chart organization and documentation, a minimum, requires the following:

- Enrollee/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language(s) spoken, and guardianship information
- Date of entry and date of encounter
- Late entries should include date and time of occurrence and date and time of documentation
- Provider identification by name and profession of the rendering Provider (e.g., MD, DO, OD)
- Allergies or adverse reactions to drugs noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)
- Identification of current problems:
- Consultation, laboratory and radiology reports filed in the medical record contain the ordering Provider's initials or other documentation indicating review
- Current list of immunizations
- Identification and history of nicotine, alcohol use or substance abuse

- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient reside or Department for Public Health
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- Documentation that Enrollee has received the Provider's office policy regarding office practices compliant to HIPAA
- Documentation regarding permission to share protected health information with specific individuals has been obtained
- Record is legible to at least a peer of the writer and written in standard English. (Any record judged illegible by one reviewer will be evaluated by another reviewer.)

An Enrollee's medical record will include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (e.g., EPSDT) are addressed from previous visits
- Plan of treatment including medication history (current medications prescribed, including the strength, amount, directions for use and refills) and therapies for other prescribe regimen
- Follow-up plans including consultation and referrals and directions, including time to return
- Education and instructions whether verbal, written or via telephone

SUBCONTRACTORS

For our Subcontractors, we incorporate the same contractual requirements as part of our delegated contracting arrangements. WellCare will ensure that for any subcontracts delegated for network management, utilization management or claims processing that medical records are maintained as well as provided to Enrollees as set forth in Section 38 of the draft managed care contract.

WellCare selects highly-qualified Subcontractors to complement and enhance the services we provide to our Enrollees and Providers. Our approach to Subcontractor oversight and to establishing and maintaining compliance with regulations is based on our thorough contracting process, rigorous upfront screening process and comprehensive ongoing review process. Prior to delegating any functions to a third party, we perform due diligence including a comprehensive assessment to prospectively evaluate the Subcontractor's ability to perform the activities to be delegated. The comprehensive vetting and due diligence process is a requirement in our delegated subcontracts, and compliance must be demonstrated prior to a

delegated Subcontractor becoming active with WellCare of Kentucky. We perform oversight and monitoring of the delegation activities through scorecards, data analysis, focused reviews, and annual audits. We develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and the Contract. All pre-delegation audits for new Subcontractors are based on the National Committee for Quality Assurance (NCQA), and Commonwealth and federal requirements.

We will not delegate to an entity unless it achieves a successful passing score on its pre-delegation audit. Our pre-delegation audit process confirms the Subcontractor has the structural elements, i.e. policies, procedures, staff, licensure, etc., in place to comply with all of the contractual requirements for the functions assigned to them. Additionally Subcontractors have to comply with the expectations of the company on an ongoing basis. After delegation, the team continues to monitor performance. In addition to the confirmation, we require the submission of supporting documentation to demonstrate compliance. Examples of documentation may include codes of conduct, compliance policies, copies of training materials, training rosters, etc. WellCare's extensive oversight of Subcontractor performance reflects our commitment to deliver high quality services and our understanding that Subcontractors' performance is a reflection of WellCare's focus on quality. Weekly operations oversight consists of meetings with our vendors to review key performance indicators, perform joint root cause analysis, and discuss opportunities to improve processes. The Quarterly Joint Operating Committee (JOC) meetings are used as a higher level status check and to set strategy for subsequent efforts.

REVIEWING COMPLIANCE

WellCare conducts Medical Record Audits to review network Provider office medical records. We utilize criteria based upon government sponsored contractual requirements and Federal and Commonwealth regulations. The medical record review is conducted to assess the quality of care delivered and documented. The process includes, but may not be limited to, evaluation of adherence to Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, provisions for continuity of care, adult preventive care rendered, identification of quality of care events, treatment for Enrollees with special health care needs, compliance with regulatory reporting requirements, compliance with coding practices, and appropriate follow up (i.e. notification to patients of adverse lab results).

We regularly evaluate utilization of recommended preventive services, chronic disease management services, and acute care. We systematically mine membership data to identify trends in adherence to recommendations. Our Quality Improvement department conducts medical record audits on a random sample of charts from Primary Care Providers (PCPs) annually in accordance with our medical record review policy. Our medical record audit assesses physician compliance with recommended preventive health and clinical practice guidelines. We also assess and trend Provider compliance with guidelines through annual administrative data and medical record reviews for HEDIS®.

Annual medical and behavioral health record audits are conducted to measure compliance with general medical record keeping practices, confidentiality of Enrollee data, adherence to certain preventive care guidelines and coordination and continuity of care.

Providers that fail to meet established standards, have instances of poor quality, or are non-compliant with contractual, Commonwealth, or federal regulations will be reviewed by our Credentialing and Peer Review Committee, with avenues of recourse including corrective actions, sanctions or Provider termination. **Since 2014, WellCare's external quality review audit, conducted by the Commonwealth's EQRO auditor, IPRO, has found WellCare to be fully compliant with all contractual requirements surrounding our medical review audit process.**

COMPLIANCE WITH CONFIDENTIALITY

WellCare of Kentucky understands and will comply with the standards set forth in Section 38.1 of the Draft Contract. WellCare maintains the confidentiality of all medical records in accordance with 42 CFR 431, Subpart F. WellCare is compliant with the Privacy and Security provisions of HIPAA as set forth in our policies and procedures. WellCare continues to enhance security of WellCare systems based upon a continuous risk assessment and remediation process by internal and external auditors and assessors.

We have clinical and medical record keeping policies and practices in place which are consistent with 42 CFR § 456 and current NCQA standards, as well as all other related Commonwealth and Federal laws for medical record documentation. Furthermore, our policies and procedures address who has access to an Enrollee's clinical and medical records, the extent of information that may be released, and protocols for obtaining consent to disclose from Enrollees and former Enrollees. This information is reinforced through initial and ongoing training and shared with our Kentucky network Providers and Subcontractors.

Written Consent

Through mandatory HIPAA training, WellCare associates are required and trained to maintain the confidentiality of all confidential information and the duty not to disclose confidential information related to proprietary information, protected health information (PHI) and personally identifiable information (PII), in accordance with applicable laws and WellCare policies, procedures and standards. We are required to disclose an Enrollee's PHI to that Enrollee, with the exception of psychotherapy notes. We are required to disclose PHI to the U.S. Department of Health and Human Services when they are performing a review, enforcement action or compliance investigation.

WellCare is permitted, but not required, to use or disclose PHI in the following situations without Enrollee authorization:

- Routine disclosures such as communications of PHI within treatment, payment, and health care operations
- Treatment activities by Providers
- Payments to other covered entities

- Health care operations including quality or competency assurance activities or fraud and abuse detection to another covered entity or WellCare associate
- PHI may be disclosed without authorization for the national priority purposes listed below:
- Required by law
- Public health activities
- Victims of abuse, neglect or domestic violence
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Decedents
- Donations/transplants
- Research
- Serious threat to health/safety
- Essential government functions
- Worker's compensation

We recognize the sensitive nature of certain conditions due to the unfortunate stigma that is often attached to certain diagnoses, such as mental health, drug and substance use disorder (SUD), abortion, HIV/AIDS, minors/incapacitated individuals and psychotherapy notes. We take our commitment to privacy very seriously for all of our Enrollees and have established protocols to protect all health information. We have protections in place to ensure compliance with all privacy and disclosure Federal and Commonwealth laws, including adequate policies and procedures to assure the confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. Our policies and procedures also address such issues as how to contact the minor Enrollee for any needed follow-up and limitations on telephone or mail contact to the home WellCare has also developed a HIPAA Handbook to educate associates on the proper handling of protected health information, and we frequently remind all associates to contact WellCare's Privacy Office if a request is made to disclose protected health information for these sensitive conditions.

Pursuant to the HIPAA Privacy Rule, WellCare must obtain an individual's authorization prior to a non-routine disclosure of these sensitive conditions, even for disclosure to a health care Provider other than the originator of the notes for treatment purposes. An exception under HIPAA exists that would permit the disclosure of these sensitive conditions if WellCare has a good faith belief that the disclosure is:

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others.

- To a person(s) reasonably able to prevent or lessen the threat. WellCare's Privacy Office and Legal Department would assess whether the request for psychotherapy notes meet this exception.

Need to Know Basis

Data and information is not disclosed to any person or entity that does not have a legitimate and demonstrable business need to receive the information. The extent of clinical or medical record information to be released is based on medical necessity and a "need to know" basis on the part of the Provider or facility requesting the information. In compliance with the Draft Contract, it is our policy to limit access to information, except as otherwise required by law, regulations, or this Contract, to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including but not limited to the U.S. Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of Attorney General, and such others as may be required by the Department.

We have security measures that protect and control access to Enrollees' clinical and medical records. WellCare focuses on verifying the identity of the person/entity making the request, controlling the information being requested, and using measures to protect data during transmission.

Substance Use Disorder

We have policies and procedures in place to ensure that all releases of information for SUD specific clinical or medical records meet Federal guidelines at 42 §CFR Part 2. WellCare has developed a HIPAA Handbook to educate associates on the proper handling of protected health information, and we frequently remind all associates to contact WellCare's Privacy Office if a request is made to disclose protected health information for any sensitive conditions, which include SUD. To reinforce these resources, associates are required to attend annual training and are tested on their knowledge.

Access to Medical Records

WellCare will provide access to the clinical and medical records and related record-keeping systems that include a complete record for each enrolled Enrollee in accordance with Section 38.1 of the draft Managed Care Contract. Our records will include sufficient information to comply with the provisions of 42 CFR §§ 456.111 and 456.211 regarding Utilization Review. WellCare will adhere to all inspection and audit requests as required in Section 5.6 of the draft contract. WellCare will also provide assurance through language within our provider agreements that authorized representatives of DMS, or other Commonwealth and federal agencies will have reasonable access to premises, physical facilities, equipment, and records for financial and medical audit purposes both during and after the term of the Provider contract.

Records Retention

WellCare of Kentucky understands and will comply with the standards set forth in Section 38.1 of the Draft Contract. We will maintain Enrollee records for a minimum of ten years from the

date of termination of this Contract. In addition, records involving matters which are the subject of litigation will be retained for a period of not less than ten years following the termination of such litigation, if the litigation is not terminated within the normal retention period. WellCare uses information security vendor Iron Mountain to maintain offsite storage needs of physical records along with encrypted tape backups. Iron Mountain is also leveraged for certified tape and physical records destruction, in addition to being the primary shredding vendor across all WellCare offices.

Records remaining under the care, custody and control of the Provider are maintained for a minimum of ten years from the date of when the last professional service was provided.

b. Describe the Contractor's approach to prevent and identify data breaches.

APPROACH TO MANAGING SENSITIVE AND CONFIDENTIAL DATA

WellCare's Security and Privacy team recognizes the impact of identity theft and medical fraud on Enrollees and works to protect them in practical and effective ways. These include mandatory training for associates, clear and descriptive policies, modern technical security solutions, and incorporating security and privacy into our daily operations (versus adding it after the fact). Our approach to meeting DMS' expectations and requirements is centered in our core design objective for our systems architecture which is grounded in Security and Privacy services. This high-level depiction of our enterprise architecture, in **Figure C.28-1**, provides an overview of our MIS and specifically depicts how our Security and Privacy services encapsulates and protects our systems and builds these concepts into our solution at the foundational level. We employ multiple physical and electronic security technologies as part of our privacy and security services and infrastructure services into every layer of our operational environment. Our principle of maintaining and enforcing a set of information security policies and standards is reflected throughout the enterprise via adoption of the HITRUST Common Security Framework. These standards are overseen by our Information Security Group and implemented by our Infrastructure Security Group, with clear segregation of duties throughout the process. Our servers, workstations, and network are continuously monitored using industry-standard intrusion protection technologies, advanced persistent threat monitoring, and data loss protection.

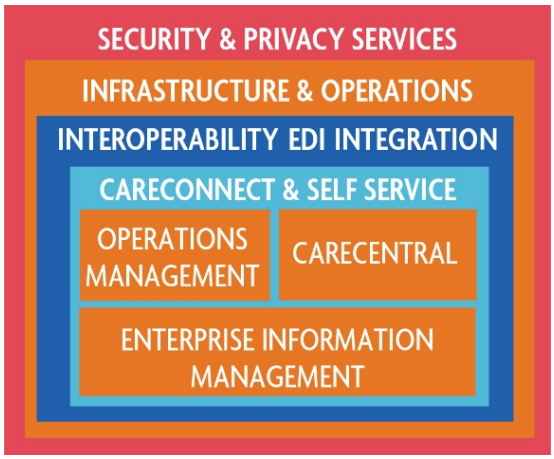

Figure C.28-1 Security and Privacy Services

The HITRUST Common Security Framework allows us to demonstrate compliance with DMS' requirements via a set of security and privacy controls in direct support of HIPAA, NIST 800-53, NIST Common Security Framework, PCI-DSS, and other industry frameworks. Our Chief Security and Privacy Officer is responsible for monitoring and auditing ongoing compliance including risk assessments based upon NIST 800-30, HITRUST compliance, application security testing,

wireless testing, and penetration testing. WellCare leverages a 3rd party firm that specializes in information security to conduct a comprehensive penetration test once a year. The results of all these tests are reviewed by our IT infrastructure management and by the Information Security team, and enhancements are made accordingly. The test results and progress tracking on enhancements and resolution are also presented to WellCare's senior leadership and the Board of Directors' audit, finance, and regulatory compliance committee.

EMPLOYEE TRAINING FOCUSED TO MINIMIZE DATA EXPOSURE

Associates' vigilance and awareness play critical roles in protecting sensitive and confidential data requiring the entire organization's awareness of the role they play, ensuring the safety and privacy of our network and our Enrollees' PHI and medical record information. Continuous and current training is used to reinforce our corporate philosophy and our Employee Code of Ethics. Within 30 days of employment and annually thereafter, all our associates are required to satisfactorily complete 16 or more hours of mandatory training on subjects including Information Security, Information Governance, HIPAA Privacy and Security, Acceptable Use, Compliance Training, and Certification of Reports and Submissions to Commonwealth and Federal agencies. We also provide our associates trainings on social engineering, PCI compliance, and phishing.

Phishing continues to be the method of choice for attackers to gain access to corporate environments. In order to prevent these breaches. WellCare performs live phishing exercises quarterly where all associates received one of ten crafted phishing emails. These phishing emails are based upon real examples received from attackers, however instead of a malicious site, these have links to an education page. The goal is for the associate to report the email for which they received a congratulatory note. If they click on the links in the email instead, they are directed to the education page. This page demonstrates how they should have identified the email as phishing and reported it. This safely raises awareness of phishing within the environment. To make reporting easier, we added a Phishing button to our email system to report suspicious email. As a result, we continue to see improvements with the reduction of back clicks and increase in reporting.

OVERALL APPROACH TO CUSTOMER AND ENROLLEE BREACH PREVENTION

WellCare of Kentucky invests heavily in the Information Security and Privacy programs in order to reduce risk of a data loss event. The HITRUST program and the implementation of the HITRUST Common Security Framework focuses on minimizing the risk of a breach while efficiently providing services to Enrollees. We employ multiple physical and electronic security controls as part of our privacy and security services and infrastructure services into every layer of our operational environment. Our environment is continuously monitored by our 24/7 Enterprise Service Operations Center (ESOC). Examples of our existing comprehensive security features include:

- Encryption of hard drives, including all desktops and laptops.
- Multifactor authentication for all remote access.

- Monitoring of laptops, desktops, and the network through automated virus scanning solutions, data loss prevention, and advanced persistent threat technologies.
- Blocking of ability to save data to portable (thumb drive), disc media (CDs), webmail, and cloud file sharing.
- Built in "Automated Wiping" for desktops and laptops in the event of loss or theft
- Encrypted storage solutions (including medical records).
- Secure decommissioning including full magnetic erasure of disc drives.
- Email controls (e.g., scans for spam, malware, and viruses; user-elected and automated email encryption; Transport Layer Security (TLS) email exchanges).
- Role-based security features based on least-privilege (e.g., two-factor authentication, automated provisioning) with annual certification.
- Implementation of a diverse set of Firewalls, Intrusion Detection Systems, virus scanning, data loss prevention, and advanced persistent threat prevention, monitoring and detection technologies.
- Recurring vulnerability testing, web application testing, and penetration test and with remediation of any identified vulnerabilities and enhancement opportunities.
- The use of encrypted file transfers with government partners and subcontractors primarily through the use of Secure File Transfer Protocol (SFTP) (which will include Department provided FTP site).
- Application designs and controls (e.g., detailed audit logs; access to display last change date, time, and user; inability to alter finalized transactions).
- Physical controls (e.g., restricted access building requiring appropriate credentials to enter; separate, highly restricted areas, like Data Center facilities).

WELLCARE'S SECURITY STRATEGIES FOR DATA PROTECTION AND ACCESS

Access to any WellCare system requires a valid user ID and password, the sharing of which is strictly prohibited. The User ID process begins at the time of hire through our user provisioning process. Provisioning occurs via role based access associated with role and job title. The user access request includes a complete description of the access needed including network drives, applications, and templates. Requests for access to in-scope applications are approved based on the individual's need to view, add, change, or delete data. "Least Privilege" access is driven by the use of templates specific to the system functions and information that the unique user requires. Once a user receives his or her ID, access attempts are monitored. WellCare's Active Directory domain policy restricts unsuccessful login attempts and can be programmed to fit DMS-specific requirements.

WellCare desktops and laptops are protected at the host level by an Enterprise Anti-Virus and End-Point Firewall solution. Password complexity is established and enforced at the domain level and administrator user privileges are limited to support staff exclusively. A mature patch

management process ensures that these devices receive scheduled vendor updates, and compliance is tracked via an enterprise distribution package. Laptops are further protected by the use of a full-disk encryption solution with full DOD level remote wipe capability.

WellCare's Chief Compliance Officer oversees implementation and compliance with all current and future HIPAA standards. He also manages the Corporate Compliance Department, which is responsible for WellCare's privacy, information security, records management, and information management programs. The COO reports to our CEO and independently reports to the Board of Directors' audit, finance, and regulatory compliance committee. The COO and his team provide support to Rebecca Randall in Kentucky.

WellCare actively promotes compliance with the requirements of this section through multiple ongoing activities, which include:

- Maintaining policies and procedures describing the types of information to be safeguarded and the proper release of protected health information (PHI). These policies, including HIPAA Privacy, HIPAA Transactions, and Information Security Policies defined and document our commitment to understanding and enforcing these standards.
- All new hires are also required to complete this training within their first 30 days of hire. Our corporate training Department independently executes the administration and completion compliance of this training.
- Requiring the completion of annual training on security, privacy, fraud waste and abuse, and HIPAA compliance by all associates as a condition of continued employment.
- Associates also attend general compliance (iCare) training designed to instill our core values and ethics. We maintain corporate policies that address system access management and information accessibility at the corporate level. In addition to the aforementioned programs, our information security council meets regularly with key leaders to communicate and govern the information security risks throughout the organization.

BREACH RESPONSE PLANNING AND EXERCISES

WellCare of Kentucky acknowledges that protecting data is critical, but also having and testing an Incident Response Plan on how to quickly react and respond in the event of a breach is important in mitigating harm to the Enrollee. WellCare has developed an extensive set of playbooks that model responses to the top anticipated events, which may impact Enrollees. These include events such as malware, ransomware, hacking events, data loss, etc. These playbooks enhance the Incident Response Plan Standard which is based upon SANS WellCare performs tabletop exercises with the incident response teams on a quarterly basis to ensure clear decision making authority, open communication channels, backup communication plans, and process improvement opportunities. Lessons learned are incorporated back into the playbooks after conclusion of the exercises. Participants in the exercises include a core team involving Legal, Privacy and Security, IT, and Communications along with a varying set of business representatives or senior leadership representatives.

Each session includes review of impacted stakeholders and communications protocols internal and external to WellCare. These stakeholders include DMS, vendors, law enforcement, incident

response specialists, etc. These exercises include development of standard communications tools, briefings, and most importantly experience for those filling the roles essential in quickly analyzing, stopping, and mitigating the harm associated with a breach.

BREACH MONITORING AND RESPONSE

Vulnerability and breach monitoring begins with system level monitoring, active event logging, frequent vulnerability scanning, and threat intelligence data from multiple sources including US CERT and H-ISAC.

WellCare leverages a centralized security event and incident management tool to collect and analyze events from systems, applications, and security tools. Security tools feeding this system include Intrusion Detection and Prevention Systems, Firewalls, VPN Concentrators, Domain Controllers, advanced threat detection tools, anti-virus, among others. This data is correlated with information provided from both public and private threat intelligence resources in addition to vulnerability scan and system information. Vulnerability scan information is updated weekly internally and multiple times per day for internet facing systems. Changes detected by vulnerability scanning on internet facing systems trigger an automated alert workflow for Information Security. Security data is augmented using threat intelligence resources to proactively block bad actors as they identified in the larger community.

Our Infrastructure and Operations ensures that all components of our systems are continuously monitored by our 24/7 ESOC. The ESOC monitors systems continuously for any and all issues, outages, or indication of potential threats to operations. We supplement the ESOC with security monitoring by interfacing with a Managed Security Services Provider (MSSP) to perform 24/7 monitoring and alerting. The MSSP performs ongoing analysis of the enriched log data from the SEIM and follows a playbook for handling events discovered within the WellCare environment. If an event is discovered, the MSSP will triage the event and, based upon the severity of the event, the Incident Response Plan is triggered.

c. Describe the Contractor's approach to conducting Application Vulnerability Assessments as defined in Section 38.6 of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

WellCare of Kentucky (WellCare) confirms adherence to DMS' expectations and requirements outlined in Section 38.6 of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Application Vulnerability Assessments occur leveraging multiple teams and toolsets. The OWASP Top Ten and the SANS Top 25 are identified as key test criteria and baked into the process from beginning to end. The application vulnerability assessment addresses, at a minimum:

- Injection
- Broken Authentication and Session Management
- Cross-Site Scripting (XSS)

- Insecure Direct Object References
- Security Misconfiguration
- Sensitive Data Exposure
- Missing Function Level Access
- Cross-Site Request Forgery (CSRF)
- Using Known Vulnerable Components
- Invalidated Redirects and Forwards

Preventing vulnerabilities from getting into code is the first step. WellCare leverages static application scanning tools to analyze code as it is developed and checked into the code repository. Any vulnerabilities are categorized as defects and addressed accordingly. Once code is produced, it is introduced to the QA environment where pre-production application scans are performed using dynamic scanning tools leveraging both authenticated and un-authenticated scans. Defects are created for any items discovered prior to go-live. Once in production, authenticated and unauthenticated scans are performed to verify no changes in the code from QA.

Quarterly web scans are performed against different sections of the Internet facing properties by Internal WellCare personnel using authenticated and unauthenticated scans. Scanning is performed using a combination of automated and manual tools. Once issues are identified, the Information Security Analyst provides the report back to the development teams and works with them on remediation planning. These items are tracked within the Information Security risk management platform with issues identified, remediation steps identified, ownership, and timelines for completion. Once the remediation is complete and introduced to production, then the item is retested and verified as closed. We will provide DMS a copy of the application vulnerability assessment within 14 Business Days of its execution.

29. Use Cases

C.29. USE CASE 1 - RHONDA

Rhonda is a 30-year-old Enrollee who recently learned that she was pregnant after visiting the Emergency Room, by ambulance, with severe nausea and dehydration. She has a history of high- risk pregnancies. Of 5 pregnancies she has experienced one (1) live birth, three (3) miscarriages occurring early in the second trimester, and one (1) abortion in her teens. In addition to her history of complicated pregnancies she smokes a half pack of cigarettes per day and drinks approximately 2 -3 beers /week. During her pregnancies, Rhonda sporadically kept prenatal visits and had a history of noncompliance with routine care instructions.

Rhonda was shocked to learn that she was pregnant since she delivered a baby girl ten (10) months earlier. Her daughter, Amanda, was born at 32 weeks and was in the NICU for three (3) weeks. Amanda is feeding well and is steadily gaining weight. With that pregnancy, Rhonda experienced post-partum depression and was concerned whether she could care for Amanda. Rhonda's closet family is in Texas but visits are infrequent. She recently separated from an abusive partner who provides minimal financial and emotional support. Rhonda and Amanda sought safety in a family shelter on three (3) different occasions after her partner threatened to harm Amanda.

Rhonda became upset upon learning she was pregnant again and kept telling the ER nurse that it could not be true. She explained that she just moved out her apartment after splitting with her partner and was staying temporarily with friends. Rhonda does not have reliable transportation and often relies on friends to provide rides to the pediatrician and grocery shopping.

The ER nurse recommended that Rhonda talk with her OB/GYN and her MCO about her options. Rhonda's electronic medical record was updated and a referral was made to her OB/GYN.

Describe how the Vendor would address Rhonda's situation including a detailed description of prenatal programs and Quality Improvement Initiatives. At a minimum, address the following programs and services:

a. Applicable evidence-based Care Management practices;
b. High risk pregnancy initiatives;
c. Health Risk Assessment and Care Planning;
d. Environmental assessment;
e. Behavioral Health Services;
f. Family planning;
g. Enrollee and family engagement;
h. Linkage to community resources and support;
i. Social Determinants of Health;
j. Provider engagement; and
k. Transportation.

C.29. USE CASE 1 - RHONDA

WellCare's discussion of this Use Case includes additional information about Rhonda and her family for the purpose of better demonstrating how we support our members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed****.*

Overall Approach and Assumptions: WellCare's approach to helping Rhonda achieve optimal outcomes for herself, her baby and her 10-month old daughter involves a full integrated maternity care management program, BabySteps, to address her physical and behavioral health, pharmaceutical and social service needs. BabySteps will address Rhonda needs for interpersonal safety plan, prenatal care, housing, and support Amanda's infant health needs. Closed-loop referrals through our long-standing community partners ensure Rhonda has safe housing, transportation, food, and support to recover from interpersonal violence and improve her ability to care for her children.

Innovations for Rhonda

- Trauma-informed and evidence-based maternity care
- Technology enabled maternity support
- Comprehensive Community Supports
- "Families First" approach to care planning

a. Evidence Based Practices for Care Management and Quality Initiatives

Our care management practices for Rhonda, as illustrated below, are built on nationally recognized evidence-based guidelines that are fully integrated and embedded into all aspects of our operations, including our care management information system CareCentral. Our Clinical Practice Guidelines are informed by the Agency for Healthcare Research (ARQH) and the American College of Obstetricians and Gynecologists (ACOG) other national standards. Rhonda's care includes in-person and telephonic care management, education for self-management, provider education, profiling and feedback. We pay close attention to the social determinants of health that can influence whether Rhonda engages in good prenatal care.

Enrollment and Health Risk Assessment: Rhonda calls the toll-free number on the back of her WellCare ID card and speaks to Emily, a WellCare Enrollee Call Center Representative. Rhonda explains that she recently went to ED by ambulance and discovered she is 10 weeks pregnant. Rhonda is new to the plan and does not know who she needs to call to help her understand her pregnancy benefits. Emily understands the importance of early access to prenatal care and transfers Rhonda to our Kentucky Maternity Care Coordinator who completes a maternity assessment to identify Rhonda's risks and needs. Rhonda is anxious and unclear about her next steps, she indicates she has had difficulties with past pregnancies and is not sure where she will be living full-time. Because Rhonda is high risk, she is assigned to Joan is a dedicated OB Case Manager who offers **intensive support to Rhonda throughout her pregnancy** and postpartum.

Enrollee Needs Assessment: Joan reviews the results of Rhonda's risk screening and asks Rhonda about her current living situation, whether she feels safe with friends and if she has contacted the Lexington Police Department for an Emergency Restraining Order. Rhonda indicates that while her friends are very supportive, she is anxious and fearful that ex-partner will easily find her there. Joan is trained in working with enrollees, like Rhonda who have trauma histories and calmly walks her through options for a safety plan. With Rhonda's agreement, Joan initiates a closed-loop referral for Rhonda to GreenHouse17, an emergency shelter and advocacy program for victims of domestic violence. GreenHouse17 is a WellCare community partner works with Joan to help Rhonda; Joan secures transportation for Rhonda and Amanda to get to GreenHouse17.

Joan reviews Rhonda's her claims information in CareCentral, our comprehensive care management information system, to determine if Rhonda has gaps in her health and prenatal care such as an annual physical, pap smear, dental visit; as well as Amanda's infant health and well-child visits. Joan sees that Amanda, 10-months old is listed in CareCentral, as a related member. Joan learns that Amanda was born at 32 weeks, spent time in the NICU and that Rhonda was sporadic in her prenatal care during Amanda's pregnancy. Joan prepares a "New Mom" packet, including a "Preparing for a Healthy Baby" book, a list of educational links on our website, and the toll-free number for our BabySteps program for Rhonda.

Joan's goal is to complete a comprehensive assessment to gain a holistic understanding of Rhonda's needs and personal strengths, parenting strengths, preferences, abilities, social service barriers, physical and behavioral health (BH) status, and goals, including the identifying: urgent and short-term needs; supportive friends and family; engagement with providers; parenting needs such as back-up caregiver plans; emergency response plans; and vocational needs. Joan will also evaluate Rhonda's knowledge of pregnancy, nutrition and healthy routines, and her current pregnancy. Joan's comprehensive assessment reveals a variety of factors influencing Rhonda's health:

Medical/Pharmacological	Behavioral	Social/Cultural
• Pregnancy discovered during ER visit 2 weeks ago • History of sporadic prenatal care with prior pregnancies • 10-month old daughter born at 32 weeks, spent 3-weeks in NICU, steadily gaining weight • 3 previous miscarriages in early second trimester • No current engagement with PCP or OBGYN • No current medications incl. prenatal vitamins or OTC • Able to perform all ADLs and IADLs	• Domestic violence trauma • Anxious and overwhelmed by current pregnancy • Drinks several beers a week to "relax" • Smokes cigarettes to "calm down" and "focus" • History of postpartum depression • History of not adhering to routine care guidelines	• Has 10-month old daughter; no childcare or back-up caregiver for daughter • No transportation; no income • Closest family is in Texas • English is primary language • Currently homeless, staying with friends in Lexington • Baby's father has history of violence • Currently connected with GreenHouse17 for support with safety concerns • Has High School diploma

Rhonda reports that she has not followed-up on her ER referral to the OBGYN because the provider is too far from her friend's house, where she is staying. Joan offers to schedule an appointment for her with the UK Women's Health Clinic and to arrange transportation. Joan discusses the importance of engaging with her OBGYN given her history of miscarriages. They also discuss the importance of follow-up for Rhonda's current level of anxiety and her history of postpartum depression following Amanda's birth. Rhonda's agrees to see a provider with the UK Psychiatry Clinic, if both UK appointments can be scheduled on the same day. Joan confirms the appointments and, with Rhonda's permission, sends the results of her needs assessment.

Integrated Interdisciplinary Team: Joan explains to Rhonda the interdisciplinary team available through the BabySteps team including RN's, social workers, pharmacy, medical and behavioral

health staff. Joan also explains how she assist with housing, food, transportation and other social services. Joan also asks Rhonda about the important people in her life, her family and friends who may be important support for her as she reestablishes a home and who she may want on her care team or who may play an informal role in supporting her. Rhonda's wants Bella, her sister in Texas, to part of her team and the counselor from GreenHouse17. Joan ensures releases are complete and entered into CareCentral; she documents contact information in the care plan and makes sure team members have her contact information.

Care Planning: Joan asks Rhonda about her goals and priorities. She will then work with Rhonda to turn her priorities in specific, measurable, achievable, relevant and timely (i.e., S.M.A.R.T.) care plan goals. Rhonda reports being extremely anxious about her current pregnancy and while overwhelmed, her priorities are to have a healthy baby and to keep Amanda healthy. Rhonda talks about her fear that her ex-partner will harm her, however she takes comfort in getting help from GreenHouse17. Joan gets Rhonda's permission to add a Care Manager from our specialty BH team to care team to assist with planning. Using a person-centered planning process and motivational interviewing techniques, Joan asks Rhonda about her goals for the week, month and year. Rhonda's goals in her own words, programs and services include:

Rhonda's Goal	Programs and Services	Focus Area
I want to be healthy for me, my baby and Amanda	• UK Women's Health and UK Psychiatry Clinic, including Federated Transportation services to/from clinic • Global authorization in CareCentral for all prenatal care • Well Care smartphone to access Pacify (prenatal advice), appointment reminders and educational materials • Kentucky Quit Line for smoking cessation • Healthy Rewards for incentives to complete prenatal and postpartum visits and smoking cessation • BabySteps care management, written and verbal education on nutrition, hydration, growth states, risks and red flags throughout pregnancy • WIC nutrition services and HANDS support • 24/7 Nurse Advice Line	Prenatal Care
	• Introduce MyStrength's self-guided online modules to learn positive coping strategies and self-management tools	Behavioral Health
	• BabySteps care management, written and verbal education on signs and symptoms of depression, when to reach out for help and building positive supports throughout pregnancy	
	• Education on the risks of street drugs and over-the-counter medications during pregnancy	
	• Education on the risks of drinking beer during pregnancy and alternative strategies for relaxation, including peer supported telehealth services through Kentucky Maternal Assistance Toward Recovery	
	• Education on the importance of birth spacing through LARC and other family planning options	Family Planning

Rhonda's Goal	Programs and Services	Focus Area
I want to deliver a full-term baby	• Universal Pregnancy Screening (Genetic testing), as recommended by OBGYN • OBGYN evaluation of the need for 17P/Makena between 16-20 weeks gestation	Prenatal Care
I want Amanda to stay healthy	• Collaboration with Amanda's Pediatric Case Manager to ensure Amanda's needs are met and she is achieving developmental milestones	Infant Health
	• Nutritional support to continue Amanda's weight gain	Infant Health
I want my family to be safe	• WellCare Community Connections assistance in expediting an application with the Lexington Housing Authority	Housing
	• Engage The Nest to provide childcare for Amanda while Rhonda attends medical appointments and looks for housing	Childcare
	• Engage the Purple Purse fund for assistance with housing cost and food	Housing and Economic Support
	• Domestic Violence Counseling and Advocacy through GreenHouse17	Interpersonal Safety
I want to be able to provide for my children	• Engage Rhonda with WellCare Works, after her pregnancy has stabilized to explore her vocational strengths and skills	Vocational
	• Educate Rhonda on how to use Federated Transportation services for medical appointments and community partners for non-medical transportation	Transportation
	• Work with HANDS, The Nest and GreenHouse17 on parenting, child development, and creating a healthy home environment	Parenting Skills
I want my sister Bella to help me make decisions	• Regular over the phone check-ins with her sister using Rhonda's WellCare enabled smartphone • Care team meetings with Bella on conference line	Social Support

Monitoring and Follow-up: Joan schedules regular monitoring calls and visits with Rhonda. Rhonda feels comfortable using GreenHouse17 as her "home-base" for visits and, if needed, her 17P/Makena injections, until she secures long-term housing. During each visit, Joan monitors Rhonda's health status, verifies that notifications for upcoming appointments are set-up on Rhonda's smart phone and confirms she can access numerous education videos and engage in video chats with experts through the BabySteps app. Joan provides on-going education to Rhonda on what to expect with her pregnancy and the importance of healthy eating and hydration and makes sure she knows the signs and symptoms of preterm labor. Joan asks Rhonda about her progress with the BabySteps Healthy Rewards Program and explains qualifying activities. Rhonda has already earned her Prenatal reward of a $25 gift card for completing her first prenatal care visit and is eligible for a Bonus Reward prior to delivery (car seat, pack n play or a stroller); as well as a reward of a $25 gift card for completing a timely postpartum visit. Joan lets Rhonda know she has access to home-delivered meals after her baby's delivery. Joan discusses Rhonda's preference for breast feeding vs formula and provides information so Rhonda can make an informed decision. If Rhonda chooses breast feeding, Joan

will arrange for a free breast pump and support from lactation consultant. Joan assist Rhonda with WIC enrollment and monitors Amanda's EPSDT milestones and care gaps. Joan enrolls Rhonda with the Lexington Health Departments HANDS program for ongoing support throughout her pregnancy and for the baby's first 2 years of life.

Quality Initiatives: To ensure high quality care for all our members, BabySteps engages in a variety of Quality Initiatives focusing on improving birth outcomes such as the reduction of pre-term and NICU birth rates; improving the timeliness of prenatal care, use of post-partum care, and birth spacing and the reduction of C-section delivery rates.

b. High Risk Pregnancy Initiatives

WellCare's BabySteps Maternity Care Management program is based on ACOG evidence-based guidelines and other nationally recognized guidelines. Key elements of BabySteps include: motivational interviewing and person-centered planning; assignment to a RN maternity care manager; an integrated care team; intensive follow-up with Rhonda, her PCP and OBGYN; a Home Care Program for high-risk women with previous preterm births for administration of 17P injections and in person nursing assessments and monitoring; identifying and addressing social barriers to health; substance use and smoking cessation; smart phone apps with education on pregnancy, appointment reminders, and a 24/7 nurse line.

c. Health Risk Assessment and Care Planning

Rhonda's initial HRA was completed within 30-days of her enrollment with WellCare and before she knew of her pregnancy. As described above, once alerted to Rhonda's pregnancy our BabySteps team completes a pregnancy assessment, within 10-days of contact, to identify risks and needs. Our assessment tool is based on ACOG and other national best practice clinical guidelines. We screen for risk factors such as: *age* (i.e., teens and women over age 35); *history of pregnancy related conditions* such as recurrent miscarriage, preterm or low birth weight births, gestational diabetes, postpartum depression; *co-morbid medical conditions* such as blood clotting, cardiac or renal conditions, diabetes; *current pregnancy conditions* such as cervical change, gestational diabetes or hypertension, HIV/AIDS, hyperemesis gravidarum, multiple gestation, vaginal bleeding; *co-occurring behavioral health conditions* such as serious mental illness, history of or current anxiety, depression, substance abuse, including alcohol, smoking, domestic abuse; and *social barrier*s such as homelessness, lack of a support system or transportation.

d. Environmental Assessment

Embedded in WellCare's HRA and all needs assessments are questions to assess the Rhonda's living situation, safety, risk of harm from domestic violence, homelessness or other unsafe or unsanitary living conditions. Safety issues are immediately addressed through our community partnerships and all environmental discussed and issues are addressed in the care plan as appropriate.

e. Behavioral Health Services

As a fully integrated health plan, Joan has access to integrated case conferences with our medical, behavioral health and maternal child health leaders for problem solving around

Rhonda's physical health care, her history of postpartum depression, alcohol use and current levels of anxiety. Joan introduces Rhonda to MyStrength, our online app that helps her understand issues such as anxiety and depression and learn new coping strategies. If Rhonda's substance use escalates, the team considers treatment and peer support through Chrysalis House. WellCare's partnerships with Chrysalis House, the Nile, and Women of the Well, provide residential treatment that allows Amanda to stay with Rhonda. Joan works with Rhonda and her providers to find the program that best fits her needs.

f. Family Planning

WellCare BabySteps provides education on family planning and the importance of birth spacing for maternal and child health, during Joan's 3rd trimester and during postpartum calls. Our evidence-based guidelines include a pre-delivery discussion of Long Acting Reversible Contraception (LARC) options and birth spacing, giving pregnant women the knowledge and power to include such options in her plan of care. Joan helps Rhonda write down questions she has for her OBGYN and explains that services are covered by Medicaid and also offered through the Lexington-Fayette County Health Department. During follow-up calls Joan will document Rhonda's decision and ensure her questions have been addressed.

g. Enrollee and Family Engagement

Joan keeps Rhonda engaged by "meeting her where she is" emotionally and physically. Joan is trained in Motivational Interviewing and uses these techniques to identify Rhonda's goals and priorities. Joan makes sure that Rhonda feels supported in addressing basic safety and housing needs first, with GreenHouse17 and meets Rhonda in-person at locations and times convenient for Rhonda and where she feels safe. Establishing a circle of support is vital for Rhonda's engagement. Joan identifies people who Rhonda trusts, including reconnecting with her sister in Texas, Bella, via a WellCare smartphone. With Rhonda's permission, Bella joins the care team to support Joan by phone during the pregnancy and schedules time off work to be with her when the baby is born.

h. Linkage to community resources and support

Joan identifies community services for Rhonda and assists her with access. Joan engages Rhonda in the WIC program and arranges transportation. She reminds Rhonda about the Kentucky Quit Line for smoking cessation assistance. Rhonda enrolls in The Nest 12-session parenting class, which uses an evidence-based nurturing parenting curriculum and provides childcare for Amanda. Joan advises Rhonda about HANDS, and the benefits of having a mentor who can visit with her as she establishes a new home and who can offer her support in building a healthy, safe environment for her family.

i. Social Determinants of Health

As part of her assessment, Joan evaluates social barriers to health. Rhonda's need for safety, housing, and transportation are include in her care plan. Joan will collaborate with Rhonda and GreenHouse17 to address needs. For example, Joan uses a closed loop referral to engage Rhonda with the Community Action Council (CAC) in the Winburn neighborhood. Joan knows CAC operates the Continuum of Care homelessness prevention program for Central Kentucky. Joan works with Rhonda to have her Lexington Housing Authority application elevated due to

her pregnancy and history of domestic violence. Joan introduces Rhonda to the God's Pantry Food Bank where she can receive emergency food assistance and can sign up to regularly receive food from the pantry. Rhonda also discusses her future plans and her goal for getting a job. Joan engages Rhonda with Opportunity for Work and Learning (OWL), an organization engaged with WellCare Works, designed to assist Rhonda with identifying skills and interests to help her find a job.

j. Provider Engagement

Joan is part of the locally based WellCare team that lives and work in the communities they serve. Part of that team includes Provider Relations Representatives (PR) who work with Joan to engage providers in understanding our integrated care model. Joan speaks directly with providers and office staff to answer questions about managed care and to talk about Rhonda's health care gaps and adherence to the care plan. The team makes sure that providers have access to Rhonda's assessments, care plans, progress notes and care plan updates via fax, hard copy and electronically through the online WellCare provider portal. Providers have real-time access all Rhonda's records.

k. Transportation

Joan arranges for transportation through Federated Transportation service for medical appointments and helps Rhonda set the appointment reminders in her smartphone. Joan calls the day of each appointment to make sure Rhonda is ready. Joan works with partners such as the Maxwell Street Presbyterian Church, Lexington Paramedical Program, Community Action and Chrysalis House to ensure that Rhonda and Amanda have a Bus Pass for Lextran Transportation Service for rides to parent support meetings, WIC and other non-medical needs. Joan will work with Rhonda and her providers to determine if telehealth appointments can help to reduce Rhonda's transportation needs.

Conclusion: Joan and her locally based colleagues provide comprehensive support to Rhonda as she obtains safe housing, delivers an infant with a minimal hospital stay, and reconnects with her family in Texas. Joan reassess Rhonda's needs and those of her growing family, she assists Rhonda to ensure that the children receive the necessary EPSDT follow-ups. Rhonda receives continuing support through HANDS, Healthy Start and other community based programs to help her create a nurturing and safe environment for her family.

C.29. USE CASE 2 - KATY

Katy is a 20 year old female who is taking classes at a local community college while living at home with her mother to help take care of her younger brother. Katy's mother works two (2) jobs and has difficulty finding time to shop for and prepare healthy meals. Katy does not assist with grocery shopping or meal preparation. Katy is significantly overweight and rarely exercises. Most of her meals are from fast food restaurants and she only occasionally eats vegetables or fruit.

Recently, Katy became light headed after eating lunch and was taken to an urgent care center by a friend. The provider asked Katy about her symptoms and whether this has happened before. Katy stated that the dizziness happens frequently after meals and she is always thirsty. The provider asked Katy if she has diabetes and Katy stated she did not think so. She told the provider that she has not seen a doctor since she was in middle school. The nurse took Katy's vital signs and a blood glucose reading. Katy's blood glucose reading was elevated and her blood pressure was 162/90. Her BMI was computed to be 32.6. The provider recommended that Katy contact her MCO to find a PCP as soon as possible before her condition worsened and she ended up in the Emergency Room.

Katy contacted her MCO's Enrollee Call Center and explained her situation.

Describe the Vendor's Enrollee engagement process and Care Management. At a minimum, address the following:

a. Evidenced based practices for Care Management;
b. Health Risk Assessment and Care Planning and monitoring;
c. Provider engagement;
d. Cultural competency;
e. Patient engagement and education;
f. Community resources; and
g. Social determinants of health

C.29. USE CASE 2 - KATY

WellCare's discussion of this Use Case includes additional information about Katy and her family for the purpose of better demonstrating how we support our members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare's care management and planning process are grounded in nationally recognized evidenced based practices. Using a fully integrated model we address Katy's physical and behavioral health, pharmacological and social service needs. Our condition specific education tools address diabetes prevention, hypertension and lifestyle routines. As a young person aging out of the EPSDT periodicity schedule, we take special care to empower her to understand and manage her health. Through education, problem solving, group support, and a mobile app to track lifestyle changes, Katy will learn self-management skills and healthy routines.

Innovations for Katy

- Technology enabled health education
- Family-based approach to care planning

a. Evidenced based Practices for Care Management

The foundation of WellCare's Care Management program is built on nationally recognized evidence-based guidelines that are fully integrated and embedded into all aspects of our operations, including our care management information system CareCentral. Our Clinical Practice Guidelines are informed by the Agency for Healthcare Research (ARQH) and other national standards and include in-person and telephonic care management, education for enrollee self-management, provider education, profiling and feedback. Every aspect of our care management is integrated and proactive to optimize enrollee health and access to care (identification and stratification of enrollees for care management, assessments, care planning, follow-up and monitoring). We pay close attention to the social determinants of health that can influence whether Katy can follow through on her treatment. As illustrated in the following sections for Katy, Dana, her Care Manager provides targeted interventions, educational materials and in-person and telephonic interaction and health coaching. Dana's work is guided by clinical best practices and programs that support Katy's health literacy, self-management of her health conditions and strategies for making lifestyle choices that lead to optimal health. Dana is supported by an interdisciplinary team trained to help members solve for social barriers that prevent them from reaching their health and wellness goals, such as gaining access to nutritious food or finding resources to help pay their water bill or secure a job.

b. Health Risk Assessment and Care Planning and Monitoring

Engagement: Katy calls the toll-free number on the back of her WellCare ID card and is connected to Rebecca, a WellCare Enrollee Call Center Representative. Katy explains that she recently went to urgent care due to dizziness, and reports that she knows nothing about health insurance or what that means for seeing a doctor. Rebecca is able to see a single integrated view of Katy's claims, providers and benefits information, including her EPSDT coverage as a young person under the age of 21. Rebecca realizes that Katy has not completed a Health Risk Assessment (HRA) and was also auto-assigned a PCP due to lack of action on her part. Katy asks about the PCP to see if he/she is close. Rebecca asks Katy where she lives and works and whether she uses public transportation or has her own car. Together they find a PCP whose location aligns better with Katy's weekly routine in Ashland. Rebecca explains the HRA and Katy agrees to complete it.

Health Risk Assessment: Rebecca completes the HRA screening tool to collect information on Katy's health status, including mental health and substance use disorders(s). Rebecca collects demographic information, Katy's personal and family medical history, and lifestyle habits. Katy begins asking questions about what to do next. Hearing about Katy's Urgent Care visit, lack of engagement with a PCP since middle school and limited knowledge about health benefits, Rebecca explains the importance of seeing her PCP and helps Katy schedule an appointment within 7-days and confirms she has transportation to Lewis County Primary Care, a full service FQHC.

Care Management Enrollment: Following her first appointment, Katy's PCP makes a referral to the Care Management program. Dana, a Care Manager who is an RN with training as a heath coach reaches out to Katy by phone to explain the Chronic Condition Management program and talk about her PCP's recommendations. Because WellCare uses a real time integrated platform, Dana is able to see notes from Katy's discussion with Rebecca and notes from her PCP

visit, including her blood pressure, BMI, and blood glucose results. Dana also understands that Katy's health literacy is low. Dana asks Katy about her PCP visit. Katy admits that she did not fully understand what pre-diabetic and diabetic meant, other than they were bad. Katy indicated that she had to pick up a medicine for the high blood pressure and learn more about cooking. Her next check-in with the PCP is in two months. Katy reported being confused because that is the same thing the Urgent Care said, she was not sure how the PCP was helpful. Dana explained to Katy the types of testing that the PCP does that are different from Urgent Care. Katy explains that her PCP's office is considered her medical home. The new PCP can help manage her medical needs, can arrange consultations with other providers and is typically available by phone or walk-in appointment, even during weekends and holidays. Dana helps her understand the adverse and long-term, or chronic, impact that high blood pressure and diabetes can have on her life. Dana confirms that Katy can get to the Pharmacy to pick up and start her prescription that same day.

Enrollee Needs Assessment: Dana asks Katy a series of questions to better understand Katy's daily routine, her lifestyle habits such as eating, exercise and what she does to relax. As Katy responds to each question, the assessment tool intelligently branches to the next relevant set of questions. This allows for a customized comprehensive assessment for behavioral health, substance use and social barriers to health. Dana's goal is to gain a holistic understanding of Katy's needs and personal strengths, caregiver responsibilities for her younger brother, abilities preferences, physical and behavioral health status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs to accelerate access to needed services; social service needs and barriers; her support system and engagement with providers; emergency response plans; school, post-secondary education; and vocational needs. Dana recognizes that although she is over age 18, Katy's health is influenced by her household routines and environment. Given that Katy has reported a supportive relationship with her mother, Dana asks Katy if she would like to invite her mother to join them on the call. Dana also explains to Katy that sometimes health conditions are common amongst family members and it would be good to talk about family history. Katy agrees it is a good idea.

When Katy's mother comes on the line, Dana asks about family routines, health history and Katy's younger brother. Dana's assessment reveals a variety of factors influencing Katy's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• BMI 32.6 • Pre-diabetic • Hypertension 162/90 • New medication for HTN, has not started • No reproductive health care or knowledge of family planning • EPSDT care gaps • Able to perform all ADLs and IADLs	• Father died when Katy was 10, saw grief counselor with Mom at that time; reports feeling resolved with grief • No substance use • No risk for depression or suicide • No wellness tools or exercise, eats fast foods with friends to 'relax' and 'have fun'	• Health literacy is low • Does not pay attention to food, groceries or know how to cook • Lives at home • Supportive mother • Has caregiving responsibilities for younger brother (age 10), while Mom works 2 jobs • Taking community college class • Uses public transportation and mother's car • English is primary language

Interdisciplinary Care Team: Dana explains to Katy and her mother the interdisciplinary team available through WellCare, including the Community Connections Advocate, who can assist with healthy food, transportation and other social services; and the WellCare clinical team of nurses, pharmacy, medical and behavioral health staff. She also asks Katy about the important people in her life, her family and friends who may be extra support for her as she learns about her health condition and works to create new lifestyle routines. Katy talks about her friends, but does not want anyone other than her PCP, mother and Dana on her care team. With Katy's consent, Dana shares the results of Katy's Enrollee Needs Assessment with her PCP within 14 days to inform care and treatment planning.

Care Planning: Dana explains that Katy's care plan is driven by both her PCP recommendations and by Katy's goals and preferences. Dana talks to Katy about her immediate health issues (e.g., hypertension and pre-diabetes) and her overall health care including filling in her gaps in immunizations, annual physicals, preventive screenings, and family planning options. Dana employs Motivational Interviewing and a person-centered planning processes to ask Katy's about what she wants to be doing in a few months and in a year. She also asks Katy about her long term goals, what she sees herself doing and where she might be living in five years. Dana's goal is to elicit priorities in Katy's own words. She will then work with Katy to turn her priorities in specific, measureable, achievable, relevant and timely (i.e., S.M.A.R.T.) care plan goals. Katy indicates she would like to know how to cook. She talks about enjoying walking and wanted to join the high school track and field team, but did not have time. Now the thought of exercise is intimidating. Currently Katy volunteers at the community college's helpline and has an interest in becoming an advocate for disability rights. Katy's immediate goal is to understand how to keep herself from "becoming sick with diabetes".

Dana provides Katy with verbal and written education on diabetes prevention and health lifestyles and including coaching on nutrition, physical activity, stress management, sleep, and weight loss. Dana helps Katy learn how to self-monitor, problem solve, and sustain positive change. Throughout the care planning process Dana with work Katy and her PCP tailored her care plan to meet Katy's needs including the use of digital technology, group support, and personalized goal setting. Dana also connects Katy with the Ashland Area YMCA for exercise classes.

To support Katy's long-term goals, Dana introduces Katy to the WellCare Works set of online tools that can help her explore her work interests and map out her education needs. She also has access to our partner CareerArc to explore career goals, build a resume and find jobs. While her focus is on Katy, Dana talks to Katy's mother about her son's health care needs and his risk for also developing hypertension and diabetes. Dana introduces Katy and her mother to the "Clean Out Your Pantry Program", an innovative program to improve healthy eating for the whole family. This program includes a Health Coach who works with Katy and her mother on changing their eating habits for the family. The Health Coach provides education about healthy eating, shopping, and active lifestyles to Katy and her mom over multiple sessions. The Health Coach visits the house to review the current inventory of food and dispose of unhealthy items (with their permission). The Health Coach then accompanies Katy and her mom on a grocery-shopping trip, trips to the Farmer's market and to the Food Bank, to identify cost-effective alternatives for healthy food; provides Katy and her mom healthy cooking guides; and assists in preparing meals. The family learns about the Double Dollars program for using the Farmer's Market. WellCare has relationship with farmers market to double the amount spent for

Medicaid members, thus Katy's voucher for $5 is worth $10 in fresh foods. Katy's goals, in her own words and the programs and services to support her include:

Katy's Goal	Person-Centered Plan	Focus Area
I don't want to get sick with diabetes	• Katy will schedule regular PCP follow-ups for hypertension and pre-diabetes monitoring	Physical Health
	• Katy and her mom will enroll in the 'Clean Out Your Pantry" program	Physical Health
I want to be healthier	• Enroll in Healthy Rewards for incentives to support Katy's follow through w/preventive visits and screens	Physical Health
	• Introduce MyStrength's self-guided online modules to learn positive coping strategies and self-management tools for relaxation and exercise	Behavioral Health
	• Improve Katy's understanding of her health services and insurance benefits	Physical and Behavioral Health
	• Establish a dental home and regular visits	Oral Health
	• Reestablish Katy's EPSDT and immunization schedule with her PCP to fill in health care gaps	Physical and Behavioral Health
	• Assist Katy in getting family planning education	Family Planning
I want to have a good job when I finish college	• Engage with WellCare Works to explore vocational strengths and skills and interests, including with work CareerArc	Vocational

Monitoring and Follow-up: Dana talks to Katy about the date and time of her next doctor appointment and shows her how to use the MyWellCare app on Katy's smartphone to set date and time reminders. Dana will also document the appointment in CareCentral, our integrated care management information system so she can outreach to Katy beforehand to remind her about the appointment and make sure she has transportation. Dana reviews with Katy all of her covered services and the recommended schedule based on the EPSDT periodicity schedule for young people under the age of 21. She also talks to Katy about her care needs as she gets older and introduces Katy to CareCentral's member portal. The Member Portal providers Katy with information on diabetes, her PCP, all scheduled visits, preventive screenings and care gaps, included needed dental care. Katy also has access to our 24/7 Nurse Advice Line, for health questions, and our Community Connections Help Line, for information on social services, transportation, employment and other community services.

Dana follows up with Katy monthly to check on her progress in managing her diabetes and discusses tips and strategies she is learning with her health coach and Clean Out the Pantry service. As Katy's health stabilizes and her care gaps are filled, Dana will adjust the frequency of check-ins and care plan meetings in collaboration with Katy and her PCP. Katy is aware that Dana is available as needed and she does not need to wait for a formal meeting to occur.

EPSDT Considerations: Katy is transitioning to adulthood and Dana will work with her on how to take control of her health care. However, she also recognizes that Katy's mother may not have received information and education on the importance of EPSDT periodicity schedule from her previous health plan. To address care gaps for Katy's younger brother, Dana talks with Katy's mother separately and sends education materials designed for parents. Dana also offers to

show her how to set up the MyWellCare app for herself and her son, so that she can get text messages and reminders of the need to schedule appointments and get immunizations. Dana offers to assist with any appointment scheduling and transportation that she may need to support the family.

c. Provider Engagement

Dana works as part of locally based team with WellCare's Provider Relations Representatives (PR) who live and work in the communities they serve. Dana and the PR team work to engage providers in understanding our integrated and comprehensive care model, EPSDT standards and integrated clinical guidelines for diabetes and hypertension management. Dana will speak directly with the PCP and other providers, and office staff to answer questions about managed care and Katy's health care gaps. Dana keeps the doctor's office informed about Katy's progress in changing her eating and lifestyle habits. Dana provides the PCP information with any signs and symptoms that Katy's condition is worsening including a pre-visit report with actionable information that details specific data points such as her cardiac risk score, cholesterol and blood pressure trending, medication adherence findings, care gaps (e.g., eye exams, lab work). Care plans are shared through paper, fax and through our secure provider portal. Dana and the PR team makes sure that providers understand how to use the online WellCare provider portal to access Katy's records, including recent assessments and her care plan. Dana additionally providers her contact information to the PCP office should she be needed to help manage Katy's care outside of the office.

d. Cultural Competency

Dana will assess Katy's cultural preferences for all aspects of health care such as: care delivery, treatment setting, care planning, coping styles, and social supports. She documents Katy's preferences to ensure they are factored into her care planning and that materials are accessible cognitively, linguistically and culturally. Katy and her family are part of the Appalachian community and culture. Dana is a part of the same community and understands Katy's cultural differences and needs. Dana recognizes that trust is important, and that Katy is very connected to her family and community. Dana knows supporting Katy to make lifestyle changes will also involve her family and friends. Katy's goals for good health may look different from the norm, for example, improved blood pressure may need to start with a goal of reaching 150/90 and build incrementally in addition to gradual weight loss to help prevent type II Diabetes. Dana includes Katy's mother on the team, with Katy's permission and works to connect them both to community resources for services and supports that benefit the whole family, including education on shopping, cooking classes, and exercise.

e. Patient Engagement and Education

All WellCare member facing staff are trained in addressing immediate needs and engaging members to understand gaps in their health care. From Katy's first call our staff work together as a team to offer personalized assistance, based on their location, daily schedules and contact preferences. Rebecca helped Katy find a PCP closer to her work and home and made a warm transfer to Dana who immediately helped her understand her health care needs and answered key questions for her. Dana helps to keep Katy engaged by "meeting her where she is" emotionally and physically. Dana is trained in Motivational Interviewing and uses these techniques to identify Katy's goals, assess her health literacy and establish her priorities. Dana

makes sure that Katy feels supported in addressing her immediate needs for hypertension, exercise and pre-diabetes prevention care. Dana is available to meet Katy in-person at locations and times that are convenient for Katy and where she feels safe. Dana makes sure Katy has information and education to understand her health conditions and understand lifestyle changes she can make to take control of her health. Dana teaches Katy how to use simple tools, calendars and mobile apps, along with how to set appointment reminders that help Katy stay on track.

f. Community Resources

Dana uses WellCare Community Connections data base of over 330,000 state and national resources to support social service needs of our members. Dana helps Katy find the CAReS, Community Assistance and Referral Services in Boyd County to assist Katy and her family with utility assistance, food, prescriptions, transportation, and housing. They act as an informational clearinghouse to prevent duplication of social services. Katy and her family receive a "Neighborhood Card" which they can use at organizations working with CAReS free of charge. The Dressing Room provides clothing, Clean Start provides hygiene items and cleaning supplies, and the Community Kitchen provides breakfast, lunch, and dinner. Dana talks Katy and her mom about The Drop Youth Center as a safe, drug free environment for young people to gain skills and support as they enter adulthood. When not in classes, Katy could access the center from 1:00 – 3:00 pm, Monday – Friday, the designated time slot for young adults ages 19-25; her younger brother could access the center Monday – Friday, 3:30 – 6:30pm when they serve youth ages 14-18. The center provides opportunities for supportive employment and education services as well as youth peer support services and case management services. There is a computer lab, pool table, and free snacks. The Drop offers free transportation to and from the location. Dana suggest to Katy's mom that Katy's brother could also consider going to the Westwood Boys and Girls Club for activities and opportunities to interact with other youth. He can also work out at Planet Fitness for free from May 15 – Sept 1 or take free tennis lessons at the Ashland Tennis Center.

g. Social Determinants of Health

Dana talks with Katy and her mom about Hope Central, a WellCare partner trained on navigating WellCare Work's suite of online tools to job skills, education, and assistance in locating employment and volunteer opportunities. Hope Central can assist Katy in honing her career path and Community College classes. Katy's mother may benefit in finding one job that will pay as much or more as her two part-time jobs. Dana refers Katy and her mom to the Hillcrest-Bruce Mission, a local food pantry and makes sure Katy takes advantage of the Ashland Bus System's half-price bus tickets for students.

In summary, WellCare is committed to whole-person care. Enrollees like Katy who are aging out require additional support through increasing awareness of our staff and providers and through our Community Connections resources to connect her with community resources.

C.29. USE CASE 3 - THE VENDOR

The Vendor is implementing a two-year initiative to improve outcomes by addressing a variety of health behaviors (e.g., tobacco use and diet) and social determinants of health in the southeast region of Kentucky. The Vendor has enrolled several primary care and multi-specialty provider groups in the area to participate in the initiative and has developed relationships with various community agencies to support the effort. The Vendor has identified five (five) quality measures for which providers will receive incentives for meeting targeted improvements. The quality measures emphasize physical and behavioral health integration, social determinants of health, and critical community resources. The Vendor intends to make initial incentive payments 14 months after the start of the initiative. Six (6) months into the project, a multi-specialty provider group's Administrator met with the Vendor to discuss challenges the group is encountering with the initiative and to raise concerns about reporting. This provider group has 50 participating practitioners, including Advanced Practice Nurses, in four different locations. Specifically, challenges are as follows:

- Some practitioners in the group are very engaged while others are not interested in supporting the effort, indicating it is too complicated and administratively burdensome as the group is also participating with similar initiatives being implemented by the other contracted Medicaid MCOs, but that have different required measures.
- The provider group has a new electronic health record (EHR) system and experienced numerous onboarding issues that haven't yet been resolved. In addition, the provider group does not plan to contribute or retrieve information from KHIE until the EHR issues are resolved. The provider group does receive ADT data from Southeastern Kentucky Medical Center and the Baptist Health hospitals.
- The Administrator has made multiple attempts to outreach to a community housing agency that the MCO indicated is supporting the effort to discuss opportunities to collaborate; however, the agency has not returned calls.
- Enrollee compliance is lower than anticipated. Follow up and other outreach has been difficult due to Enrollees not returning calls and also incorrect Enrollee contact information.
- The Administrator is frustrated that the MCO had not provided feedback on the first set of required reports that were submitted three months after project initiation. Communication has been minimal and the Administrator is concerned about lack of support.

The Administrator and practice leadership are concerned with the extended timeframe for incentive payments and the ability to impact providers' behaviors.

Describe the Vendor's approach in addressing the Provider's concerns. At a minimum, address the following:

a. Provider engagement at local, regional, and statewide levels;

b. Provider education, communications, and support;

c. Simplification of provider administrative burden;

d. Enrollee engagement; and

e. Vendor assessment of internal operation challenges and mitigation strategies.

C.29. USE CASE 3 - THE VENDOR

WellCare of Kentucky is well-positioned to focus on and improve health outcomes in southeastern Kentucky. We have been serving the needs of Enrollees in Region 8 continuously since 2011 and have strong, trusting relationships with providers and community service organizations. We understand the health issues in the population and know how to work with our providers, Enrollees and the community to address them and implement successful interventions. We also have extensive experience implementing incentive-based initiatives to improve health outcomes such as our Partnership-for-Quality (P4Q) program that rewards providers for improving key quality measures.

In 2018, WellCare of Kentucky implemented a two-year initiative to improve health outcomes in Region 8. We approached a number of large provider groups to participate in the initiative including a provider group with 50 practitioners across four locations in Bell and Knox Counties. The residents of Bell and Knox Counties face a range of health challenges including high rates of obesity, diabetes and tobacco use. The provider group was therefore a good fit for the initiative, which ties five quality measures to financial incentives:

- BMI and nutritional intervention and reassessment: The number of Enrollees categorized by age and BMI category--obese (>30) or morbidly obese (>40) who completed nutritional counseling and received a follow-up visit within three or six months.
- Pre-diabetes intervention and reassessment: The number of Enrollees categorized by age and HbA1c level of 5.7-6.4 who completed nutritional counseling and received a follow-up visit within three or six months.
- Tobacco assessment and intervention: The number of Enrollees categorized by age who screened positive for tobacco use and/or vaping and (1)received a tobacco cessation intervention; (2) received a tobacco cessation intervention and a follow-up visit within three months; and (3) received a tobacco cessation intervention and a follow-up visit within three months with a negative tobacco screening.
- BH Diagnosis and PH Visit**:** The number of Enrollees with a Behavioral Health diagnosis who had an annual preventive health visit.
- BH Diagnosis with Medical Record of BH Consult**:** The number of Enrollees with Behavioral Health diagnosis whose medical record reflected a note/consult from the Behavioral Health provider.

The measures were specifically designed to capture a rate, an intervention and an outcome. A rate alone does not improve population health. A rate combined with an intervention allows insight into the effectiveness of the intervention.

The provider community is key to any successful intervention. Their interactions with our Enrollees determine the success or failure of any intervention. With this in mind, WellCare of Kentucky Quality Manager Sharon Hall, RN and Provider Relations Manager Brandon Cornett, who both live in Region 8, presented the initiative to the provider group's Administrator at their monthly Joint Operating Committee (JOC) meeting, describing the benefits of the initiative for

the group's Medicaid Enrollees, the financial incentives it could receive for closing care needs, and the support WellCare of Kentucky would provide to help them succeed.

a. Provider engagement at local, regional, and statewide levels

Supporting the initiative at the local level are WellCare's Provider Relations (PR) Representative Scott Smith and Quality Practice Adviser (QPA) Johnnie Keaton, RN. PR Representatives serve as the primary point of contact for network providers. QPAs help educate providers to improve quality measures and data capture, share best practices, and provide cost-efficient care. Working out of our Hazard, Kentucky office, Scott and Johnnie meet with practitioners at each of the provider group's four locations on a monthly basis.

Our local teams have a regular reporting and communication structure that moves from local to regional to statewide visibility. Scott reports Brandon Cornett, one of the three regional PR Managers working under Provider Services Manager Anthony Piagentini, who leads the statewide Provider Relations team. Johnnie reports to Quality Manager Sharon Hall, one of the three regional Quality Managers who work under statewide Quality Improvement Director Laura Betten. This structure maximizes local decision making, reveals trends at a regional or state level and allows for the deployment of resources to happen at the appropriate level when problems occur. It empowers local or regional staff to make decisions and solve problems but if issues are beyond their control, leadership are quickly engaged to deploy resources to create solutions.

Mr. Piagentini and Ms. Betten meet on a bi-weekly basis to discuss ongoing provider quality initiatives. On a monthly basis, the PR and Quality leadership collaborate on our P360 providers. P360 providers have large memberships or have ongoing initiatives like this that we are monitoring closely. These P360 meetings start with regional meetings with our PR and Quality Managers on a more local level and then roll up to a statewide conversation with Quality and PR leadership to ensure there is oversight from each level of the organization.

b. Provider education, communications, and support

The success of the initiative is critically dependent on active communication with providers, including sharing data with providers and educating providers on operational best practices. As the QPA for the program group's practitioners, Johnnie regularly communicates with providers at their offices to review quality measures and clinical practice guidelines, provide toolkits that support ongoing quality improvement activities, and share reports that track progress toward the initiative goals at the location and individual provider level, allowing each location to understand their performance and identify where improvement opportunities exist. Some of the customized reports developed for this initiative include a Behavioral Health Gaps in Care report, Social Determinants report, BMI report, Pre-Diabetes report, and Tobacco Cessation report. These reports, which are also available on the provider portal, offer the providers actionable information as they track progress toward program goals.

Regular communication and support for the initiative also occurs at the provider group level. WellCare holds a monthly JOC meeting with the provider group's leadership including the Program Administrator to review comprehensive performance metrics and mutually identify opportunities to improve the overall success of the partnership. WellCare representatives at

the JOC meeting include Provider Relations manager Brandon Cornett, Quality Manager Sharon Hall, Senior Project Manager Johnnie Akers, Pharmacy Manager Ayonna Talbert, Scott Smith and Johnnie Keaton. During the JOC meeting, summary reports that identify patterns by provider, by locations and by a provider at a specific location track progress toward the goals of the initiative. In addition, participants can ask questions and describe challenges involved in implementing the initiative; WellCare can incorporate feedback and improve support to the provider group in meeting incentive targets.

Addressing the Administrator's Concerns. It is at the monthly JOC meeting where the Program Administrator alerts Brandon and Sharon about some concerns the provider group is having. These include lack of provider engagement due to administrative burden; lower than anticipated Enrollee engagement; difficulties with EHR implementation and information exchange with KHIE; difficulty reaching out to a community housing agency that WellCare had indicated was interested supporting the initiative; concerns about the timeliness of feedback on reports submitted to WellCare; and concerns about the timeframe for incentive payments. Upon hearing these concerns, WellCare of Kentucky representatives at the local, regional and statewide levels take action to address these concerns and support the provider group in achieving success in the initiative.

c. Simplification of provider administrative burden

EHR Implementation and data exchange. Although the provider group does receive Admit Discharge Transfer (ADT) messages from its two area hospitals, Southeastern Kentucky Medical Center and Baptist Health, they are experiencing issues with their new electronic health record (EHR) system and they do not plan to contribute or retrieve information from KHIE until the EHR issues are resolved. To address the issue, Brandon and Sharon engage WellCare's Practice Transformation Specialist, whose role at WellCare is to assist practices in overcoming obstacles like EHR adoption that may prevent them from participating successfully in incentive-based quality initiatives. After an initial introduction to discuss the problem, Johnnie and the Provider Transformation Specialist work with the provider group to set up a process which would facilitate automated submission of EHR data between the group's provider locations and WellCare using a WellCare-formatted eMR “flat file”, enabling WellCare to gather quality measure data with no additional administrative burden on the part of the providers once the connection was set up. WellCare of Kentucky has also committed $2,000 to any practice to assist in EHR implementation. We offer to use this and explore other grants to bring needed financial resources to the practice resulting in proper EHR deployment so they can fully connect with KHIE.

As an additional interim workaround for exchanging data with WellCare, we offer the practices our Electronic Data Submission program, in which data is not required to be submitted in WellCare’s structured flat file format but in the file format of the practice’s choosing, including a file layout that is sent to other payers. We then work to ensure that the data exchange is established and that the administrative burden on the provider to report quality measures is minimized.

Varying Levels of Practitioner Engagement. Another concern the Program Administrator has brought up at the JOC is that some its practitioners are less engaged with the initiative, finding

it administratively burdensome as they are also participating in similar quality initiatives with other MCOs but with different required quality measures. Brandon and Sharon offer to set up a meeting with Provider Services Manager Anthony Piagentini and Quality Improvement Director Laura Betten to discuss with them how WellCare can modify the initiative to make it less burdensome for the provider group. At the meeting, Mr. Piagentini and Ms. Betten ask about what measures are being tracked in the provider group's similar quality initiatives with other MCOs and discuss if there are opportunities for alignment. They explain that while substantive changes would impact the desired outcomes, WellCare can be flexible on the implementation if that would increase compliance and the chances for successful outcomes. They offer to make some operational adjustments to the program to better align with their market experience if that would ease the burden of participation without sacrificing the overall goals of the initiative.

At the state level, Mr. Piagentini has the ability to work through the Managed Care Trade Association or through the practice executive leadership to recommend more substantive changes such as a re-examination of the data gathering process to better align with other MCOs so the practitioners have an easier time complying with the requirements. This commitment to industry collaboration extends through our leadership team and into the Department.

d. Enrollee engagement

Lower than Anticipated Enrollee Engagement. During the JOC meeting, the provider group's Program Administrator alerts the WellCare team that Enrollee compliance has been lower than anticipated, and that follow up and other outreach had been difficult due to Enrollees not returning calls and also incorrect Enrollee contact information. To address his concerns, Sharon offers the assistance of our Field-based Outreach Coordinators (FOCs) who begin reaching out to these Enrollees. The FOCs attempt to contact Enrollees by calling each of the phone numbers in the Enrollee's files. They also call home health agencies, pharmacies, discharge stations in hospitals, billing departments and any provider associated with the Enrollee to locate a viable phone number. In addition, we have a contract with the Commonwealth to use the KHIE tool through the state files without having to wait for it to be uploaded in our system.

Enrollees we are still unable to engage through the FOCs are reported to Brittany Triest, one of our non-clinical Enrollee Outreach Coordinators (EOCs) who works in the area. Our EOCs are frontline community health workers who live in the community and serve as liaison between the Enrollee, WellCare and the social and medical entities. As an EOC, Brittany leverages her relationships with local pharmacies, durable medical equipment (DME) suppliers and other community resources to obtain correct contact information for these hard-to-reach Enrollees and then establish a trusting relationship with them. From there she engages the Enrollees and facilitates a visit for them with their PCP and ensure they make it the provider's office.

Once at the office, providers participating in the initiative can connect Enrollees to programs and services that support the health behaviors they are seeking to change. Scott and Johnnie have facilitated this effort to engage Enrollees by educating providers about these programs through our **Community Connections** model, which was developed specifically for the WellCare of Kentucky in 2011 to effectively and systematically address unmet social needs that impact the health of our Enrollees. It features our **Community Connections Help Line (CCHL)**, a social

service referral telephone line that connects Enrollees and the community-at-large to community resources to address unmet social needs. We have four call centers nationally, with one located in Hazard. The model also features Community Engagement Partners who work with social resource organizations to address social barriers and support safety net infrastructure.

Scott and Johnnie also connect the providers with WellCare's Community Connections local Community Engagement Partner, Cortney Caudill, who assists them in making connections with community agencies who can support their efforts to meet targeted improvements of the incentive program. To support quality measures associated with BMI, nutritional intervention and reassessment, they refer Enrollees to the **University of Kentucky Cooperative Extension's Family & Consumer Sciences** Agents Rebecca Miller and Danielle Barret in Bell and Knox Counties, respectively. Enrollees can be placed in their monthly Lunch & Learn programs where families cook together and get tips that make cooking fast, healthy, and affordable. There they receive recipes, share shopping trips, and if in Knox County can shop at the **Knox County Farmer's Market**. Families qualifying for the **Kentucky Double Dollars Program** can double their SNAP benefits when buying produce, reducing the barrier of cost associated with fresh fruits and vegetables. In Bell County, Enrollees can utilize **Lighthouse Mission Center** for access to a monthly food box from their pantry.

To support **pre-diabetes intervention and reassessment**, Enrollees are referred to **Kentucky Homeplace (KHP)**, which provides no-cost Chronic Disease Self-Management (CDSMP) and Diabetes Self-Management (DSMP) health coaching to their clients in 30 counties in Eastern Kentucky. WellCare entered into a data-sharing agreement with KHP to identify WellCare clients who participated in their health coaching and classes and has provided $28,150 in funding for operational costs and so program participants could receive gift cards to help offset the cost of transportation across the 30 participating counties in Eastern Kentucky. Through this collaboration, WellCare and KHP removed social barriers and increased participation in the Stanford Model of CDSMP and DSMP health education for Enrollees and the broader community through a network of CHWs. Between 2016 and 2018, 1,903 WellCare Enrollees received 9,066 total services. There was a 16.4% reduction in ER visits, a 28.9% reduction in inpatient admissions, and a 31.5% reduction in inpatient days for Enrollees with diabetes.

To support **tobacco assessment and intervention**, Enrollees are referred to our **Tobacco cessation program.** In this program, Optum health coaches telephonically manage Enrollees by coaching and educating them to make lifestyle behavior modifications. During coaching sessions, Enrollees receive encouragement, problem-solving techniques, relapse prevention strategies, and a smoking cessation toolkit to reinforce training sessions and coaching calls. All enrollees can receive tobacco cessation counseling and pharmacotherapy.

In order to support Enrollees who may need assistance with doctors' appointments or accessing any of these community services, WellCare has funded a **"Healthy Stops Program"** in Knox County that allows any Knox County resident free transportation that is non-billable which includes, but is not limited to, doctor appointments, mental health assessments, dentist, food pantry, employment, and child care.

Housing Agency Unresponsive. Housing is another key concern in Knox and Bell counties and one of the social supports that affects health behaviors. Having heard that the provider group's Program Administrator was having difficulty contacting a community housing agency in the area, Cortney calls and then personally visits the agency's office to see why they haven't responded. When they are unable to assist, Courtney, who is familiar with all of the housing support agencies in the Knox and Bell County areas, will work with the others in the area who are ready to assist. Cortney will also connect with the Housing Authority in both Bell and Knox Counties so Community Connections has the most updated information about their services and their correct contact. Cortney can then ensure the provider has this information and make an introduction. Cortney will also connect the provider group with Jerry Lambdin, Director of Mission Outreach, at **Henderson Settlement** in Bell County who offers housing repair.

e. Vendor assessment of internal operation challenges and mitigation strategies

Concerns over Communication and Responsiveness. As soon as Brandon is made aware of the delay in receiving feedback on the provider group's initial submitted reports, he escalates the issue to Mr. Piagentini. Brandon also ensures that the Administrator is aware that he always has the ability to contact any level of WellCare leadership including the Chief Executive Officer William Jones at any time. WellCare leadership regularly give out their contact information including at Provider Summits because it is our philosophy that it is everyone's role to help support providers in the field.

With the understanding that the provider's concern is about reporting, Mr. Piagentini escalates the issue to Ms. Betten, who involves Shannon Johnston, Business Technical Analyst, to troubleshoot the issue. If Shannon is able to address the issue, he is empowered to solve the problem with the provider as soon as possible. If he requires support from the WellCare of Kentucky or the WellCare corporate team, he is empowered to coordinate additional support or solicit help from his leadership until the proper people are involved who can solve the problem. Leadership is structured to break down barriers for associates to help them solve problems more independently. They are not designed as an impediment to rapid problem resolution. After the solution is reached, James Smith from Provider Relations coordinates a meeting with the provider group to include the appropriate WellCare Subject Matter Experts. The purpose of the call is to resolve the problem with the provider and explain the changes we have implemented to fix this permanently.

Our Provider Relations team uses a variety of formal and informal methods to assess internal operations and improve when there are identified problems. The formal assessments are done via bi-weekly staff meetings and bi-weekly one-on-one meetings between the Provider Relations management staff and Mr. Piagentini. Both formal venues include a standing agenda item to review existing and escalating issues. As they are brought up, the management team collaborates to define the next steps and solution to the problem. If additional resources are required, Mr. Piagentini and his management team then set follow-up discussions with WellCare of Kentucky or corporate leadership such as our Quality, Operations or Claims teams to help solve the problem.

In the WellCare of Kentucky operations team, tracking reports capture these escalated issues which are reported out to leadership at least monthly. This provides a defined method from

issue to resolution where all operational challenges can find the right team to resolve while leadership is tracking and reporting on the progress of the problem. This monthly reporting is distributed to the Provider Relations team so they are aware of the current status of all operating problems.

Timeframe for Incentivizing Providers. In response to concerns over the extended timeframe for receiving the first incentive payments and the ability to impact providers' behaviors, Mr. Piagentini and Ms. Betten meet personally with the provider group's executive leadership to discuss the initiative. At the meeting, they offer to extend the timeframe by six months so that the providers have adequate time with the appropriate reports to achieve the goals and incentive payments. Additionally, they offer to move the first payment up by six months to encourage the group's practitioners to stay engaged.

D.

Implementation Plan

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D. IMPLEMENTATION PLAN

1. Describe the Vendor's proposed approach to support the readiness review process, and include the following information:
    a. **A proposed Program Implementation Plan beginning from Contract Execution through ninety (90) days post go live, including elements set forth in the Contract, such as:**
        i. Establishing an office location and call centers.
        ii. Provider recruitment activities.
        iii. Staff hiring and a training plan.
        iv. Developing all required materials.
        v. Establishing interfaces to other Information Systems operated by Subcontractors, the Department, or others as required.
    b. **Proposed staffing to support implementation activities and readiness reviews.**
    c. **An overview of system operational implementation requirements and related milestones.**
    d. **Required MCO, Department, and other resources to ensure readiness.**
2. Describe potential limitations or risks that the Vendor has identified that may impact planning and readiness, and indicate the Vendor's proposed strategies to address those limitations and risks. Include examples of similar situations the Vendor has encountered with prior readiness planning and resulting solutions.

D. IMPLEMENTATION PLAN

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

Since 2011, WellCare of Kentucky has collaborated with the Kentucky Department for Medicaid Services (the Department) as a managed care partner to strengthen and enhance achievement its goals for the Medicaid managed care system. Together, we have focused on and implemented initiatives and programs to better coordinate and integrate quality care for Enrollees in Contract-specified populations throughout the Commonwealth. The driving force behind these innovative initiatives and programs has been our willingness to partner with Commonwealth staff, our providers, and community-based organizations to empower and encourage Kentucky Enrollees to take an active role in their own health, make informed decisions about their health care, and close their care needs, ultimately leading to improved health outcomes.

Over the past eight years, our leadership staff and subject matter experts have worked with the Department to continually enhance its Medicaid managed care system to improve care for populations with chronic and complex conditions, align payment incentives with quality goals,

and drive quality care to improve health outcomes. We have successfully completed and passed all required readiness reviews for the Kentucky Medicaid Managed Care Contract. Our Kentucky Medicaid leadership team comprises thought leaders with significant managed care and Kentucky Medicaid expertise, including several who have played pivotal roles in prior readiness review activities. We plan to continue to build upon our existing expertise to support the readiness review process for the new Contract rebid. Examples of our prior successful implementations in Kentucky include:

2011 Kentucky Medicaid Managed Care Contract: Managed care was launched in Kentucky in 2011. The original Contract for the managed care program was awarded July 2011 for all regions within the state except Region 3. The project go-live date was November 1, 2011. Despite an aggressive four-month implementation period (and the first time the Commonwealth had implemented statewide managed care program), WellCare of Kentucky successfully passed all readiness requirements, with no corrective actions, prior to beginning operations.

WellCare of Kentucky received from the Department of Medicaid Services on December 21, 2012 the following note of appreciation for a successful readiness review:

> "I wanted to take this opportunity to congratulate and thank all of the WellCare staff that worked so hard to make the readiness review process successful. All of the documentation has been received and sent to CMS for their approval. I look forward to the year ahead and hope that we can work together to make managed care and WellCare a success story in Kentucky. Thanks for your continued support."
>
> – CINDY ARFLACK, DEPARTMENT OF MEDICAID SERVICES, MANAGED CARE OVERSIGHT BRANCH

2013 Kentucky Medicaid Managed Care Statewide Contract and Medicaid Expansion: In 2013, the Commonwealth moved to a statewide Contract that included Region 3 and added a new eligibility category, Medicaid Expansion Enrollees. This Contract was awarded October 2013, bringing both the Region 3 membership as well as the Medicaid Expansion Enrollees onboard for a January 1, 2014 go-live. WellCare of Kentucky successfully passed the readiness review, also with no corrective actions, prior to the launch of these programs. This Contract more than doubled our expansion enrollment, from approximately 45,000 to 100,000 Medicaid Expansion Enrollees, within six months of the program's launch. This successful transition to the new Contract provides evidence of our adaptability to a new regulatory environment and our ability to make quick business rule changes to accommodate new regulatory guidance and new programs. Today we serve 143,500 Medicaid Expansion Enrollees.

2015 Kentucky Medicaid Managed Care Contract Rebid: In 2015, the Commonwealth issued a renewal Contract, which was awarded in July 2015 with a go-live of November 2015. We addressed operational changes disclosed within the renewal contract. This necessitated swift operational changes, including the implementation of new privacy and security provisions, a new policy that prohibited offshoring of subcontracted functions, and new behavioral health medical necessity criteria. Despite the three-month implementation timeframe, WellCare of Kentucky implemented all changes timely and seamlessly, continuing to serve our Enrollees. Operations continued without disruption.

2020 Kentucky Medicaid Managed Care Rebid: Based upon the current solicitation documents, the Commonwealth expects to award the Managed Care Contracts Spring 2020 with a go-live date of January 1, 2021. As with our prior launches, we will conduct the 2020 Kentucky Medicaid Managed Care Contract Rebid Implementation in the same professional and thorough manner as our previous Kentucky implementations, applying all of our experiences, lessons learned, and best practices, which we have acquired and adopted.

WellCare of Kentucky has successfully completed four separate Medicaid program implementations in Kentucky since 2011. Each of these implementations was achieved as a joint effort between our accountable Kentucky leadership team working collaboratively with our enterprise Shared Services team.

WELLCARE IMPLEMENTATION EXPERIENCE

WellCare Health Plans, Inc. (WellCare) nationally has successfully completed and passed every Managed Care Contract readiness review since 2009. On a national level, WellCare transitioned more than 1,880,000 Enrollees on managed care contracts over the last eight years, as illustrated in **Figure D-1**, which presents the timeline, program and size of our most recent implementations.

WELLCARE IMPLEMENTATION EXPERIENCE

The total is more than **1,880,000** members over 10 years.

Implementation Description	2019	2018	2017	2016	2015	2014	2013	2012	Pre 2012	Number of members Transitioned
WellCare Transition of Florida children with special healthcare needs, including foster care, to our statewide Children's Medical Services (CMS) Health Plan	✓									68,000 members
Staywell Transition of Florida Medicaid members, including the SMI and LTSS populations	✓									78,000 members
Harmony Health Plan Statewide Medicaid expansion into all Illinois counties		✓								190,000 members
Care 1st Health Plan Arizona Transition of Arizona members		✓								100,000 members
Missouri Care Statewide expansion of Medicaid managed care into all 115 counties			✓							179,000 members
WellCare of Nebraska Statewide implementation of Medicaid managed care for Heritage Health			✓							70,000 members
WellCare of South Carolina Transition of Medicaid members from Advicare Corp.				✓						30,000 members
WellCare of New York Statewide carve-in of behavioral health services for adult Medicaid members				✓	✓					71,000 members
WellCare of New Jersey Transition of 46k Healthfirst members & implementation of LTSS program						✓				46,000 members
Staywell Transition of Florida Medicaid members from FFS due to mandated managed care						✓				394,000 members
WellCare of Kentucky Transition of 43k members due to realignment of MCOs (open enrollment): enrollment of 28k members (Reg 3 expansion)							✓	✓		71,000 members
WellCare of Kentucky Transition of members due to realignment of MCOs							✓			63,000 members
`Ohana Health Plan Statewide implementation of the Hawaii QExA, QUEST and CCS programs								✓	✓	30,000 members
WellCare of Georgia Transition of Medicaid members									✓	490,000 members

Figure D-1. WellCare implementation experience

WELLCARE OF KENTUCKY ORGANIZATIONAL STRUCTURE

WellCare of Kentucky's locally based transition team, led by Chief Executive Officer William (Bill) Jones and Chief Operating Officer Benjamin (Ben) Orris, assumes overall responsibility for the Kentucky Implementation Plan activities and readiness review requirements. They lead the WellCare of Kentucky Program Steering Committee, Program Leadership, Program Management, along with other dedicated resources across the organization and assigned to the Kentucky Implementation.

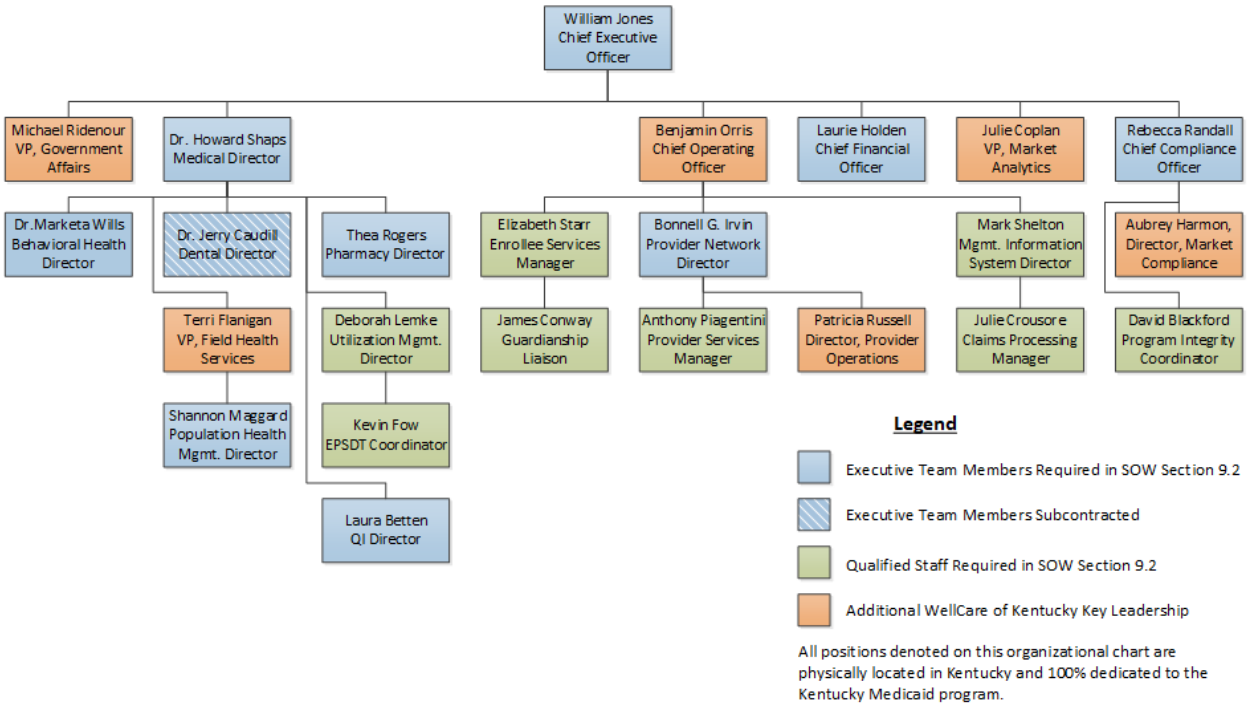

Figure D-2. WellCare of Kentucky Organizational Structure

1. Describe the Vendor's proposed approach to support the readiness review process, and include the following information:

Our approach to implementation and readiness review calls for an alignment of dedicated resources across the WellCare organization and includes the existing WellCare of Kentucky leadership team, our Project Management Office (PMO), and Business Area Teams. The existing WellCare of Kentucky Team, staffed as part of current operations, will continue to conduct normal business operations for the existing Kentucky Medicaid Managed Care Contract. In addition, they serve as the subject matter experts and stewards for the new Medicaid Managed Care Contract implementation and requirements.

Upon Contract award, our primary focus to align expectations around project meetings, 30, 60, 90, and 120-day deliverables, key milestone dates, and requirements. As documented in the Project Initiation section of the Implementation Plan, we assign a dedicated Project Management Team, including a dedicated Readiness Manager responsible for all readiness review activities. The Readiness Manager works hand-in-hand with the Kentucky PMO, in close

collaboration with the Department's Readiness Team, and in unison with our Compliance and Regulatory Affairs Team to usher policies and procedures and other deliverables through the Department's review and approval process. Our Readiness Manager provides oversight for the overall readiness review process and is in direct contact with our Business Owners and Business Leads for required updates and revisions to policies and procedures and other deliverables, as well as requirements and evidence for Desk Readiness and the Onsite Readiness Review.

Other Project Initiation activities include engaging with business leads and subject matter experts from each of our business areas to conduct a GAP requirements assessment of the overall Medicaid Managed Care Contract and Appendices, and document any important information about each of the requirements and assign business owners for accountability. All GAP Assessment findings serve as input to the final and baselined Implementation Plan.

Our draft Implementation Plan is based on the Procurement Milestone dates in **Table D-1**.

Table D-1 Implementation Plan Procurement Milestones

Procurement Milestones	Start Date	Finish Date
Kentucky Request for Proposal Posted	1/10/2020	1/10/2020
Kentucky Proposal Response Submission	2/7/2020	2/7/2020
Kentucky Contract Award Date	Spring 2020	Spring 2020
Kentucky Readiness Review - Anticipated	7/1/2020	10/1/2020
Kentucky Project Go-Live Date	1/1/2021	1/1/2021
Kentucky Post Go-Live + 90-Days	1/1/2021	4/1/2021

Our PMO meets at least weekly with our business area teams to collaborate on project activities, risks, issues, action items, and updates to the Implementation Plan. This information is provided to our Kentucky Program Leadership Team, which meets weekly to review the overarching project status, review weekly synopsis for project status updates, and serve as the key liaison(s) with the Department. Our Program Steering Committee meet weekly to provide executive program oversight, make needed decisions, remove roadblocks, and resolve escalations.

a. A proposed Program Implementation Plan beginning from Contract Execution through ninety (90) days post go live, including elements set forth in the Contract, such as:

i. Establishing an office location and call centers.
ii. Provider recruitment activities.
iii. Staff hiring and a training plan.
iv. Developing all required materials.
v. Establishing interfaces to other Information Systems operated by Subcontractors, the Department, or others as required.

WellCare of Kentucky's Implementation Plan supports the successful implementation of all the requirements outlined in the Request for Proposal (RFP) and the Medicaid Managed Care Contract. This draft Implementation Plan was developed by WellCare's Business Owners and Business Leads, also referred to as the Implementation Plan Oversight Team, as described later in this section.

The implementation plan is included as **Attachment D WellCare of Kentucky's Implementation Plan.**

We organized the Kentucky Implementation Plan by business areas. For each of these functional areas, we have detailed project plans, which roll-up into one cohesive master Implementation Plan. WellCare of Kentucky's Implementation Plan business areas are:

- Project Initiation
- Readiness Review
- Facilities
  - Evaluate existing office locations and call center/customer service facility
- Human Resources
  - Staff recruiting, hiring, and onboarding
  - Training plan development and delivery for external partners and key stakeholders
- Finance
- Information Technology and Reporting (included establishing interfaces to other Information Systems operated by Subcontractors, the Department, or others as required)
- Product
- Provider Operations
- Channel Communications, including development of all required materials
- Eligibility & Enrollment
- Stakeholder Engagement
- Population Health
- Network, includes provider recruitment activities
- Pharmacy
- Compliance and Regulatory
- Quality and Analytics
- Legal

- Project Go-Live

Our Implementation Plan is validated by readiness review, where all the activities and teams come together to demonstrate our services and solutions to the Commonwealth of Kentucky. We will submit the final Implementation Plan at Contract award or as otherwise specified by the Department.

b. Proposed staffing to support implementation activities and readiness reviews.

As stated above, we align staffing and assign a dedicated PMO Project Team, which includes a dedicated PMO readiness manager who oversees all readiness review activities. Our existing WellCare of Kentucky team, staffed as part of our current operations, will continue to conduct normal business operations for the existing Kentucky Medicaid Managed Care Contract. In addition they serve as the subject matter experts and stewards for the new Medicaid Managed Care Contract implementation and requirements.

Project Initiation activities include identifying the appropriate staff from each of our business areas to support the overall implementation. We refer to these staff as our Implementation Plan Oversight Team. This team is accountable for day-to-day implementation and readiness review activities and for providing weekly status reports to the Kentucky Program Leadership Team and Program Steering Committee. The Kentucky PMO PM coordinates all the activities of the Implementation Plan working closely with our Implementation Plan Oversight Team. Refer to **Table D-2** for the WellCare of Kentucky Implementation Plan Oversight Team.

Table D-2 WellCare of Kentucky Implementation Plan Oversight Team

Business Area	Business Owner	Business Lead
Overall Implementation plan	Ben Orris/Angela Flynn	PMO PM
Project Initiation	Paulo Vieira	PMO PM
Readiness Review	Paulo Vieira	PMO PM
Human Resources	Ray McComb	Allison Porter
Facilities	Alex Valdes	Shane Mihok
Finance	Jeff Skobel	Laura Holden
Information Technology & Regulatory Reports	Bob Klopotek	Rhonda Mitchell
Product	Felicia Thomas	Deanna Creamer
Provider Operations	Jessica White	Talena Jones
Channel Communications	Terrence Southward	David Dawkins
Marketing	Cindy Hatcher	Brandon Lau

Business Area	Business Owner	Business Lead
Community Engagement & Unmet Social Needs	Emmalee Ericksen	Elizabeth Starr
Quality & Analytics	Laura Betten	Rebecca Carpenter
Population Health Services	Terri Flanigan	Shannon Maggard
Network	Bonnell Irvin	Candice Bowen
Pharmacy	Bill Davies	Thea Rogers
Compliance and Regulatory	Rebecca Randall	Aubrey Harmon
Legal	Greg Stiefvater	Nina Ruparel

c. An overview of system operational implementation requirements and related milestones.

We include system operational implementation requirements in the overall implementation plan managed and maintained by the PMO to ensure independent oversight and alignment with the large scope of the enterprise activities and DMS's objectives and timelines. We will also dedicate a Project Manager located in Kentucky to liaison with DMS and other stakeholders (e.g., other MCOs, Department of Juvenile Justice, Department of Community Based Services, etc.) to ensure coordination activities are monitored closely by someone intimately familiar with the Commonwealth's needs.

As part of the process of submitting our RFP response, WellCare of Kentucky has identified the draft list of system operational implementation requirements and expectations, including the identification of any system modifications and interface development anticipated to be necessary to support the Contract requirements and effectively meet the needs of our Enrollee and provider community. The proper planning for any necessary funding and resource commitments, occurs prior to Contract award to ensure WellCare of Kentucky's ability to begin execution of these activities immediately upon award.

We will also maintain the Business Owners and Business Leads in **Table D-2** above during all stages of the implementation to service as our operational subject matter experts and stewards for the new Medicaid Managed Care Contract implementation and requirements.

High-level system operational requirements and the currently projected milestones are outlined in **Table D-3**. This list of requirements and associated milestones is further reviewed, refined, and incorporated into the PMO implementation plan upon Contract reward.

Table D-3 High Level System Operational Requirements and Milestones

System Operational Implementation Milestones	Number of Days
Initial identification of new interfaces and system requirements	28

System Operational Implementation Milestones	Number of Days
Internal review, communication and validation of requirements, funding and commitment	60
Development, testing, and validation of any new interface and system requirements	180
Review of production system capacity requirements and implementation of any required enhancements and upgrades	90
Establishment of System Readiness Review environment	60
Deployment of changes and validation of Readiness Review environment	14
System Readiness Review activities	60

d. Required MCO, Department, and other resources to ensure readiness.

Our implementation and readiness review activities do not happen in a silo and affect every aspect of the project, including processes, procedures, technology, and resources collaborating together. Successful implementations require coordination with other MCOs, the Department, and other State agencies, such as the Department for Behavioral Health, Developmental and Intellectual Disabilities, the Department for Community Based Services, and the Cabinet for Health and Family Services' independent ombudsman program.

For example, when we prepared for the anticipated July 1, 2018 Kentucky HEALTH Implementation, we actively engaged in Kentucky HEALTH implementation meetings with the Department and other MCOs. Director of Market Analysis Robin Rhea was an active participant and leader in those implementation meetings.

Similarly, we engage with the Department and with other MCOs to ensure a smooth transition and continuity of care for Enrollees newly assigned to WellCare of Kentucky from other MCOs. This includes outreach to a relinquishing MCO's care coordinator for our transitioning Enrollee to secure copies of the Enrollee's care plan and to arrange the Enrollee's transition of care.

2. Describe potential limitations or risks that the Vendor has identified that may impact planning and readiness, and indicate the Vendor's proposed strategies to address those limitations and risks. Include examples of similar situations the Vendor has encountered with prior readiness planning and resulting solutions.

The PMO identifies and discusses risks, issues and action items as part of all of our weekly meetings, and documents these items into the project RAID log. Risk items are shown on all of our project dashboards and status reports.

We follow a standard five-step approach to risk management, as shown in **Figure D-3**.

Figure D-3: Risk Management Steps

Risk Identification: When risks are identified they are documented in our Kentucky Project RAID log

Risk Evaluation: We analyze each risk for probability and potential impact to the implementation and add a priority ranking

Risk Mitigation: Our project team works together to determine the mitigation strategy

Risk Contingency: The project team determines contingencies where needed

Risk Communication: Risks are an integral part of our weekly Executive Leadership Team meeting and status report, our Steering Committee Meeting and status report, and our work stream team meetings and status reporting to ensure effective communication, timely project delivery, issue resolution, scope control, and escalation to appropriate parties when necessary.

POTENTIAL LIMITATIONS OR RISKS

As a long-term incumbent plan within Kentucky since 2011, we have fully implemented the Kentucky Medicaid Managed Care Contract and already have in place the vast majority of the requirements in the Medicaid Managed Care Contract and Appendices. We have thoroughly reviewed the new Contract and are confident of our ability to implement the new requirements and meet readiness review standards. **Table D-4** contains key new requirements in the new Contract that will impact planning and readiness and our strategy to address them.

Table D-4 Potential Limitations or Risks and Strategy to Address

Potential Limitations or Risks	Strategy to Address
All authorizations or pre-authorizations for treatment of an Enrollee with substance use disorder are now treated as expedited reviews.	We staff to accommodate the new requirement and configure our system to treat these authorizations as an expedited review with a 24-hour response with real-time monitoring reports.
Increased transparency in Utilization Management requirements	All of our Clinical Coverage Guidelines, Claims Policy Guidelines, and Claim Edit Guidelines are available through our website. Currently, our prior authorization requirements are available through our on-line authorization look up tool on our Provider Website. We are currently engaged in a project to enhance our provider web portal to expand the capabilities of our look-up tool. Once completed, we educate providers on this tool through all avenues of provider communication, including in-person

Potential Limitations or Risks	Strategy to Address
	meetings, summits, newsletters, and our Provider Manual.
Provider inquiries responded to within two business days	We assure appropriate staffing to meet these requirements and establish real-time reports to monitor turnaround times.
New Population Health Management program requirements	We build on our local expertise as well as WellCare's national experience with Population Health Management as we implement this new program. Our Population Health programs are in line with NCQA guidelines and will be NCQA Population Health Management certified.

EXAMPLES OF SIMILAR SITUATIONS WE HAVE ENCOUNTERED

WellCare of Kentucky is an experienced managed care partner, as demonstrated by our ability to take on and implement program changes, including new populations, quickly and efficiently with minimal Enrollee and provider abrasion. Examples of our ability to implement new programs or changes quickly and successfully include:

2014 Medicaid Expansion: The Contract was awarded November 1, 2013 and went live January 1, 2014. WellCare of Kentucky accepted 45,000 Medicaid Expansion Enrollees at go live. This number quickly grew to 100,000 within six months and 136,000 by the middle of 2015.

Kentucky HEALTH Readiness: WellCare of Kentucky fully operationalized the Kentucky HEALTH program for an anticipated implementation date of July 1, 2018 when it was delayed by a federal judge on June 30th, the day before go-live. WellCare of Kentucky employees spent the weekend reverting the system to the pre-waiver implementation status with minimal disruption to our Enrollees.

D. Implementation Plan

- Attachment D WellCare of Kentucky's Implementation Plan

WellCare of Kentucky Implementation Plan - Medicaid		
Procurement Milestone Dates	**1/10/2020**	**4/1/2021**
Kentucky RFP Posted	1/10/2020	1/10/2020
Kentucky Proposal Response Submission	2/7/2020	2/7/2020
Kentucky Contract Award	Spring 2020	Spring 2020
Kentucky Readiness Review Period - anticipated	7/1/2020	10/1/2020
Kentucky Project Go-Live Date	1/1/2021	1/1/2021
Kentucky Post Go-Live + 90 Days	1/1/2021	4/1/2021
Project Initiation and Planning	**7/1/2019**	**4/1/2021**
Project Team	8/1/2019	8/15/2019
Project Tools	7/1/2019	8/6/2019
Project Kickoff	12/9/2019	12/9/2019
Project Meetings	8/19/2019	4/1/2021
Implementation Plan Submission to the state	2/6/2020	2/6/2020
Readiness Review	**5/15/2020**	**10/15/2020**
Deliverables Due to the State (30, 60, 90, 120-Day Deliverables - assumes 4/15 award date)	5/15/2020	8/15/2020
Submit 30-Day Deliverables for State Approval	5/15/2020	5/15/2020
PHM Program Plan	5/15/2020	5/15/2020
Program Integrity Plan	5/15/2020	5/15/2020
Staffing Plan	5/15/2020	5/15/2020
Organizational Chart	5/15/2020	5/15/2020
Job Descriptions	5/15/2020	5/15/2020
Provider Network Plan	5/15/2020	5/15/2020
UM Program Description	5/15/2020	5/15/2020
QAPI Program Plan	5/15/2020	5/15/2020
CAHPS Survey	5/15/2020	5/15/2020
Submit 60-Day Deliverables for State Approval	6/15/2020	6/15/2020
Provider Orientation and Education Plan	6/15/2020	6/15/2020
Submit 90-Day Deliverables for State Approval	7/14/2020	7/14/2020
Staff Roster	7/14/2020	7/14/2020
Provider Grievances & Appeals P&P	7/14/2020	7/14/2020
Submit 120-Day Deliverables for State Approval	8/19/2020	8/19/2020
Reporting Requirements & Deliverables	8/19/2020	8/19/2020
Policies & Procedures Due to the State	6/1/2020	6/1/2020
State Readiness Reviews	7/1/2020	10/9/2020
Desk Readiness Review with the State	7/1/2020	7/31/2020
Onsite Readiness Review with the State	9/14/2020	10/1/2020
Readiness Review Approval (Go No-Go Decision)	10/9/2020	10/9/2020
Facilities	**4/15/2020**	**4/15/2020**
KY Office Space - already established	4/15/2020	4/15/2020
KY Office Space Locations (already in place)	4/15/2020	4/15/2020
KY Office Space Contract and Lease (already in place)	4/15/2020	4/15/2020
KY Office Space Physical Infrastructure and Technology (already in place)	4/15/2020	4/15/2020
Human Resources	**11/1/2019**	**9/15/2020**
Staffing	11/1/2019	9/1/2020
Staffing Plan	11/1/2019	5/15/2020
Create requisitions for new positions	11/1/2019	5/31/2020
Recruiting	11/1/2019	5/31/2020
Onboarding and Orientation	4/27/2020	9/1/2020
Training	12/2/2019	9/15/2020
Training Plan	12/2/2019	5/29/2020
General Training Materials	4/20/2020	5/29/2020
Market Training Materials	4/20/2020	5/29/2020
Customer Service Training Materials	4/20/2020	5/29/2020
Population Health Services Training Materials	4/20/2020	5/29/2020
Provider Training Materials	4/20/2020	5/29/2020
Subcontractor Training Materials	4/20/2020	5/29/2020
Conduct Training	8/1/2020	9/15/2020

Marketing	5/4/2020	9/4/2020
Update existing State & corporate Policies and Procedures	5/4/2020	9/4/2020
IT & Reporting	**5/4/2020**	**4/1/2021**
Complete KY HIE Integration (KHIE)	5/4/2020	9/30/2020
Implementation of any unique letters needed for KY	5/4/2020	6/30/2020
Additional feeds to/from the state that need to be loaded into Raw	5/4/2020	9/3/2020
Create Custom Set of Regulatory Reports (22)	5/4/2020	4/1/2021
Product	**5/4/2020**	**9/30/2020**
Product Source of Truth (SOT) Development	5/4/2020	8/4/2020
Create Source of Truth	5/4/2020	7/17/2020
Update Benefit Master List (BML)	5/4/2020	7/31/2020
LOB/Plan Code and Group ID Updates	5/4/2020	8/4/2020
Product Communication	5/4/2020	9/30/2020
Create Benefit Change Memo	5/4/2020	9/30/2020
Update Covered Services/Value-Added Benefit Processes	5/4/2020	9/30/2020
Update Product Value-Added Benefits Vendor(s)	5/4/2020	9/30/2020
Pharmacy	**5/4/2020**	**8/14/2020**
Confirm Network Adequacy	5/4/2020	6/29/2020
Update Pharmacy Lock-In Process	5/4/2020	5/29/2020
Update Pharmacy Provider & Member Materials	5/4/2020	8/14/2020
Pharmacy Review of Website Updates Prior to Go-Live	5/4/2020	5/20/2020
Create/Update Pharmacy Oversight Regulatory Reports	5/4/2020	7/17/2020
Update Pharmacy Policies and Procedures	5/4/2020	7/16/2020
Provider Network	**5/4/2020**	**12/29/2020**
Provider Network Update and Management Plan	5/4/2020	6/26/2020
Update Strategy for Utilization of Urgent Care Clinics	5/4/2020	6/12/2020
Update Strategy to Meet PCMH Access Standards	5/4/2020	6/26/2020
Update Strategy to Meet Specialty Provider Access Standards	5/4/2020	6/26/2020
Confirm required BH Provider Types	5/4/2020	6/12/2020
Update Strategy for Telemedicine Providers	5/4/2020	6/12/2020
Update Strategy for State Hospitals	5/4/2020	6/12/2020
Update Strategy for Substance Abuse Providers	5/4/2020	6/12/2020
Update Pharmacy Provider Network, Pharmacy Access Strategies	5/4/2020	6/26/2020
Identify/Update required Essential Providers	5/4/2020	6/26/2020
Provider Contract, Marketing Materials and Mailing	5/4/2020	5/22/2020
Provider Network Credentialing	5/4/2020	12/29/2020
Update & Upload Provider Network Roster	5/4/2020	7/14/2020
Update Provider Manual and Training Materials	5/4/2020	9/30/2020
Update Provider Engagement and On-Going Communication Materials	5/4/2020	9/30/2020
Provider Operations	**5/4/2020**	**12/31/2020**
Provider Operations	5/4/2020	9/30/2020
Configuration - All Business Units	5/4/2020	9/30/2020
EDI	5/4/2020	9/30/2020
Updates to EDI Provider Packet	5/4/2020	9/30/2020
Updates X-Engine Setup	5/4/2020	9/30/2020
Updates to CIS	5/4/2020	9/30/2020
Updates to Inbound Mailroom processes	5/4/2020	9/30/2020
Updates to Provider Configuration	5/4/2020	9/30/2020
Update Fee Schedules (Fee Schedule Pricing, Interest, Custom Fees)	5/4/2020	9/30/2020
Updates to Benefit Configuration	5/4/2020	9/30/2020
Claims	5/4/2020	9/30/2020
Update Correspondence (Letters, Accounts Payable, Reporting)	5/4/2020	9/30/2020
Claims Workflow Updates (PEGA, SAT, P&Ps, Vendors)	5/4/2020	9/30/2020
Update Prepay Configuration, Customizations, and Provider Notifications	5/4/2020	9/30/2020
Update COB/Recovery/TPL Processes - State Plan	5/4/2020	9/30/2020
Encounters	5/4/2020	9/30/2020
Update Medical Encounters Processes	5/4/2020	9/30/2020
Update Pharmacy Encounters Processes	5/4/2020	9/30/2020
Monitoring	5/4/2020	12/31/2020

Population Health Solutions	5/4/2020	10/30/2020
Identify and Close UM Nurse Gaps	5/4/2020	12/15/2020
Identify and Close UM MD Gaps	5/4/2020	12/15/2020
Implement Utlization Management Committee	5/4/2020	12/15/2020
Implement PHM Program	5/4/2020	12/15/2020
Behavioral Health Network	5/4/2020	12/23/2020
Case Management	5/4/2020	12/15/2020
Quality and Analytics	**5/4/2020**	**11/27/2020**
Update Quality Medical Records Standards - add KY to policy	5/4/2020	6/26/2020
CAHPS Member Satisfaction Survey (CAHPS 2021 Deliverable)	5/4/2020	8/14/2020
NCQA Accreditation	5/4/2020	7/27/2020
Survey Evidence Preparation	5/4/2020	7/27/2020
Survey Submission Date	5/4/2020	5/26/2020
Implement Quality Rating System	5/4/2020	11/27/2020
Update Member and Provider Materials for Kentucky	5/4/2020	9/8/2020
Channel Communications	**5/4/2020**	**10/1/2020**
Close Identified Gaps	5/4/2020	6/11/2020
Update Enrollment Deliverables	5/4/2020	10/1/2020
Update Billing Welcome Letter	5/4/2020	10/1/2020
Update Member Engagement Deliverables	5/4/2020	10/1/2020
Update Core Operations (CTO, ICS, DigiComm, Telecom, Command Center) Deliverables	5/4/2020	10/1/2020
Update Customer Service Quality Processes & Deliverables	5/4/2020	9/18/2020
Update Provider Engagement Materials	5/4/2020	10/1/2020
Update Grievances and Appeals Policies & Procedures	5/4/2020	10/1/2020
Testing/Go-Live Readiness	5/4/2020	10/1/2020
Compliance and Regulatory Affairs	**5/4/2020**	**10/30/2020**
Update SIU/CIU Processes & Program Details	5/4/2020	6/26/2020
Update Delegation Tools with State Requirements	5/4/2020	7/24/2020
Policies and Procedures Compliance	5/4/2020	7/10/2020
Compliance	5/4/2020	9/30/2020
Develop Corrective Action Plan	5/4/2020	9/30/2020
Close Pro-Forma Staffing Gaps	5/4/2020	10/30/2020
Update Security/Privacy Policies	5/4/2020	7/17/2020

E.

Emergency Response and Disaster Recovery Plan

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E. EMERGENCY RESPONSE AND DISASTER RECOVERY PLAN

Describe the Vendor's proposed emergency response and disaster recovery plan, including a summary of how the plan addresses the following areas:

1. **Essential operational functions and responsible staff members;**
2. **Plans to ensure critical functions and continuity of services to Providers and Enrollees will be met;**
3. **Staff training;**
4. **Contingency plans for covering essential operational functions in the event key staff are incapacitated or the primary workplace is unavailable;**
5. **Approach to maintaining data security during an event;**
6. **Communication methods with staff, Subcontractors, other key suppliers, and the Department when normal systems are unavailable; and**
7. **Testing plan.**

E. EMERGENCY RESPONSE AND DISASTER RECOVERY PLAN

Describe the Vendor's proposed emergency response and disaster recovery plan, including a summary of how the plan addresses the following areas:

WellCare of Kentucky will comply with the Department for Medicaid Services' (DMS) expectations and requirements as specified in in Appendix Q Cabinet for Health and Family Services Contractor Security Requirements, Disaster Recovery (DR) Drill Suggestions and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

We have reviewed Appendix Q and confirm our Business Continuity Plan (BCP) and a Disaster Recovery (DR) plan are tested and updated on an annual basis. We understand that the Cabinet for Health and Family Services (CHFS) will be invited to all meetings related to Disaster recovery Drills and that the Commonwealth and CHFS maintains the right to audit at any time without notice. In accordance with requirements, we will submit a customized comprehensive Business Continuity Plan (BCP), Business Impact Analysis (BIA), and DR plan to DMS annually. Our current BIA,BCP, DR plans are included (electronically) as **Attachment E-1 BIA, Attachment E-2 BCP, Attachment E-3 Emergency Preparedness Plan,** and **Attachment E-4 IT Disaster Recovery Plan.** Our comprehensive Business Continuity and Disaster Recovery Plan have ensured service continuity for our enrollees, providers, and state partners for 30 years in 12 states. Hardened data centers in multiple locations (including Florida, Georgia and Michigan), our recovery site in Carlstadt, NJ, and operations across the United States(including Hawaii) give us geographic diversity that we leverage to ensure no single local, statewide, or regional event in Kentucky prevents us from delivering services. Experienced Business Continuity (BC), Disaster Recovery (DR), and Emergency Response teams prepare for threats and disasters, ensuring system availability and minimal disruption of services, regardless of extraordinary events. When requirements, information systems or policies and procedures change we use an integrated

update process. We test our plans at least annually at the corporate and local levels, and collaborate with DMS to make updates to ensure constant emergency readiness. As required in Appendix Q, we will schedule a review of the test of our plans with DMS' team, including security staff.

A key component of our Emergency Preparedness and Disaster Recovery operations is the ongoing monitoring of weather and other potential risks to operations and continuity. Based on the potential scope, timing, and severity of the risk event WellCare is able to take preparatory actions to increase our ability to complete recovery capabilities. As just one example, 3 days prior to the arrival of Irma in Florida, WellCare had already deployed away teams at our Carlstadt, NJ recovery site and staged the recovery failover should it have been required.

Historically we have maintained stable operations in such situations, evidenced by continual, uninterrupted operations through storms over the last two years: Harvey (Texas), Irma (Florida), Lane (Hawaii), and Florence (North Carolina). We are prepared to enact our IT Disaster Recovery plan if necessary, however, we have not had to failover, as our hardened facilities have remained operational.

The viability of our contingency planning and our ability to execute on those plans was demonstrated through real world situations. WellCare of Kentucky works with the Commonwealth to ensure its members receive disaster assistance as well as uninterrupted access to health care services and supplies during natural disasters, as well as other tragic events. Recent examples include:

- In August 2018 WellCare's local Community Engagement Partner met with Jeff Tackett, Community Outreach Coordinator with Water into Wine Food Pantry, a non-profit organization created to help families impacted by tornadoes in Eastern Kentucky. We provided a $5,000.00 grant to Water into Wine to purchase commercial refrigeration to store milk and dairy products. This has also assisted in the storage of fresh fruit and vegetables that are susceptible to a short shelf life.
- In February 2018, WellCare donated $10,000 to Marshall County for long-term counseling and support in the wake of the school shooting that happened at Marshall County High School counseling support where two students were killed and 16 suffered gunshot wounds.

We also leverage the experience of our affiliates in other states. For example, during Hurricane Irma, our Florida affiliate had a dedicated team committed to ensuring Enrollees continuity of care. The transportation team prioritized transportation to critical care appointments including dialysis, chemotherapy, and behavioral health services (i.e., methadone treatment). They met daily during the span of the storm to identify any barriers to securing transportation such as fuel shortages, power outages, and road hazards preventing access, and remediated these barriers and ensured transportation to these critical care appointments were completed, so Enrollees did not have any gaps with their care. During this time, WellCare maintained constant communication with all stakeholders both internal and external. Technology such as the IVR messages and web portal were used to inform stakeholders on the expected delay of services due to emergency. Our Florida affiliate achieved this without any disruption in service and

balanced the work across all locations to ensure that impacted and non-impacted states received the same level of service.

Information System Stability During and After a Disaster Event: Our operational, infrastructure, security and communications environments contain preventive measures to ensure system availability, data integrity and business continuity. The key components of our plan to recover from disaster scenarios include the following:

- WellCare employs a Tier III certified data center that is highly secured utilizing key systems and personnel. The data center includes exterior and floor level biometric security systems and has built in redundancies for power, HVAC (heating, ventilation, and air conditioning), and fire detection and suppression. Additionally, the data center has redundant data connections and a robust switched network to support continuous connectivity.
- WellCare has contracted with Sungard Availability Services to provide recovery services, co-location of key WellCare systems and managed IT Services in the event of a disaster. WellCare has deployed redundant systems at Sungard's state of the art Carlstadt, New Jersey data center and has access to key systems, technology and personnel in the event of an emergency at WellCare's primary location. The data center includes exterior and floor level biometric security systems and has built in redundancies for power, HVAC (heating, ventilation, and air conditioning), and fire detection and suppression. Additionally, the data center has redundant data connections and a robust switched network to support continuous connectivity.
- Leveraging multiple load-balanced servers for our applications, including redundant hardware configurations for network and storage, which prevents individual failures from impacting operations.
- Leveraging virtual servers to enable the staging and rapid deployment of new application instances and fail-over of applications across multiple servers and geographies without production disruption.
- Supporting access to applications through multiple methods, including onsite through user network connectivity, remotely through direct connectivity and remotely through secure Internet access to the central data center to enable ongoing access to production systems.
- Maintaining – and requiring subcontractors to maintain – fail-over connectivity to our primary and recovery data centers to ensure access to production systems whether in primary or recovery locations.
- Actively monitoring weather and news media for natural and man-made events that would threaten the security of our Corporate Data Center or local business operations and responding pre-emptively.
- Cross-training staff and leveraging multiple locations to allow workloads to migrate to trained staff when needed.

1. Essential operational functions and responsible staff members

Every Enrollee and provider-facing department at WellCare has a detailed business impact analysis (BIA) and business continuity plan (BCP) to ensure continuity of services to our Enrollees and providers. In the event of an emergency, our business continuity plan members employ a work from home and work load shifting strategy, engaging our corporate office to ensure continuity of communications and all critical business functions.

- The BIA is an essential component of any business continuity program. The BIA identifies, quantifies and qualifies the business impacts of a loss, disruption or interruption of critical business processes in an organization. In addition, the BIA provides pertinent data from which appropriate continuity and recovery strategies can be determined. Each BIA describes the critical business functions performed within that Business Unit and the resources required to support these processes. Resources include people, systems and applications, vendors, among others. The content of the BIA provides the organization with a tool to fully characterize and correlate these resources.
- Each BCP describes the critical business functions performed within that Business Unit as indicated in their BIA, resources required to support these processes and how to maintain these processes during an emergency event. The content of the BCP provides the organization with a tool to maintain business continuity during an outage.
- WellCare's emergency plans ensure continuity of services to our Enrollees and providers. If there is an impact to our Corporate office:
    - All enrollee service operations can be shifted to other market offices and vendors, and our associates will be working remotely to continue operations.
    - Claims processing can be shifted across multiple on-shore vendors, and associates will be working remotely
    - Appeals and Grievances can be shifted to the California, Florida and Missouri offices, and the vendor, Results.

CALL CENTERS

- The call center volume for Kentucky Enrollees is handled by our back up centers in Columbia, SC, work from home agents in Kentucky, Results in Winter Haven, FL; which provide back up for each other. We also have trained back-up capacity centers in 26 locations across United States to provide temporary support while we investigate the issue and make adjustments to restore the call center to full strength
- Kentucky provider is handled by TelePerformance, Results and C3 at the following sites which provide back up for each other:
    - TelePerformance in Columbia, SC
    - TelePerformance in Augusta, GA
    - TelePerformance in Fort Lauderdale, FL
    - Results in Paris, TX
    - C3 in Tucson, AZ

- WellCare utilizes real time replication along with NetBackup from our Data Domain, employs constant monitoring with various software on all systems and applications, and have appropriate firewalls and security in place.
- Plans are tested at least once a year, via a mock disaster exercise

RESPONSIBLE STAFF MEMBERS

WellCare of Kentucky has identified critical business processes and key personnel, depicted in **Table E-1**, who would be instrumental in ensuring business continuity and a quick recovery of the Business Unit. These associates would be the first responders and responsible for the execution of the recovery activities.

Table E-1: Critical Operational Functions

Critical Operational Functions	Staff Member	Responsibilities
Field Case Management	Terry Flanigan, VP, Field Health Services	Performs outbound Enrollee phone calls to coordinate care and meet their special needs, as well as inpatient hospital discharge planning
Reporting & Analytics	Rebecca Randall, Chief Compliance Officer	Responsible for the completion and submission of all state Regulatory reporting
Network Development	Bonnie Irvin, Provider Network Director	Responsible for providing a network of physicians, pharmacies, hospitals, and other health care providers through whom it provides the items and services included as “Covered Services”
Provider Relations	Tony Piagentini, Provider Services Manager	Responsible for all provider specific and widespread education.
Field Operations	Patricia Russell, Director Provider Operations	Intakes all new/revised provider contracts, load contracts into OmniFlow and store the hardcopy original contracts
Field Health Analytics	Kim Fighter, Director, Strategic Initiatives	Performs state specific functions, such as, create HS&R reports for each hospital in the state, create regulatory reports using SAS and Toad, analyze vendor data, analyze cost trends, pull quarterly

The critical operational functions are backed up by our key personnel who are instrumental in maintaining communication with DMS, associates, Enrollees and providers in the advent of any disaster.

The list below, in **Table E-2**, is in a descending order starting with the Business Unit leader, who would be the person in charge of the Business Unit during an emergency.

Table E-2: Communication Responsibility Table

Key Members	Title	Responsibilities
Bill Jones	Chief Executive Officer	Communicates with all business unit leaders and DMS and CHFS
Benjamin Orris	Chief Operations Officer	Responsible for Business Unit during emergency event. Ensures associates are working from home effectively, works with IT to ensure system access, and facility recovery and readiness point person
Allison Porter	Human Resources Business Partner	Communication to all associates
Bonnie Irvin	Provider Network Director	Manages communications to Department and providers
Aubrey Harmon	Director, Market Compliance Officer	Mitigates compliance risks
Rebecca Randall	Chief Compliance Officer	Manages communications with State Partners

2. Plans to ensure critical functions and continuity of services to Providers and Enrollees will be met

Ensuring minimal disruption to providers and enrollees should a disaster impact our operations is the core tenet of WellCare's extensive emergency preparedness planning. On the business side, functions that would impact services to Providers and Enrollees are accounted for, and alternative approaches are outlined in the Business Impact Analysis (see Attachment E-1 BIA, provided electronically). WellCare's Business Continuity Plan (see Attachment E-2 BCP, provided electronically), details how services will continue during a disaster event, including, but not limited to, the rerouting of calls, implementing remote work options, leveraging corporate resources and manual work-around so that enrollees and providers will always have a way to reach WellCare, and continuity of services is assured. For instance, the plan includes a section on business continuity and work-around solutions for Provider Relations, Case Management and Claims.

All of the business functions are supported by a fully networked Information System that has multiple failovers and back-up systems to ensure system functionality regardless of the situation. Continuity and recovery plans for WellCare's information systems are detailed in our Corporate Emergency Preparedness Plan (See Attachment E-3 Emergency Preparedness Plan, provided electronically), and the IT Disaster Recovery Plan (See Attachment E-4 IT Disaster Recovery Plan, provided electronically).

The Information Technology Disaster Recovery Plan (IT DRP) establishes the WellCare IT data center remote recovery procedure. The plan outlines the procedures to be executed in the event the Corporate Data Center is impaired and information or telecommunications processing capabilities are not available.

WellCare has contracted with Sungard Availability Services to provide recovery services, colocation of key WellCare systems, and managed IT Services in the event of a disaster. WellCare has deployed redundant systems at Sungard's state of the art Carlstadt, New Jersey data center and has access to key systems, technology, and personnel in the event of an emergency at WellCare's primary location. The data center includes exterior and floor level biometric security systems and has built in redundancies for power, HVAC (heating, ventilation and air conditioning), and fire detection and suppression. Additionally, the data center has redundant data connections and a robust switched network to support continuous connectivity. The plan includes procedures to restore IT managed services and information processing infrastructure. Additionally, this document contains procedures to manage activities in preparation of a pre-announced event that will have significant impact to the Corporate Data Center and affecting information or telecommunications processing. The plan addresses events including, but not limited to the following: extended power outage, extended network outage (LAN/WAN), severe data corruption, security threats, environmental disruptions and localized disasters.

The IT DRP is activated per the direction and authority of the WellCare Corporate Emergency Preparedness Committee (EPC) in cooperation with WellCare Information Technology (IT) leadership. The disaster preparation procedures are executed in its entirety or in part depending on the available amount of time leading up to the event. A preparation timeline is provided to show the various steps to be taken prior to the event.

The disaster recovery procedures are executed after the event to restore IT services and information processing infrastructure at a remote data center if the Corporate Data Center is not available. The same steps and procedures are followed regardless of the type of event or if preparation procedures were executed. The recovery procedures identify restoration decision points, criteria, actions, contacts and responsible individuals. These procedures are to be executed by qualified personnel with experience in the respective technology. The scope of this plan includes restoration of information processing capabilities and addresses events that include, but are not limited to:

- Extended Power Outage
- Extended Network Outage (LAN/WAN)
- Catastrophic Data Corruption
- Security Threat
- Localized Disaster

Event Watch procedures are activated approximately 72 hours prior to the anticipated event impact. The following procedures are initiated at the discretion of the IT DR Incident Management Team based on event information from a recognized, official source; i.e., FEMA, National Weather Center and local stations.

- Issue Event Alert: The IT DR Incident Management Team will deem when it is necessary and will Issue an Event Alert to all IT managers and above by any and all means of communications to include Emails, Outlook Calendar, SMS and Voice.

- Alert DR Vendor (SunGard): The IT Infrastructure Management will notify SunGard of an Alert Status.
- Based on the scope, scale and anticipated timing of the event, WellCare will take proactive steps to increase our recovery capability. These steps can include actions such as sending an away team to the recovery site to proactively prepare for the potential need to switch operations to the recovery site, as would be the case of a Hurricane threatening a data center.

REMOTE DATA CENTER RECOVERY PROCEDURES

In the event of a data center interruption, all detailed recovery procedures are stored electronically on the SunGard Recovery portal. The following will be recovered in the following order:

- Validate Network
- Configure DR Host Servers
- Configure/Allocate DR Storage (SAN/NAS)
- Establish Remote DR Citrix Farm
- Build DR Exchange Server
- Verify DR Backup Domain
- Restore Critical System Back-up Images
- Recover and Verify Critical Applications

APPLICATIONS RECOVERY SEQUENCE

WellCare systems are recovered in the following order by the Recovery Time Objective (RTO) and the Maximum Tolerable Period of Disruption (MTPD) as mandated by the Business in the annual update to the Business Impact Assessment (BIA). Refer to the Attachment E-1 BIA for the Tier 1 Mission Critical Applications and the 2015 BIA.

- Timeframe (D= Declaration Point + RTO to MTPD)
- Tier 1 – Timeframe (D+24 to 72hrs) 5.1
  - Customer facing applications
  - Critical ERP systems
  - Vendor facing applications
  - Channel Communications
- Tier 2 – Timeframe (D+ 24 to 96hrs)
  - Surround Applications and Tools;
- Tier 3 – Timeframe (D+ 24 to 120hrs)
  - BI / Reporting
- Tier 4 - Timeframe (D+ 24 to 144hrs)

- Ancillary

3. Staff training

All WellCare associates are provided Emergency Preparedness Training upon hire and at least annually thereafter. The training has a consistent focus on ensuring employees' safety, the continued safeguarding of Protected Health Information (PHI), and the protection of and continuity of care for our enrollees during a disaster. Our Emergency Preparedness Committee (EPC), which is responsible for facilitating an inter-departmental focus on our emergency preparedness, business continuity and disaster recovery planning initiatives and execution, created and maintains our corporate level employee training. Our Emergency Preparedness Training educates all associates on the various methods of protecting WellCare plan and enrollee information during an emergency. The module is designed to provide employees information to facilitate a rapid, coordinated and effective response during any emergency. WellCare supplements these efforts through additional training and information sharing with local employees related to specific local business continuity plans (BCPs) such as alternate sites.

Our employee training emphasizes the protection of **"three Ps"** when responding to any emergency: People, PHI (Protected Health Information) and Production.

PROTECTING PEOPLE: OUR ASSOCIATES ARE TRAINED ON THE FOLLOWING KEY AREAS:

- Associates' responsibilities during an emergency
- Steps to take during a safety incident
- How associates will be notified in the event of an emergency situation, including safety incidents and natural disasters

PROTECTING PHI: THIS MODULE FOCUSES ON METHODS TO SECURE DOCUMENTS CONTAINING PHI DURING AN EMERGENCY. THIS INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:

- Locking computers before leaving the work area
- Securing PHI materials in a locked drawer or having managers assigned to collect PHI/Confidential materials
- Security protocols to handle company laptops while working from a location offsite during an emergency
- Guidelines to protect paper PHI if it needs to be taken offsite during an emergency

PRODUCTION: OUR ASSOCIATES RECEIVE GUIDANCE ON ENSURING ENROLLEES AND PROVIDERS HAVE ACCESS TO CARE AND SERVICES BEFORE, DURING AND AFTER AN EMERGENCY. EVERY BUSINESS UNIT THROUGHOUT WELLCARE PROVIDES BUSINESS CONTINUITY TRAINING TO THEIR STAFF ANNUALLY. AT A MINIMUM TRAINING INCLUDES:

- How to obtain update their emergency contact information via Human Resources
- How to obtain a copy of the associate emergency contact information

- How to execute the Call Tree
- Roles and responsibilities for all associates and specifically the Recovery Team during an emergency
- Typical preparation activities (specific to their business unit)
- Typical actions if there is a loss of facilities (specific to their business unit)
- Typical actions if there is a loss of the data center (specific to their business unit)

4. Contingency plans for covering essential operational functions in the event key staff are incapacitated or the primary workplace is unavailable;

In the event of an emergency where the primary workspace is unavailable, WellCare has a provision that allows associates to work from home or from an alternative/remote location. Many associates are on laptops which provide for secured VPN access to network. Additionally, we have multiple offices around Kentucky that our associates can relocate to, including Owensboro, Louisville, Bowling Green, Lexington, Ashland, and Hazard. If the key employees in Kentucky are incapacitated, the workload will shift to the Tampa (corporate) office or a vendor's site in order to ensure no disruption of services for enrollees, particularly at a time when they may need us most.

As detailed in the attached WellCare Business Continuity Plan (See Attachment E-2 BCP, provided electronically), each business function and designated member of the Business Unit Recovery team are identified. This is critical to ensure all contingencies are in place and can be executed in the event key employees are incapacitated or the primary workplace is unavailable. Very specific steps to be followed for each function at each stage of an emergency are laid out in the plan. For instance, one day prior to an anticipated event such as a hurricane, the plan outlines communication procedures, mobilization and evacuation protocols and reporting responsibilities to business partners, which is then carried out through the event cycle into recovery and resumption of normal business operations.

Additionally, WellCare benefits from the broad reach of WellCare's corporate offices and other local business units, all of which are connected electronically and can step in to assure all essential business functions are operating in the event of an emergency.

WellCare has successfully tested our work from home strategies and the utilization of alternative/remote locations. Our local BCP and BIA are updated annually before the start of each Atlantic hurricane season.

5. Approach to maintaining data security during an event;

WellCare maintains the security and privacy of all sensitive data entrusted to us during and emergency event as all operational, access, and system controls in place for normal operations remain in effect throughout emergency plan execution, beginning at the declaration of an event, through recovery, and including the resumption of standard operations. This includes ensuring the recovery of our security and system monitoring solutions, the ongoing requirement for two-factor authentication, and the use of encryption for data at rest and in

motion (file transmissions and connections). In addition, as part of our all-employee disaster recovery training, we educate our staff on additional security and privacy steps to be taken to ensure with respect to the safe and proper management of PHI.

WellCare has policies and procedures for data replication, data center recovery, business continuity, and records retention to prevent data loss. We backup systems and applications nightly, and store encrypted copies of the data at a secure, remote site vendor location external to any WellCare data center or office location. Operationally, we use data replication capabilities to stream databases in real-time to cold site locations. This minimizes data exposure and accelerates the pace at which our recovery efforts can be initiated. WellCare contracts with Sungard Availability Services to provide recovery services, co-location of key WellCare systems, and to manage IT services when disasters occur. We have deployed redundant systems at Sungard's innovative Carlstadt, New Jersey data center and have access to key systems, technology, and personnel in the event of an emergency at WellCare's primary location. The data center includes exterior and floor level biometric security systems and built-in redundancies for power, HVAC (heating, ventilation, and air conditioning), and fire detection and suppression. It also has redundant data connections and a robust switched network to support continuous connectivity. All detailed recovery procedures are stored electronically on the SunGard Recovery portal at https://www.mysungard.com. The recovery process for those procedures is: 1) validate network, 2) configure DR host servers, 3) configure/allocate DR storage (SAN/NAS), 4) establish remote DR Citrix farm, 5) build DR exchange server, 6) verify DR backup domain, 7) restore critical system back-up images, and 8) recover and verify critical applications and monitoring of production environment.

Each year, as part of ongoing efforts to ensure privacy and security of sensitive information, an independent organization performs HIPAA Risk Assessments, following the National Institute of Standards and Technology (NIST) Risk Assessment guidance in NIST SP 800. We also have been audited for and achieved HITRUST certification. Our approach to privacy and security remains the same when we must invoke our Business Continuity or Data Center Recovery plans.

6. Communication methods with staff, Subcontractors, other key suppliers, and the Department when normal systems are unavailable; and

In case of any safety incidents within our offices or work sites, our associates are notified by a safety coordinator or by alarms within the building. When a safety incident becomes an emergency, or a natural disaster occurs, there are several different ways that associates can gather information on the situation:

ASSOCIATES

- The Emergency Hotline: 1-866-473-9135
- WellCare Link myHR Portal/HR Service Center: available at https://portal.adp.com
- Associate Connect Online
- Workplace/Facebook

- Emails
- Voicemails
- WellCare's Emergency Notification System

DMS, SUBCONTRACTORS, OTHER KEY SUPPLIERS

In the event of an emergency, WellCare of Kentucky will communicate with subcontractors, other suppliers and DMS on a regular basis to keep them informed and updated of the situation via:

- Email
- Phone call
- Posts to our external websites

7. Testing plan.

We employ two strategies to test ours Corporate Emergency Preparedness Plan (EPP):

- Annual table-top exercises are used to evaluate plans and identify possible gaps for remediation
- Annual systems recovery testing before the start of the Atlantic hurricane season

Testing results are documented and presented to the EPC and the EP Steering Committee. In addition, our Internal Audit Department audits the annual testing process and has not noted any significant issues.

On February 16, 2015 WellCare completed a system recovery test, which validated our ability to fully recover a data center loss. This test validated improvements in recovery approaches and solutions that were based on all prior tests, which were also successful. The improved techniques reduced the recovery time significantly (50%) hours from initiation to full validation of all systems. During the 2016 DR test, all 15 core systems tested were recovered successfully and approximately 50% faster than the required recovery time objectives. In 2017, despite increasing the scope, the Recovery Time Objective (maximum acceptable downtime) was reduced from 25 hours to 24 hours and Recovery Point Objective (maximum acceptable data loss) was 30 minutes due to new automation technology and increased planning. In our 2018 test, all systems were successfully recovered and verified well under 24 hours. The improved techniques reduced the recovery time 60% from initiation to full validation of all systems and our recovery point to less than 30 minutes. In 2019 we increased the scope significantly. Despite this increase, the Recovery Time Objective was less than 22 hours and Recovery Point Objective stayed below 30 minutes with all systems successfully recovered and verified. Our IT and EPP teams use these test results to further refine and improve data center recovery capabilities leading to the demonstrated year-over-year improvements.

Our DR Results

2017: Despite increasing the scope, the Recovery Time Objective (maximum acceptable downtown) was reduced from 25 hours (in 2016) to 24 hours and Recovery Point Objective (maximum acceptable data loss) was 30 minutes due to new automation technology and increased planning

2018: All systems were successfully recovered and verified well under 24 hours. The improved techniques reduced the recovery time significantly (60%) from initiation to full validation of all systems and our recovery point to less than 30 minutes.

2019: The scope of the 2019 test was greatly increased from the 2018 Test. Despite the increase, the Recovery Time Objective was less than 22 hours and Recovery Point Objective was less than 30 minutes, and all systems were successfully recovered and verified.

The annual Disaster Recovery Test is based on the known impact of a Category 4 or greater hurricane. The Plan has been designed to handle a worst-case data center interruption, i.e. total destruction of facilities or data center site. In reality, however, data center disruptions occur in varying degrees. Each situation requires careful consideration before a decision can be made regarding disaster qualification. The IT Disaster Recovery Organization is structured so that competent and knowledgeable personnel are placed in the evaluation role. The scope of this plan includes restoration of information processing capabilities, which is validated by independently by the execution of actual test transactions by the appropriate business users from remote locations, just as would be the case in an actual event. To help ensure independent validation of the appropriateness and test activities and results, WellCare's internal audit team observes the annual Data Center Recovery test exercise.

E. Emergency Response & Disaster Recovery

- Attachment E-1 BIA (Provided Electronically)
- Attachment E-2 BCP (Provided Electronically)
- Attachment E-3 Emergency Preparedness Plan (Provided Electronically)
- Attachment E-4 IT Disaster Recovery Plan (Provided Electronically)

F.

Turnover Plan

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F. TURNOVER PLAN

Submit a detailed description of the Vendor's proposed approach to providing turnover planning, as it relates to the Contract resulting from this RFP, in the event of Contract expiration or termination for any reason, including the following:

1. **A summary of the support the Vendor will provide for turnover activities, and required coordination with the Department and/or another Vendor assuming responsibilities.**
2. **Approach to identifying and submitting all documentation, records, files, methodologies, and data necessary for the Department to continue the program.**
3. **Resources and training that the Department or another contractor will need to take over required operations.**
4. **Methods for tracking and reporting turnover results, including documentation of completion of tasks at each step of the turnover.**
5. **Document and verify how all data is securely transferred during a turnover ensuring integrity of same. Maintain the CIA concept in turnover, Confidentiality, Integrity, and Availability.**

F. TURNOVER PLAN

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

To minimize the disruption of services to enrollees and providers, WellCare of Kentucky is committed to partnering with DMS and associated vendors during all stages of the contract, including our obligation to fully support turnover planning in the event of a contract termination. Our primary aims in turnover planning are to minimize any disruption in the delivery of healthcare services to enrollees, minimize any disruption in authorization and payment to our providers contracted during transition to a subsequent contractor, cooperate with DMS and the subsequent vendor in notifying enrollees and providers of the transition, and cooperate with DMS and the subsequent contractor in securely transferring information to the subsequent contractor in the form required by DMS.

Our approach to turnover planning is detailed in the attached sample Turnover Plan, **Attachment F. Sample Turnover Plan**, which outlines all turnover activities, as well as coordination with DMS and the Vendor assuming responsibilities upon contract termination. In compliance with the Commonwealth's requirements and as described below, our Turnover Plan:

- Provides a summary of the support the WellCare will provide for turnover activities, including required coordination with DMS or another Vendor assuming responsibilities
- Describes the activities associated with identifying and submitting all documentation, records, files, methodologies, and data necessary for DMS to continue the program,

including pre-transition data (such as PCP assignments), operational transition data (such as open authorizations, care plans, and benefit accumulators) and historical data (such as encounter history)

- Identifies the Resources and training that DMS or another contractor will need to take over required operations
- Describes the methods for tracking and reporting turnover results, including documentation of completion of tasks at each step of the turnover
- Describes how WellCare will document and verify all data will be securely transferred during a turnover ensuring integrity of same, and acknowledgement that WellCare must maintain the CIA concept in turnover, Confidentiality, Integrity, and Availability.

Our business turnover methodology ensures continuity of operations throughout the duration of runout obligations (as much as 18 months after termination) using the same infrastructure, security, and application solutions in place under the contract to ensure seamless, uninterrupted transition of service to enrollees and our provider network.

1. A summary of the support the Vendor will provide for turnover activities, and required coordination with the Department and/or another Vendor assuming responsibilities.

The scope of our Turnover Plan includes contractual obligations that extend beyond the contract termination date, such as network relations, claim processing, service management, enrollee services, issue management (appeals, grievances, and disputes) and regulatory reporting functions during the runout period. Our ability to leverage resources from across the local market and corporate resources ensures our ongoing ability to fulfill these obligations.

As the accountable owner, WellCare of Kentucky Chief Executive Officer William Jones will work hand-in-hand with DMS, successor Vendor and sub-contractors throughout all phases of the transition. Bill Jones' involvement will ensure agreement on scope, planning and roles and responsibilities throughout the turnover effort. WellCare of Kentucky will provide the necessary resources to ensure a smooth turnover while continuing to meet contractual obligations through contract close-out. We will maintain adequate staffing levels to serve enrollees and providers through contract termination and the run out period. Above all, we will work with all participants to ensure enrollees continue to receive the care and services needed.

During the planning phase, WellCare of Kentucky will designate a WellCare Regulatory Affairs Officer (RAO) as the SPOC (Single Point of Contact) who will report directly to Bill Jones. The RAO will have accountability for all turnover project matters. We will designate a Turnover Manager to facilitate day-to-day turnover activities who will report to the RAO and will identify turnover leads for Enrollee Services, Provider Services, transition of care, claims, and financial accounting. While we are fortunate to have limited opportunities to execute on Turnover plans, our experience shows that outcomes are greatly improved when the successor MCO also appoints a designee to service as the Turnover Manager.

WellCare employs a dedicated team representing key organizational areas for implementing and carrying out the turnover plan. The team works together to make team assignments both

at corporate and market levels, establishing milestones and identifying critical dependencies. The key areas and staff involved in carrying out turnover activities includes the following:

- Bill Jones will provide leadership, guidance, and knowledge of current practices, tasks to be completed and, along with the SPOC, will perform close-down activities for all areas of the project and remain the key contact with DMS.
- Regulatory Affairs Officer (RAO) SPOC will report directly to Bill Jones and lead the Turnover Management Team. We will designate a Turnover Manager to facilitate day-to-day turnover activities who will report to the RAO and will identify turnover leads for Enrollee Services, Provider Services, transition of care, claims, and financial accounting.
- Key Subject Matter Experts provide guidance and knowledge and perform particular close down functions for their areas of responsibility throughout the transition period including functions such as Enrollee transition of care to identified agencies.
- IT Staff ensure data will be extracted, formatted, and transferred securely and timely. They assist in report development, generation, and submission.
- Project Management Office (PMO) provides the project management of the entire process to ensure tasks and timelines are being met.

WellCare plans for both pre-transition and post-transition data extracts and operational requirements. Examples of such data extracts include Enrollee PCP assignments, risk stratification and health condition scores, and active care plans. Our transition planning approaches account for the early identification, testing, and execution of these types of extracts. Where possible, WellCare will utilize existing DMS and industry standard formats for these extracts to reduce the development and testing impacts to DMS or a successor MCO.

WellCare also realizes and acknowledges that our existing contractual obligations remain in effect for a run out period, which is typically 18 months, to accommodate timely filing and appeals-rights timelines.

Subject Matter Experts at our corporate offices provide guidance and knowledge and perform particular close down functions for their areas of responsibility throughout the runout period of obligations. Examples include functions, such as Enrollee services, Provider services, appeals and dispute processing, claims runout processing, encounter submission, financial reporting and supporting any ongoing reporting requirements for DMS. The same operational practices, policies, and monitoring will continue to apply to runout transactions as were in effect during the contract term.

An advantage of WellCare's single integrated platform is the leverage provided in runout situations. This strategic approach ensures the staff knowledge and technical agreements needed to maintain operations and compliance with regulatory commitments (including new but applicable changes) will be able to be supported.

2. Approach to identifying and submitting all documentation, records, files, methodologies, and data necessary for the Department to continue the program.

Turnover planning includes the HIPAA-compliant collection and transfer of records, files, methodologies, data and any supplemental documentation, which DMS would require to continue the program. We would first work with DMS to determine what type of records, files, methodologies, data, and documentation would be needed and requested to seamlessly transition the Enrollee to the new program.

Then, using our internal systems documentation, we would identify the source systems and locations of the appropriate records to ensure a complete accounting of all record sources. Using existing processes where possible, we would extract Kentucky's specific information, create data extracts in a format defined and acceptable to DMS, encrypt them, and deliver them through existing secure FTP arrangements we currently have with DMS or establish similar arrangements to exchange the information with another Vendor.

WellCare also suggests that often, as an alternative to the creation of separate processes for transition, the ability to leverage the KHIE be considered. The KHIE will be in possession of large amounts of data about Medicaid membership in Kentucky. The use of the KHIE as a central, MCO-neutral data source would allow new Vendors to establish interfaces to support transition services and subsequently leverage those same capabilities to implement effective and efficient ongoing operations. Note that these same methods and solutions can serve as the standard MCO-to-MCO transition support mechanism during the normal course of the contract as well.

If DMS requires Enrollee-specific claims, correspondence, or medical records, we would image the collateral, create zip files, and deliver the images to DMS using the same delivery method described above. We could also provide examples of our health risk assessment survey questions and acceptable responses.

WellCare recognizes that the successful transfer of these data, records, and methodologies is necessary to allow for seamless transition of care from WellCare to DMS or a successor Vendor should that be necessary and would comply with all requests to provide such information in a timely, comprehensive and efficient manner.

3. Resources and training that the Department or another contractor will need to take over required operations.

Once the state approves the scope and approach of our Turnover Plan, WellCare's transition team will begin executing the plan, including the transfer of relevant assets and knowledge necessary to smoothly transition. The actual execution of the turnover plan would begin 100 days prior to the end of the contract, including the transfer of relevant assets and knowledge necessary to smoothly transition Enrollees and Providers to the successor MCO(s) or DMS (e.g., data, files, records, methodologies and other supporting documentation). . At this point, the successor Vendor should appoint a designee who will serve as the Single Point of Contact for our RAO and Turnover Manager and work with WellCare of Kentucky to develop an organizational chart defining their functional area work stream leads and training audience. Once the successor identifies their respective transition team, all stakeholders, including WellCare of Kentucky, DMS, the successor MCO(s) and subcontractors would agree upon a

regularly scheduled day and time for a weekly cross-functional task coordination meeting. During this transition phase, WellCare of Kentucky will provide a team of training resources who will:

- Flesh out the details of the training plan
- Develop a training curriculum and materials necessary for the successor staff to fully and seamlessly service our Enrollees and providers.
- Assemble a training schedule with the assistance of the successor Vendor work stream leads
- Deliver the training to the State and successors where appropriate.

The scheduled end date for knowledge transfer would be no later than 15 days before the contract end date. However we will process claims beyond the contract dates, through the claims run-out period. It is our expectation that DMS would perform a readiness review of a successor Vendor. We would acknowledge the successful conclusion of the execution and knowledge transfer phase upon their sign-off of the Turnover Results Report that WellCare of Kentucky would use to document the completion of all tasks in the turnover plan. Upon sign-off, we would hand over the turnover plan management to the successor MCO.

4. Methods for tracking and reporting turnover results, including documentation of completion of tasks at each step of the turnover.

Once the successor identifies their Transition Team, all stakeholders, including WellCare of Kentucky, DMS, the successor vendor, and subcontractors will agree upon a regularly scheduled day and time for a weekly cross-functional meeting where progress toward completion of each turnover task is monitored and identified issues resolved. We will work closely with DMS to develop a Turnover Plan, determine turnover stakeholder roles, responsibilities, and construct an organization chart. DMS will acknowledge the successful conclusion of the execution and knowledge transfer phase of the turnover upon their sign-off of a Turnover Results Report that WellCare of Kentucky would use to document the completion of all tasks in the Turnover Plan. Upon sign-off, we would hand-off Turnover Plan management to the successor Vendor.

A routine aspect of our project management process is to maintain a detailed Microsoft Project plan to manage and track the overall progress and completion project tasks, such as:

- Tracking progress on a task-by-task level
- Providing DMS weekly status reports, or another frequency preferred by DMS.
- Developing and executing an external stakeholder communication strategy no later than 60 days before the contract expires. Upon DMS' approval, WellCare of Kentucky would:
    - Notify our Enrollees about the contract termination via both mailed letters and the Member portal aimed at assuring them that there would be no disruption to their current service levels

- Notify network Providers about our contract termination via both mailed letters and the Provider portal, and provide them regular updates on the status of the transition on the Provider portal

- Updating our call center representative and case manager scripts so both teams can accurately and appropriately respond to Member and Provider inquiries about the transition

During the final phase of the transition, WellCare of Kentucky staff would be available to Enrollees, Providers, DMS, the successor MCO(s) and subcontractors for at least 30 days to answer questions and troubleshoot "people, process, or technology" issues associated with the turnover. We would continue to meet with DMS, the successor MCO(s) and subcontractors every week to review status and operational metrics. For a minimum of 90 days following the termination of the contract, we would be available on an as needed basis to address any outstanding issues until they are fully resolved.

5. Document and verify how all data is securely transferred during a turnover ensuring integrity of same. Maintain the CIA concept in turnover, Confidentiality, Integrity, and Availability.

WellCare understands the vital importance of ensuring that all data is completely and properly transmitted in a secure manner during a turnover. We collaborate to ensure a secure connection for exchanging files with DMS, existing vendors and subcontractors, and any successor MCO.

Secure Transfer of Data. Our experience is that through the course of normal operations, WellCare will already have deployed the delivery methods (such as secure FTP or other data media) that are preferred by Department (and is consistent with their security and privacy guidelines). Our intent would be to continue leveraging those exact same capabilities to complete the transition and transfer of any necessary data. For instance, WellCare will continue to use secure FTP sites for data transfers between WellCare and DMS, WellCare and KHIE, and if appropriate create secure FTP transfer sites with the new Vendor. Additional methods can be considered and implemented as needed, including the use of encrypted mass storage for data transfer, with only WellCare and DMS (or its subcontractors) being aware of the encryption key.

Ensuring Data Integrity. All data extracts and exchanges created and executed as part of our obligations under the Turnover plan will be created and validated using our standard Software Development LifeCycle (SDLC). Specifically relevant to ensuring the integrity of any data provided are the SDLC steps to formally document the requirements, functional design, and technical design to eliminate any ambiguity. Test plans and test cases are independently developed and executed by WellCare's Quality Assurance department to ensure that all requirements (including data integrity requirements) are met as part of the extract process.

Maintaining the CIA Concept. Specifically with respect to our runout processing and execution commitments, all of our existing Security and Privacy policies would remain in effect, and continue to be enhanced, throughout the transition. These practices, including least-privileged access, the use of encryption both in transit and at rest, and 24/7 security monitoring meet current Confidentiality, Integrity, and Availability (CIA) requirements and, through their

continued use, would meet CIA requirements throughout the transition. Further, when WellCare subcontractors are involved, WellCare's contracts will continue to require them to maintain the same level of standards.

An advantage of WellCare's single integrated platform is the leverage provided in runout situations. This strategic approach ensures the staff knowledge and technical agreements needed to maintain operations and compliance with regulatory commitments (including new but applicable changes) will be able to be supported. As a result, in addition to existing confidentiality and integrity practices, the data integrity, and system availability requirements of the CIA philosophy will also continue to be met.

F. Turnover Plan

- Attachment F. Sample Turnover Plan

ID	Task Name	Duration	Start	Finish
1	**Kentucky Medicaid Turnover Plan**	**379 days**	**6/1/20 8:00 AM**	**11/11/21 5:00 PM**
2	**Phase 1: TURNOVER PLANNING**	**30 days**	**6/1/20 8:00 AM**	**7/10/20 5:00 PM**
3	Receive " Intent to Terminate " notice from State	1 day	6/1/20 8:00 AM	6/1/20 5:00 PM
4	Establish SPOC with State for Turnover activities	1 day	6/2/20 8:00 AM	6/2/20 5:00 PM
5	Send communication to functional area VPs informing them of Contract termination and effective date	1 day	6/3/20 8:00 AM	6/3/20 5:00 PM
6	**Initiate Turnover Project**	**27 days**	**6/4/20 8:00 AM**	**7/10/20 5:00 PM**
7	**Wellcare of Kentucky Turnover Team and Responsibilities**	**4 days**	**6/4/20 8:00 AM**	**6/9/20 5:00 PM**
8	Assign RA Turnover Officer	1 day	6/4/20 8:00 AM	6/4/20 5:00 PM
9	Assign Turnover PM	1 day	6/4/20 8:00 AM	6/4/20 5:00 PM
10	Assign Wellcare of Kentucky functional work stream leads	1 day	6/4/20 8:00 AM	6/4/20 5:00 PM
11	Create Turnover Scope document	2 days	6/4/20 8:00 AM	6/5/20 5:00 PM
12	Create Turnover Team Organizational Chart	1 day	6/4/20 8:00 AM	6/4/20 5:00 PM
13	Create Turnover Team Contact List	1 day	6/4/20 8:00 AM	6/4/20 5:00 PM
14	Create RACI chart	3 days	6/5/20 8:00 AM	6/9/20 5:00 PM
15	**Establish internal communication strategy**	**8 days**	**6/10/20 8:00 AM**	**6/19/20 5:00 PM**
16	Set up Project SharePoint	1 day	6/10/20 8:00 AM	6/10/20 5:00 PM
17	Establish weekly internal status, risk, and issue meetings cadence	1 day	6/10/20 8:00 AM	6/10/20 5:00 PM
18	Establish status reporting audiences, templates and cadence	1 day	6/10/20 8:00 AM	6/10/20 5:00 PM
19	Create Turnover Project Plan	8 days	6/10/20 8:00 AM	6/19/20 5:00 PM
20	Create Turnover Results Report	8 days	6/10/20 8:00 AM	6/19/20 5:00 PM
21	Submit Turnover Project Plan and Turnover Results Report to State for approval	1 day	6/10/20 8:00 AM	6/10/20 5:00 PM
22	**Develop Current Member notification strategy, collateral, and plan**	**22 days**	**6/11/20 8:00 AM**	**7/10/20 5:00 PM**
23	Develop overall strategy, media and messaging goals	7 days	6/11/20 8:00 AM	6/19/20 5:00 PM
24	**Develop collateral**	**17 days**	**6/11/20 8:00 AM**	**7/3/20 5:00 PM**
25	Develop letter notifications	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
26	Develop Portal messaging and upload to web	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
27	Develop care management scripting	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
28	Develop CSR scripting	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
29	Develop Member Communication project plan (contingent on Turnover Plan approval date)	5 days	6/11/20 8:00 AM	6/17/20 5:00 PM

Attachment F. Sample Turnover Plan

ID	Task Name	Duration	Start	Finish
30	**Develop Network Provider notification strategy, collateral, and plan**	**17 days**	**6/11/20 8:00 AM**	**7/3/20 5:00 PM**
31	Develop overall strategy, media and messaging goals	7 days	6/11/20 8:00 AM	6/19/20 5:00 PM
32	**Develop collateral**	**10 days**	**6/22/20 8:00 AM**	**7/3/20 5:00 PM**
33	Develop letter notifications	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
34	Develop Portal messaging and upload to web	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
35	Develop care management scripting	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
36	Develop CSR scripting	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
37	Develop talking points and education deck for PR Reps	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
38	Develop Provider Communication project plan (contingent on Turnover Plan a	5 days	6/22/20 8:00 AM	6/26/20 5:00 PM
39	**Develop Sub-Contractor notification and communication strategy**	**17 days**	**6/11/20 8:00 AM**	**7/3/20 5:00 PM**
40	Develop overall strategy	7 days	6/11/20 8:00 AM	6/19/20 5:00 PM
41	**Develop collateral**	**10 days**	**6/22/20 8:00 AM**	**7/3/20 5:00 PM**
42	Develop letter notifications	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
43	Develop Sub-Contractor Communication project plan (contingent on Turnover	5 days	6/22/20 8:00 AM	6/26/20 5:00 PM
44	**Develop Community Stakeholder notification strategy, collateral, and plan**	**22 days**	**6/11/20 8:00 AM**	**7/10/20 5:00 PM**
45	Develop overall strategy	7 days	6/11/20 8:00 AM	6/19/20 5:00 PM
46	**Develop collateral**	**15 days**	**6/22/20 8:00 AM**	**7/10/20 5:00 PM**
47	Develop letter notifications	10 days	6/22/20 8:00 AM	7/3/20 5:00 PM
48	Develop Community Stakeholder Communication project plan (contingent on	5 days	7/6/20 8:00 AM	7/10/20 5:00 PM
49	**Receive State approval on Turnover Plan and Turnover Results Report**	**2 days**	**6/11/20 8:00 AM**	**6/12/20 5:00 PM**
50	Receive actual approval of Turnover Plan and Results Report	1 day	6/11/20 8:00 AM	6/11/20 5:00 PM
51	Confirm Contract Termination Date	1 day	6/12/20 8:00 AM	6/12/20 5:00 PM
52	**Collaborate Successor MCO**	**15 days**	**6/15/20 8:00 AM**	**7/3/20 5:00 PM**
53	Confirm successor MCO and obtain contact information from State	1 day	6/15/20 8:00 AM	6/15/20 5:00 PM
54	**Establish Contact with MCO**	**3 days**	**6/16/20 8:00 AM**	**6/18/20 5:00 PM**
55	Determine MCO SPOC	3 days	6/16/20 8:00 AM	6/18/20 5:00 PM
56	Determine MCO PM	3 days	6/16/20 8:00 AM	6/18/20 5:00 PM
57	Determine MCO work stream leads	3 days	6/16/20 8:00 AM	6/18/20 5:00 PM
58	Create inter-stakeholder org chart	3 days	6/16/20 8:00 AM	6/18/20 5:00 PM
59	Create inter-stakeholder RACI chart	3 days	6/16/20 8:00 AM	6/18/20 5:00 PM
60	Create inter-stakeholder contact list	1 day	6/16/20 8:00 AM	6/16/20 5:00 PM
61	Establish PM communication cadence and artifacts	3 days	6/16/20 8:00 AM	6/18/20 5:00 PM
62	Give State and MCO access to Project SharePoint	3 days	6/19/20 8:00 AM	6/23/20 5:00 PM
63	Establish weekly internal status, risk, and issue meetings cadence	3 days	6/19/20 8:00 AM	6/23/20 5:00 PM

Attachment F. Sample Turnover Plan

ID	Task Name	Duration	Start	Finish
64	Establish status reporting audiences, templates and cadence	3 days	6/19/20 8:00 AM	6/23/20 5:00 PM
65	**Update Artifacts**	**6 days**	**6/24/20 8:00 AM**	**7/1/20 5:00 PM**
66	Refine Scope document	6 days	6/24/20 8:00 AM	7/1/20 5:00 PM
67	Refine Turnover Project Plan	6 days	6/24/20 8:00 AM	7/1/20 5:00 PM
68	Refine Turnover Results Report	6 days	6/24/20 8:00 AM	7/1/20 5:00 PM
69	Submit Turnover Project Plan and Turnover Results Report to State for approval	0 days	7/1/20 5:00 PM	7/1/20 5:00 PM
70	Establish Phase 2 kickoff date with MCO and State	1 day	7/2/20 8:00 AM	7/2/20 5:00 PM
71	Share Member, Provider and Sub-Contractor communication plans and collateral	1 day	7/3/20 8:00 AM	7/3/20 5:00 PM
72	**Phase 2: TURNOVER EXECUTION AND KNOWLEDGE TRANSFER**	**92 days**	**7/6/20 8:00 AM**	**11/10/20 5:00 PM**
73	**Cease processing of new enrollees**	**31 days**	**7/6/20 8:00 AM**	**8/17/20 5:00 PM**
74	Cease processing of incoming new 834 enrollments (dependent on state required date	1 day	7/6/20 8:00 AM	7/6/20 5:00 PM
75	Receive 834 and process disenrollment based on effective date	1 day	7/7/20 8:00 AM	7/7/20 5:00 PM
76	Determine process, medium and messaging for rejected Enrollees	4 days	7/8/20 8:00 AM	7/13/20 5:00 PM
77	Direct rejected 834 enrollees to State Enrollment Broker to enroll in another plan via le	19 days	7/14/20 8:00 AM	8/7/20 5:00 PM
78	Cease Member Outreach community events	4 days	7/14/20 8:00 AM	7/17/20 5:00 PM
79	Enrollment - Set Term Date for KY Medicaid members in Xcelys	13 days	7/8/20 8:00 AM	7/24/20 5:00 PM
80	Confirm members were disenrolled	5 days	8/10/20 8:00 AM	8/14/20 5:00 PM
81	Disable automated 834 processing (dependent on state required date)	1 day	8/17/20 8:00 AM	8/17/20 5:00 PM
82	**Execute Approved Member, Provider, Sub-Contractor, and Community Stakeholder Cor**	**42 days**	**8/18/20 8:00 AM**	**10/14/20 5:00 PM**
83	**Execute Member Communication Plan**	**42 days**	**8/18/20 8:00 AM**	**10/14/20 5:00 PM**
84	Send notification letters to existing members	5 days	8/18/20 8:00 AM	8/24/20 5:00 PM
85	Unhide new Member portal content re: contract termination and enrollment broke	1 day	8/18/20 8:00 AM	8/18/20 5:00 PM
86	Load new call scripts into CareConnects	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
87	Train CSRs on new call scripts	20 days	8/18/20 8:00 AM	9/14/20 5:00 PM
88	Share new talking points with care managers	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
89	Create and send Prior Auth Re-Direction notifications	42 days	8/18/20 8:00 AM	10/14/20 5:00 PM
90	**Execute Provider Communication Plan**	**42 days**	**8/18/20 8:00 AM**	**10/14/20 5:00 PM**
91	Send notification letters to network providers	5 days	8/18/20 8:00 AM	8/24/20 5:00 PM
92	Unhide new Provider portal content re: contract termination and TOC policy and ne	1 day	8/18/20 8:00 AM	8/18/20 5:00 PM
93	Load new call scripts into CareConnects	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
94	Train CSRs on new scripts	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
95	Share new talking points with care managers	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
96	Create and send Prior Auth Re-Direction notifications	42 days	8/18/20 8:00 AM	10/14/20 5:00 PM
97	Train PR Reps	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
98	PR Reps visit providers, if necessary	42 days	8/18/20 8:00 AM	10/14/20 5:00 PM

Attachment F. Sample Turnover Plan

ID	Task Name	Duration	Start	Finish
99	**Execute Sub-Contractor Communication Plan**	**7 days**	**8/18/20 8:00 AM**	**8/26/20 5:00 PM**
100	Send letters re: contract termination with contact information and next steps	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
101	Reach out to sub-contractor account managers to determine next steps	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
102	**Execute Community Stakeholder Communication Plan**	**7 days**	**8/18/20 8:00 AM**	**8/26/20 5:00 PM**
103	Send letters re: contract termination with contact information and next steps	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
104	Reach out to Community Stakeholder Liaisons to determine next steps	7 days	8/18/20 8:00 AM	8/26/20 5:00 PM
105	**Train successor MCO staff and State on identified areas for knowledge transfer**	**33 days**	**8/27/20 8:00 AM**	**10/12/20 5:00 PM**
106	Identify scope of knowledge transfer	6 days	8/27/20 8:00 AM	9/3/20 5:00 PM
107	Identify audience for knowledge transfer	6 days	8/27/20 8:00 AM	9/3/20 5:00 PM
108	Create curriculum and materials for knowledge transfer sessions	12 days	9/4/20 8:00 AM	9/21/20 5:00 PM
109	Gather necessary data, files, and other documentation to support knowledge transfer	12 days	9/4/20 8:00 AM	9/21/20 5:00 PM
110	Schedule knowledge transfer sessions	5 days	9/22/20 8:00 AM	9/28/20 5:00 PM
111	Conduct knowledge transfer sessions	10 days	9/29/20 8:00 AM	10/12/20 5:00 PM
112	**Create and send clinical data files to MCO or State**	**21 days**	**10/13/20 8:00 AM**	**11/10/20 5:00 PM**
113	Review procedure for data transfer for HIPAA compliance	1 day	10/13/20 8:00 AM	10/13/20 5:00 PM
114	**Create clinical data files for transfer to MCO or State**	**19 days**	**10/14/20 8:00 AM**	**11/9/20 5:00 PM**
115	Create Case Management Data File	13 days	10/14/20 8:00 AM	10/30/20 5:00 PM
116	Create Disease Management Data File	13 days	10/14/20 8:00 AM	10/30/20 5:00 PM
117	Create Inpatient Facility Stays Data File	13 days	10/14/20 8:00 AM	10/30/20 5:00 PM
118	Create PCP Assignments Data File (from Enrollment team, for BH, Dental, Medical w	6 days	10/14/20 8:00 AM	10/21/20 5:00 PM
119	Create Pregnant Member Data Files	6 days	10/14/20 8:00 AM	10/21/20 5:00 PM
120	Return DCH-related data to DCH	6 days	10/14/20 8:00 AM	10/21/20 5:00 PM
121	**Create Prior Authorizations Data File**	**13 days**	**10/22/20 8:00 AM**	**11/9/20 5:00 PM**
122	Transplants	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
123	OB	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
124	Oncology	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
125	Chemotherapy	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
126	Radiation	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
127	DME	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
128	Behavioral Health	13 days	10/22/20 8:00 AM	11/9/20 5:00 PM
129	Send clinical data files to MCO or State	0 days	11/9/20 5:00 PM	11/9/20 5:00 PM
130	**Final Turnover Results**	**1 day**	**11/10/20 8:00 AM**	**11/10/20 5:00 PM**
131	Review Final Turnover Results Report with State for final sign off	1 day	11/10/20 8:00 AM	11/10/20 5:00 PM
132	**Phase 3: POST-TURNOVER MONITORING AND SUPPORT**	**262 days**	**11/11/20 8:00 AM**	**11/11/21 5:00 PM**
133	Monitor email and telephone support line for State, MCO and sub-contractor issues	24 days	11/11/20 8:00 AM	12/14/20 5:00 PM

Attachment F. Sample Turnover Plan

ID	Task Name	Duration	Start	Finish
134	Hold weekly status checkpoints to review Post-Turnover metrics and issues log	24 days	11/11/20 8:00 AM	12/14/20 5:00 PM
135	**KY Exit Tasks**	**262 days**	**11/11/20 8:00 AM**	**11/11/21 5:00 PM**
136	**Close Market Offices**	**110 days**	**11/11/20 8:00 AM**	**4/13/21 5:00 PM**
137	Terminate real estate leases	110 days	11/11/20 8:00 AM	4/13/21 5:00 PM
138	Turn off technology infrastructure	45 days	11/11/20 8:00 AM	1/12/21 5:00 PM
139	Develop plan for market office staff termination (will maintain adequate staff levels	75 days	11/11/20 8:00 AM	2/23/21 5:00 PM
140	Market to provide phone number and email listing for porting	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
141	Market to work with IT to plan equipment retention and dismantling	11 days	11/11/20 8:00 AM	11/25/20 5:00 PM
142	Dismantle equipment	25 days	11/26/20 8:00 AM	12/30/20 5:00 PM
143	**IT corporate close out tasks**	**1 day**	**11/11/20 8:00 AM**	**11/11/20 5:00 PM**
144	Turn Off KY Medicaid as Right Fax Option	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
145	Modify IVR feed for KY Medicaid	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
146	Turn off FTP connection between Wellcare of Kentucky and KY DCH	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
147	**Turn Off Portal functionality**	**1 day**	**11/11/20 8:00 AM**	**11/11/20 5:00 PM**
148	Turn off member portal	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
149	Turn off provider portal	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
150	Remove KY Medicaid content from public portal	1 day	11/11/20 8:00 AM	11/11/20 5:00 PM
151	**Archive Compliance records**	**33 days**	**11/11/20 8:00 AM**	**12/25/20 5:00 PM**
152	Determine materials to archive	22 days	11/11/20 8:00 AM	12/10/20 5:00 PM
153	Coordinate material achiving with Iron Mountain	11 days	12/11/20 8:00 AM	12/25/20 5:00 PM
154	**Perform Revenue Reconciliation**	**45 days**	**11/11/20 8:00 AM**	**1/12/21 5:00 PM**
155	Receive payments from KY during transition period	45 days	11/11/20 8:00 AM	1/12/21 5:00 PM
156	Wellcare of Kentucky will send payment to providers	45 days	11/11/20 8:00 AM	1/12/21 5:00 PM
157	Wellcare of Kentucky will send payment to vendors	45 days	11/11/20 8:00 AM	1/12/21 5:00 PM
158	Submit report of capitation or other overpayments made by the state	45 days	11/11/20 8:00 AM	1/12/21 5:00 PM
159	**Perform Finance Closure**	**134 days**	**11/11/20 8:00 AM**	**5/17/21 5:00 PM**
160	Maintain financial requirements through termination date	92 days	11/11/20 8:00 AM	3/18/21 5:00 PM
161	Maintain fidelity bonds until DMS written notice	133 days	11/11/20 8:00 AM	5/14/21 5:00 PM
162	Maintain insurance until DMS written notice	133 days	11/11/20 8:00 AM	5/14/21 5:00 PM
163	Perform final accounting of amounts related to KY Medicaid program	133 days	11/11/20 8:00 AM	5/14/21 5:00 PM
164	Return overpayments to state, if discovered after termination date	133 days	11/11/20 8:00 AM	5/14/21 5:00 PM
165	Close Bank Accounts	1 day	5/17/21 8:00 AM	5/17/21 5:00 PM
166	**Set Up Claims Run-Out Period**	**262 days**	**11/11/20 8:00 AM**	**11/11/21 5:00 PM**
167	Maintain claims processing for run-out period post contract termination for dates o	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
168	Maintain claims adjudication process for claims with dates of service through termi	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM

Attachment F. Sample Turnover Plan

ID	Task Name	Duration	Start	Finish
169	Maintain financial responsibility for services rendered through termination date for	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
170	Grievance/Appeals - Resolve grievances with dates of service prior to termination d	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
171	**Required on-going reporting**	**262 days**	**11/11/20 8:00 AM**	**11/11/21 5:00 PM**
172	Encounter data to DMS for claims incurred before the termination date per termina	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
173	Quality performance data covering reporting period before termination date	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
174	**Regulatory Reports Run-out**	**262 days**	**11/11/20 8:00 AM**	**11/11/21 5:00 PM**
175	Financial Reports	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
176	Member Services Reports	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
177	Provider Network Reports	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
178	Quality Management Reports	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
179	Utilization Reports	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
180	Claims Reports	262 days	11/11/20 8:00 AM	11/11/21 5:00 PM
181	**Phase 4: CONTRACT CLOSE OUT**	**90 days**	**5/18/21 8:00 AM**	**9/20/21 5:00 PM**
182	Corrective Action Plans - must be completed unless otherwise specified	90 days	5/18/21 8:00 AM	9/20/21 5:00 PM
183	Pay all outstanding obligations	90 days	5/18/21 8:00 AM	9/20/21 5:00 PM
184	Cooperation with Medical Records review	90 days	5/18/21 8:00 AM	9/20/21 5:00 PM

Attachment F. Sample Turnover Plan

G.

Kentucky SKY

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Beyond Healthcare. A Better You.

1. Executive Summary

G.1. EXECUTIVE SUMMARY

a. Provide an Executive Summary that summarizes the Contractor's proposed technical approach, staffing and organizational structure, and implementation plan for the Kentucky SKY program. The Executive Summary must include a statement of understanding and fully document the Contractor's ability, understanding and capability to provide the full scope of work.

b. The Contractor's statement of understanding of the unique needs of Medicaid Enrollees in the Commonwealth enrolled in the Kentucky SKY program;

c. An overview of the Contractor's proposed organization to provide coordinated services for the Kentucky SKY program;

d. A summary of the Contractor's strategy and approach for administering services for Kentucky SKY Enrollees;

e. A summary of the Contractor's strategy and approach for establishing a comprehensive Provider network able to meet the unique physical and Behavioral Health needs of Kentucky SKY Enrollees; and

f. A summary of innovations and Trauma-informed initiatives the Contractor proposes to implement to achieve improved health outcomes for Kentucky SKY Enrollees in a cost effective manner. Include a discussion of challenges the Contractor anticipates, how the Contractor will address such challenges, and a description of the Contractor's experience with addressing these challenges for similar contracts and populations.

G.1. EXECUTIVE SUMMARY

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc. On January 23, 2020 WellCare Health Plans, Inc. was acquired by Centene Corporation (Centene). WellCare is now a wholly owned subsidiary of Centene. **WellCare of Kentucky's leadership, staff, branding, and model for delivering services to the Commonwealth are not changing and we remain committed to partnering with the Department of Medicaid Services (DMS) to ensure Kentucky's Enrollees, communities, providers and other stakeholders receive the integrated, whole-person care and services necessary to address all of their physical, behavioral, and social needs.** With the acquisition, WellCare of Kentucky is now also able to leverage the combined experience and best practices of our Centene affiliate health plans, which is now managing the care of more than 12.9 million Medicaid Enrollees across 30 states.

WellCare of Kentucky currently serves more than 430,000 Medicaid Enrollees across the Commonwealth. We have served SKY-eligible Medicaid Enrollees in the Commonwealth for eight years, currently managing the care of approximately 8,100 Foster Care Enrollees, Former Foster Care Youth Enrollees, Adoption Assistance Enrollees, and Juvenile Justice (JJ) Enrollees (hereafter referred to collectively as Foster Care Enrollees), across the Commonwealth, which constitutes the single largest concentration of these Enrollees served by any Medicaid managed care organization (MCO) in Kentucky.

WellCare of Kentucky also leverages the experience and expertise of our affiliate health plans in other states. Nationally, as of yearend 2019, WellCare managed the care of more than 20,000 Foster Care Enrollees across seven other states. Additionally, we are now able to leverage the experience and best practices of our Centene affiliate health plans, which manage the care of

more than 150,000 children in Foster Care across 17 states. This experience includes statewide, sole sourced, Foster Care contracts in Florida, Illinois, Texas, and Washington.

WellCare of Kentucky has been privileged to serve the Kentucky Medicaid program and our foster care, adopted and DJJ members over the last eight years. We have embraced our role as a supporter to the Department and as an advocate for these vulnerable members. Children in foster care have unique needs. Not only are they suffering with trauma, but they are living in a substitute home that does not belong to them. They are in a hospital with no idea of where they will go next. They have medical and behavioral health issues that are complex and overwhelming. Because of their complex trauma, caring, housing and treatment needs, the system of care must be purposeful and strategic and collaborative. From the beginning of managed care in Kentucky, WellCare has been the one MCO that recognized the complex and challenging needs of our members in foster care. We have understood the important responsibility on our shoulders and have developed comprehensive, Kentucky specific, innovative programs that are improving not only the health of members in foster care, but improving their quality of life in Kentucky. Since 2011 we have grown to the largest health plan in the commonwealth, bringing the largest network, the highest NCQA quality rating, and the highest provider and member satisfaction scores among all MCOs. Our foster care, adopted and DJJ membership continues to grow monthly, demonstrating that DCBS, DJJ, and adopted parents view WellCare as THE MCO to take care of their children. For our foster care members, we have created innovative programs, piloted services, trained foster parents, and engaged DCBS, DJJ, the Department and private child care providers in out of the box thinking to serve these members. We are deeply committed to our 8,100 Foster Children that we serve today and are passionate about providing a single MCO solution for the entire Foster Care population. Through collaboration with DMS, DCBS and DJJ, we know we can contribute to improved health care and improved futures for these vulnerable children.

a. ***Provide an Executive Summary that summarizes the Contractor's proposed technical approach, staffing and organizational structure, and implementation plan for the Kentucky SKY program. The Executive Summary must include a statement of understanding and fully document the Contractor's ability, understanding and capability to provide the full scope of work.***

TECHNICAL APPROACH

As described below and throughout this proposal, WellCare of Kentucky offers an approach for the Kentucky SKY program that builds on our unmatched experience serving foster care, former foster care, juvenile justice, and adoption assistance Enrollees here in Kentucky. We leverage the strengths and capabilities of our existing systems and infrastructure which include:

- An experienced leadership team, including Lori Gordon, SKY Executive Director, and LeAnn Magre, SKY Provider Relations Liaison, that has supported DMS over the past eight years through numerous program changes and brings unparalleled expertise with the Kentucky SKY population and established relationships with DCBS and DJJ.
- Field-based staff located throughout the Commonwealth to support providers and Enrollees, including dedicated Care Coordination staff who have been providing high-touch services working in the field with DCBS, DJJ, Enrollees, and caregivers for 8 years.

- The largest Medicaid provider networks in Kentucky, which is #1 in provider satisfaction and already includes many providers that are unique to and critical for this population as well as telehealth capabilities that align with new Kentucky rules.
- Our industry-leading CareCentral system which integrates internal and external data to ensure staff, providers, and Enrollees/caregivers have a 360 degree view of each Enrollee.
- A fully integrated model for physical, behavioral health and social determinants of health that extends all the way from our executive leadership and quality structure through our network and oversight functions to our integrated Care Coordination teams.
- Community Connections, our nationally-recognized social determinants of health platform and program for meeting individual Enrollee needs and supporting community-level resource development and deployment.

We will tailor this strong foundation to the unique needs of SKY Enrollees, understanding that our task is to pull together the disparate pieces of multi-system involvement and create a unified system of care around each child and youth. Key to this endeavor will be our trauma-informed model of care that we will extend throughout the systems and stakeholders involved in the care of this population. Other important elements of our approach include:

- A detailed plan for collaborating with DMS, DCBS, and DJJ to ensure a smooth implementation, based on our experience implementing new programs in Kentucky and other states as well as work we have already done with our Kentucky partners to coordinate care for foster care, former foster care, juvenile justice, and adoption assistance Enrollees.
- Locating Field Outreach Coordinators and Care Coordination staff at DCBS regional offices and DJJ Community Districts to facilitate close communication and bring together all system of care partners to ensure integration across the Commonwealth service continuum.
- Our secure, HIPAA-compliant Clear SKY solution to ensure all providers and authorized DCBS, DJJ, foster and adoptive parent users and former foster care youth have 24/7 access to up-to-date, comprehensive information on Enrollee services and needs. Because of the frequent moves and transitions that often occur, ensuring access to information so to assure appropriate care is critical.
- Expanding availability of trauma-informed and other relevant expertise, including promotion of additional evidence-based practices specific to this population and bringing new providers of scarce but critical services into Kentucky, which we have already begun.
- A robust plan for training all system stakeholders, including Enrollee-facing staff, providers, caregivers, the courts and law enforcement in trauma-informed care and the unique needs of this population. We will also provide Mental Health First Aid training for all stakeholders.
- Targeted programs that address unique needs such as transition to adulthood, challenges finding appropriate post-discharge placements, increased risks for suicide and human trafficking, preventing further abuse and neglect, and supporting successful adoption.
- Existing relationships with community organizations that support this population such as Kentucky Partnership for Children and Families and local groups across the Commonwealth.

STAFFING AND ORGANIZATIONAL STRUCTURE

Local staffing and leadership have been foundational to our successful implementation and ongoing operations in Kentucky, and our structure for Kentucky SKY will follow this model. Our SKY Executive Team lives and work in Kentucky today, and we are the only MCO with Enrollee- and Provider-facing staff located throughout the Commonwealth. We will implement a regionally-based organizational model that includes embedding staff in DCBS regional offices and DJJ community districts. This model will facilitate high-touch, intensive support to DCBS, DJJ, other cabinet agencies, providers, Enrollees, caregivers and other stakeholders through highly qualified and trained provider engagement and Care Coordination staff.

IMPLEMENTATION PLAN

WellCare of Kentucky will use the foundation of our comprehensive Medicaid program and established relationships with DCBS and DJJ regional staff as a springboard for our implementation plan, which is based on industry best practices and our experience implementing new programs in Kentucky and other states. We successfully completed all required readiness reviews for the Kentucky Medicaid Managed Care contract and implemented new populations and program changes quickly and efficiently with minimal Enrollee and provider issues and impacts. On a corporate level, WellCare has transitioned more than 1,880,000 Enrollees over the last eight years.
Our implementation strategy is comprised of three key elements:

1. A command center approach that begins with Readiness Reviews and continues through at least 90 days after go-live
2. Clear accountability for each requirement
3. A comprehensive training plan that ensures that our staff are prepared to address 100% of new contract requirements prior to go-live.

Bob Diver, Project Manager, and Chief Operating Officer, Ben Orris, in collaboration with Lori Gordon, our SKY Executive Director, and LeAnn Magre, our SKY Provider Relations Liaison, will lead our locally-based Kentucky SKY Governance team and have overall responsibility for Implementation Plan and readiness review activities. A central focus of implementation will be collaborating with DMS, DCBS, and DJJ to put processes in place that will ensure continuity of care for Enrollees and enable continuation or rapid initiation of services for those with immediate and high needs.

STATEMENT OF UNDERSTANDING

WellCare of Kentucky acknowledges and understands that DMS seeks to improve health outcomes and strengthen support to families in crisis through contracting with a single statewide MCO to oversee and coordinate physical health, behavioral health, dental, and social services for children in foster care, dually committed youth in both the foster care and juvenile justice systems, former foster youth under age 26, and post-adoptive children with subsidized care. We further understand that the selected MCO must collaborate closely with DMS, DCBS, DJJ, and other stakeholders to implement the program and provide enhanced care coordination and service integration to meet the unique needs of this population.

ABILITY, UNDERSTANDING, AND CAPABILITY TO PROVIDE FULL SCOPE OF WORK

WellCare of Kentucky is strongly positioned to improve quality, health outcomes, and stability and permanency for SKY Enrollees. The experience and relationships our staff already have with our current foster care, juvenile justice, and adoption assistance Enrollees as well as with DMS, DCBS, DJJ, providers serving the population, and key stakeholders mean we are not starting from scratch and can hit the ground running on Day 1. We are deeply familiar with and have experience navigating the regional and community contexts that impact children and families and what it takes to promote resiliency, stability, and permanency among this population. Our ability, understanding, and capability to provide the full scope of work is reflected in the outcomes we have achieved for these Enrollees:

- From 2017 to 2019 HEDIS scores for well-child visits in the third, fourth, fifth and sixth years of life **increased 10%.** Adolescent well-care visits increased 28%.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents had a significant increase for all ages and is in the top 75 percentile and had a 68% increase.
- The use of first-line psychosocial care for children and adolescents (12-17 years) on **antipsychotics increased 9%.**
- HEDIS scores increased for all five Immunizations for Children and Adolescents measures as well as for Adolescent Well Care, Timeliness of Prenatal Care, and Chlamydia Screening from 2017 to 2019.
- Among those with co-morbid physical and behavioral health (BH) issues, inpatient admissions/1000 decreased by 11%, ER visits/1000 decreased by 13%, and specialist visits/1000 increased by 29% from 2016 to 2019.
- Among those with co-occurring mental health and substance use issues, ER visits/1000 decreased by 14%, inpatient mental health admits/1000 **increased by 3%,** PCP visits/1000 increased by over 7%, and specialist visits/1000 increased by 84% from 2016 to 2019.

Perhaps the best evidence of WellCare's ability, understanding, and capability is the fact that our foster care enrollment continues to increase***. In 2018, our foster care enrollment grew by 30%. This is strong evidence that WellCare is highly trusted and is the preferred MCO for DCBS caseworkers.***

As DMS places its trust in a single point of accountability for these children and youth, WellCare is uniquely positioned as a leader to bring the vision of the Families First Prevention Services Act to life and support our Commonwealth partners in moving the program forward.

WellCare of Kentucky implemented services required under the Families First Prevention Services Act, well ahead of the required 2021 implementation.

b. The Contractor's statement of understanding of the unique needs of Medicaid Enrollees in the Commonwealth enrolled in the Kentucky SKY program;

WellCare understands the unique needs of children and youth and their families here in Kentucky and the local issues and barriers they face. In 2016, children in Kentucky experienced abuse and neglect at a rate more than twice the national average, and parental substance

abuse is a major factor driving foster care entry. While the children and youth in this population share many needs and characteristics, each one has their own individual needs influenced by their experiences; race/ethnicity; family and community background; sexual orientation, gender identity and expression (SOGIE); personal strengths and resiliencies; and goals and dreams for their future. We recognize that Enrollees need an advocate to promote their voice and choice and ensure services are Enrollee/family-driven and support permanency and stability.

NEEDS FOR TRAUMA TREATMENT AND TRAUMA INFORMED APPROACHES

Every Kentucky SKY Enrollee has experienced Adverse Childhood Experiences (ACEs) and trauma. By the time removal occurs, many children have trauma from abuse, neglect, and witnessing violence, and they experience further trauma from being removed from their homes and separated from parents and siblings. Trauma-informed assessment and treatment approaches are critical and all stakeholders in the child's care must understand the impacts of trauma and how it manifests. Often, trauma must be addressed before treatment for medical or BH conditions will be effective. Everything we do across the entire organization must be trauma-informed in order to effectively and appropriately address SKY Enrollee needs.

INTENSIVE AND UNMET HEALTH CARE NEEDS

Preventive, Primary, and Chronic Care. Children often receive limited health care prior to entering foster care, presenting with significant gaps in recommended services. Few have had a medical home and many have undiagnosed or under-treated conditions. The American Academy of Pediatrics and Child Welfare League of America (AAP/CWLA) recommend a higher frequency and intensity of medical home services for these children.

Services to Address Disabilities. Abuse and neglect during infancy and early childhood can impair physical, cognitive, and emotional development. Many Enrollees need services for vision and/or hearing loss. Others need treatment for neurological disorders and lasting health and developmental effects of in utero substance exposure or premature birth.

Oral Health Care. Nearly 40% of those entering foster care have significant dental and oral health problems. In 2017 in most Kentucky counties, fewer than half of the children covered by Medicaid or CHIP used dental services. While the impact of trauma makes many children reluctant to receive dental care, other barriers in Kentucky include limited access to dental providers and lack of family and caregiver understanding of the importance of dental care.

Behavioral Health Care. BH crises are more common in this population. These enrollees need crisis planning, mobile crisis services, and step-down levels of care.

Medication Management. Enrollees in foster care have three times the rate of psychotropic medication prescribed, higher polypharmacy, and longer treatment regimens than other children in Medicaid.

Providers with Specific Expertise. This population requires specialized, evidence-based treatment such as Trauma Focused Cognitive Behavioral Therapy or Parent Child Interaction Therapy. They may need specialized services to address sexual acting out, behavior dysregulation, and developmental disabilities including autism spectrum disorder.

CARE COORDINATION NEEDS

Immediate Evaluation Upon Entry. Children and youth in foster care need immediate, comprehensive evaluation when they enter the system due to urgent and unmet needs and a history of lack of care.

Central Repository of Medical Records. Many children come into foster care with few or no medical records to inform assessment and treatment. Providers and those making care decisions need a single, easily accessible record of assessment results, claims and utilization data, care plans, and other information to ensure continuity and accurately assess needs.

Integration of Health Care and Other Needed Services. These children and youth often are served by multiple providers and receive services through community agencies. A designated point of coordination is needed to facilitate information sharing; identify and alert stakeholders to duplication, gaps, or contraindications; and integrate social determinant of health needs.

Navigation Support. Newer foster parents, those who have never parented a child with complex needs, kinship caregivers, and former foster youth generally need significant support navigating the health care system. Adoptive parents new to the Medicaid system also need support, such as locating network providers and understanding EPSDT requirements.

STABILITY AND PERMANENCY SUPPORTS

Support for Community Placement Success. Out of home placements should be used only when clinically necessary and should focus on preparing the Enrollee to return to a community placement. The foster care system and the health care system must work in tandem to secure appropriate post-discharge placements, such as training a potential foster family so that an inpatient medically complex child can discharge to an appropriate community placement.

Family Support. Kinship caregivers may experience emotional distress due to family dysfunction. Existing children in an adoptive family may experience distress at family change. Families need connection to support groups, therapy, peer supports, and respite.

Caregiver Education and Training. Caregivers need to understand the child's conditions, needs, and care, and how to manage behaviors, oversee medications, engage with school staff, and maintain health appointments. For instance, caregivers of children with intellectual and developmental disabilities (IDD) often need assistance understanding behaviors, such as difficulty toileting and sexual acting out, against normative standards.

Coordination With Schools. Nearly half of school-age children in foster care are involved in special education, and of those, half have severe behavior problems that can lead to suspension and missed educational opportunities. Due to the impact of trauma, even children who are not in special education may require support, such as ensuring their teacher can accurately identify emotional dysregulation that presents as behavioral acting out. Educating the Individualized Education Plan team, school nurses, and teachers about the child's needs and effectively addressing behaviors can mitigate suspensions and missed class.

SAFETY NEEDS

Abuse and Neglect Prevention and Detection. Children with disabilities and those with behaviors due to trauma, IDD, or a mental health condition are at higher risk for experiencing abuse. To prevent further abuse or neglect, families and caregivers need education and support to understand the child's needs and how to manage them, and support for their own needs.

Human Trafficking Prevention and Treatment. The National Foster Youth Institute estimates that 60% of child sex trafficking victims in the US have a history of child welfare system involvement. Caregivers, providers, and communities must be well informed about risks and detecting potential danger. Enrollees need age-appropriate education about risks, including the use of peers to lure children and youth into situations in which they can be exploited. Those who have been victimized need treatment for this extra layer of trauma and often sexual abuse.
Consent and Confidentiality Issues. When a child is removed from the home, their safety is paramount. A DCBS-approved 'source of truth' ensures Care Coordinators, Community Connections Help Line staff, providers, and others are clear about who is authorized to have and discuss information about the child. Additionally, timely access to needed care requires real-time information about who may consent to treatment.

NEEDS SPECIFIC TO SUBGROUPS OF THE KENTUCKY SKY POPULATION

Within the overall Kentucky SKY population, subgroups of Enrollees have their own specific needs. We describe a sampling of these below.
Medically Complex Children. These children require intensive management to ensure timely care and continuity. They are at risk of hospitalization and long lengths of inpatient stay and need a strong medical home to prevent underutilization of preventive and primary care due to heavy use of specialty services. These children need comprehensive evaluation by a team of appropriate experts to identify all needs. For example, we have found that many of our medically complex Enrollees have undiagnosed and untreated autism spectrum disorder. They are also more likely to be technology dependent (e.g., on a ventilator), increasing the challenge of finding an appropriate placement. Their care requires close partnership with DCBS to find and support willing foster families who will accept the placement and provide adequate care.
Youth in the Juvenile Justice System. Some studies indicate that abuse and neglect increase a youth's likelihood of being arrested by 55%. In 2017, nearly 400 Kentucky youth were placed in a DJJ detention center due to status offenses such as running away, skipping school, and underage drinking. Most DJJ-involved Enrollees require the same intensive mental health and behavioral supports as other SKY Enrollees. Many will have exhibited trauma-impacted behaviors, especially in their teen aged years, and these behaviors contribute to their juvenile-justice involvement. Juvenile justice and school staff often serve as parental substitutes and need education and training to ensure long-term Enrollee success. Since the court system, instead of clinical assessment, often drives treatment, judges and court personnel need education to identify appropriate services. In addition, girls in the 'crossover' population, or move back and forth from foster to juvenile justice care, disproportionately lack appropriate care compared to male counterparts.
Transition Age Youth. This population requires support on a wide range of issues to prepare them for transition, including education and support for their health care needs and for social determinants needs such housing, education and employment. Youth also need education and support to exercise their 'voice and choice' during planning. Many desire to 'leave the system', which puts their continued Medicaid coverage at risk. They distrust adults, requiring a strong peer support resource to ensure engagement. They are at high risk for issues such as truancy, early sexual activity and pregnancy/repeat pregnancy, sexually assault, human trafficking,

homelessness, substance abuse, self-harm, and suicide. They need education on healthy relationships and families need support to manage the transition to teen years.

Former Foster Youth. These Enrollees have many of the same needs and issues as Transition Age youth. In addition, many have poor support systems as reunification with the family of origin may be challenging or not in their best interests. They need assistance to connect with peer and other supports and create a 'village' that provides a sense of mutual care and belonging. While this age group becomes more likely to start families, they need education and services to support healthy relationships and develop parenting skills. They remain at risk for poor health outcomes and should be encouraged to maintain Medicaid coverage.

Adoption Assistance. Support for a successful adoption requires educating the adoptive parents about the child's needs and care as well as issues that may arise well after the adoption is final. For example, the transition to the teen years may bring up past trauma or emotions and grief over loss of the family of origin may last indefinitely. Adoptive parents also need assistance with their own support needs.

c. An overview of the Contractor's proposed organization to provide coordinated services for the Kentucky SKY program;

WellCare of Kentucky's organizational infrastructure provides integrated accountability with behavioral, social, pharmacy and physical health staff aligned through our clinical, administrative and operational structure. This supports integrated delivery of services across our staff, contractors, systems, call centers, and all available resources to provide a unified, streamlined managed care experience for our Enrollees, caregivers/families, and providers.

Our organization is built around WellCare's 'One Team' philosophy of a fully integrated, holistic approach to Enrollee care. One Team means that our philosophy applies to every aspect of our organization, from executive leadership staff to the fully integrated Care Coordination Team, across all entities that support our Enrollees, including our Enrollee Call Center, Nurse Advice Line, and BH Crisis Line and local subcontractors. For those services that we subcontract, we provide close oversight to ensure subcontractor adherence to guidelines and standards. WellCare does not subcontract BH services.

Kentucky-Based Leadership. Our Kentucky SKY organization will be led by our SKY Executive Team. These Kentucky-based individuals have significant experience serving the SKY-eligible population and established relationships with our DMS, DCBS, and DJJ partners. Our Kentucky leadership Lori Gordon, LeAnn Magre and BH Medical Director Tim Houchin in particular have worked closely with DMS, DCBS, and DJJ to integrate our services with the foster care and juvenile justice systems. Beyond their experience with managed care for these Enrollees, our Executive Team offers deep, Kentucky-based experience providing direct services to SKY and other Medicaid Enrollees in settings such as institutions, out of home placements, BH treatment facilities, and acute care facilities. This direct care experience informs our approach with clinical insight into effectively serving these children and youth.

Dedicated Regionally-Based Teams. To provide a streamlined managed care experience for our Enrollees, foster and adoptive parents, fictive kin, caregivers, and providers and ensure close collaboration with DMS, DCBS, and DJJ, we have developed an organizational structure that includes regional teams of operational and clinical staff in each of our six regional offices throughout the Commonwealth. Through our proposed structure, we will embed staff in DCBS

regional offices and DJJ community districts to ensure quick engagement and collaboration. Our regional team leaders will support their teams to ensure adherence to escalation protocols and timely, accurate, and proactive services.

Dedicated, Field-Based Care Coordination Staff. A key WellCare differentiator is our field-based Care Coordination staff, which already work face-to-face with Enrollees, DCBS, DJJ, and other stakeholders to ensure timely access to appropriate services. While initially we provided Care Coordination services through a telephonic model, which remains the predominant model among other current Medicaid MCOs, we moved to a field-based model in 2011 with an expanded team in 2013. We specifically dedicated trained and experienced Care Coordination staff to this population based on lessons learned about effectively meeting their needs. We are expanding our Care Coordination staff to deliver face-to-face services to every DCBS regional office and in each DJJ Community District.

Integrated Care Coordination Teams. Our Care Coordination Teams incorporate medical, BH, pharmacy, and social work expertise based on each Enrollee's needs. The team coordinates across the health and social services continuum and bridges Medicaid and the foster care and juvenile justice systems to create a seamless experience of care.

Dedicated Liaison and Training Staff. To ensure we provide targeted communications and training to providers, law enforcement, the judicial system, advocates, and other stakeholders, we are adding several positions to our organizational structure. These positions include:

- Our **Training Specialist** will provide education and training to DMS, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel. This role is also responsible for providing quarterly training for law enforcement officials, judges, district and county attorneys, including the Kentucky Administrative Office of the Courts (AOC), the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy.
- **Field Outreach Coordinators** will serve as our liaisons to DCBS. We plan to locate them at DCBS regional offices to promote timely identification of, and provision of services to, children who have been taken into state custody or have changed placements.
- Our **DJJ Specialist** will serve as our liaison with DJJ, DCBS, Kentucky Department of Corrections (KDOC), and AOC, coordinating training and serving as the point of cross-system contact for evaluations, treatment, and transfers for juvenile justice-involved Enrollees.

Dedicated Provider Engagement Teams. Building on our local provider engagement model that places representatives within the communities they support to provide face-to-face service, we are establishing a separate SKY Provider Engagement Team to provide a high level of service to SKY providers. For example, the team will provide support to private child care providers who are new to a managed care system and may need extra assistance enrolling in Medicaid, learning new systems, and resolving any issues that arise at implementation.

Enhanced Quality Structure. To support effective collaboration with our cabinet partners and ensure specialized focus on SKY operational and quality processes, we will add two new committees to our existing QMC structure: a Collaboration Optimization Committee and a SKY Enrollee Outcomes Committee. The Collaboration Optimization Committee will monitor the effectiveness of collaboration and coordination among WellCare of Kentucky, DMS, DCBS, and DJJ across all operational areas and issues. The committee, which will include DMS, DCBS, and DJJ representation, will recommend policy and process changes to facilitate our joint

cooperative performance to improve quality and outcomes. The SKY Enrollee Outcomes Committee will monitor the quality of care and service for all Kentucky SKY Enrollees receiving Medicaid services and the network of providers who deliver services. Each committee will include provider, caregiver, and former foster care Enrollee representation and report into the QMC oversight committee.

d. A summary of the Contractor's strategy and approach for administering services for Kentucky SKY Enrollees;

COMPREHENSIVE TRAUMA TRAINING ACROSS THE SYSTEM OF CARE

To ground our model of care and stakeholders in trauma-informed approaches, we will provide our evidence-based Healing Futures training to all SKY dedicated and shared staff and providers and make the training available to our DMS, DCBS, and DJJ partners and other stakeholders such as foster and adoptive parents, law enforcement, and judges. Healing Futures specifically addresses trauma informed care, ACEs and service interventions needed to support this population. We will supplement this with trauma and SKY-specific training through our partnership with the University of Louisville School of Social Work. We are also working with the Orphan Care Alliance and Kentucky Partnerships for Families and Children to develop foster parent education.

HIGH-TOUCH, TIMELY ENROLLEE SERVICES

Our strategy and approach to administering services to SKY Enrollees includes a high touch Enrollee Services model that bridges the Medicaid and foster care systems to ensure timely notification of new Enrollees and rapid identification of needs and access to services.

Expediting Immediate Services. WellCare will assign a Field Outreach Coordinator (FOC) to each DCBS regional office and DJJ community districts to quickly screen and initiate services for immediate needs. We will work with DCBS, DJJ and DMS to develop a mechanism to receive notification within 24 hours of a court order. The FOC will serve as the "One Call" coordinator for all stakeholders, removing barriers and improving communication and can issue a temporary ID number if necessary. The Care Coordinator will conduct a Health Risk Assessment, if not completed during the Welcome Call, and a Comprehensive Needs Assessment and schedule an Assessment Team meeting to begin care planning.

Providing Timely Access to Comprehensive Enrollee Data. We will give authorized DCBS and DJJ staff, caregivers, and former foster care Enrollees access to the Medical Passport and other critical information (e.g., current providers, medications) to support decision-making. Foster and adoptive parents and former foster care Enrollees will be able to access WellCare's ClearSKY mobile application via their mobile device or, if they do not own a device, through a tablet issued by their Care Coordinator. Through the ClearSKY app, they also can print an ID card or forward it to their provider.

Facilitating Timely Medical and Dental Home Access. Our FOC will identify existing PCP relationships, determine if they are within access standards, and as needed assist with new PCP selection. Once assigned, an email to the PCP will alert them to the new Enrollee and encourage them to access the Provider portal to quickly address any care gaps. We will also assign each Enrollee to a primary care dentist and, if necessary, an orthodontic dental home.

POPULATION HEALTH MANAGEMENT ALIGNED WITH UNIQUE POPULATION NEEDS

We have refined our PHM model and care coordination approach to align with the goals, needs, and processes of DCBS, the Children's Review Program (CRP), and DJJ. Our strategy and approach for Kentucky SKY builds on this experience to address unique factors that make PHM and care coordination for this population different than for other Medicaid populations. Our tailored PHM model incorporates features such as the following.

Population Trauma Management. Every SKY Enrollee has a history of trauma, which influences health, behavior, participation in care, and other factors that impact outcomes, stability, and permanency. Our entire population health program model, including our care management model, will be trauma-informed.

Expanded Approach to Preventive Care. We will use American Academy of Pediatrics and Child Welfare League of America (AAP/CWLA) standards for higher frequency and intensity of well-child services. Our approach also incorporates prevention of placement disruption, as well as abuse, neglect, and maltreatment.

Population-Specific Approach to Utilization Management. We will support providers in the use of evidence-based guidelines specific to this population. Our UM approach will go beyond strict adherence to medical necessity, accounting for factors like post-discharge placement availability and appropriateness, supports needed for placement stability, and the impact of trauma. Understanding the role of the courts for this population, we will offer grand rounds with judges to promote evidence-based, appropriate services.

Customized Care Coordination Model. Our field-based, fully integrated model will ensure continuity of and access to care upon entry into foster care and through placement changes and transitions across care settings, to adulthood, or out of WellCare. Our Care Coordination Services are person-centered, culturally competent, using a strengths-based approach with a focus on resiliency and intensive support for shared decision-making. Our Care Coordinators have a primary mission to promote Enrollee and family voice and choice throughout the planning process and advocate for what the Enrollee and family say are important to them.

Intensive Support for Enrollees with High Needs. Through our more than eight years of experience managing the care of Kentucky Foster Care Enrollees we know that a large percentage of Foster Care Enrollees have medically complex needs. WellCare will assume all new Enrollees are high needs to ensure no child falls through the cracks. Upon notification, Enrollees with high BH needs will be assigned a BH clinician as the Care Coordinator who will immediately begin the High Fidelity Wraparound process. For those with complex physical health needs, including those with a Medically Complex designation, we will assign a nurse Care Manager as the Care Coordinator to ensure continuity and quickly arrange needed services, coordinating Individual Health Plan (IHP) meetings and working with the Children's Review Program and the Children's Commission to ensure appropriate treatment and placement.

BH Crisis Prevention and Management. Care Coordinators will collaborate with the Enrollee and circle of support to develop a crisis plan as part of the care plan that identifies triggers and specific de-escalation actions for the Enrollee and others to take. Care plans will address non-medical factors that can contribute to crises and to inappropriate hospitalizations, including effects of Adverse Childhood Events (ACEs), SDOH needs, caregiver/family respite needs, and supports within the school environment. We provide 24/7 availability of face-to-face

Emergency Services including in-community mobile crisis intervention services and in-home services; 24/7 availability of telephonic licensed clinical support from our Nurse Line and BH Crisis Line for routine, urgent, and emergent issues; provider education on acceptable after-hours telephonic support for Enrollees so that an incident does not become a crisis; training for all WellCare Enrollee-facing staff on recognizing and managing a crisis call; and ongoing collaboration with DCS and DBHDID on improving BH crisis services.

Programs to Support Enrollee Health, Stability, and Permanency. All Enrollees have access to a full range of wellness, clinical, and condition management programs as needed. We have also developed evidence-based programs to address population-specific needs, including psychotropic drug utilization, frequent BH readmissions, challenges appropriate post-discharge placements, sexual orientation and gender-related issues, suicide and adoption success.

Enhanced Focus on SDOH Resources to Promote Protective Factors. Through our Community Connections program we are seeking new SDOH resources to reduce the risk of delinquent behavior and future adult offending due to exposure to ACES. We will use SDOH data collected through assessments and Z-codes to identify and address Enrollee SDOH needs to support health and permanency outcomes and pinpoint 'hotspots' where community resources must be developed to meet population needs.

Integrating Data to Support a Holistic Enrollee View. We will leverage our CareCentral health management system to integrate claims and utilization data, care plans, and other information to provide a Medical Passport supporting informed treatment and a holistic view of Enrollee needs. The Medical Passport will be available to providers via our Provider Portal and to other authorized users via our Clear SKY solution.

TAILORED QUALITY MANAGEMENT

WellCare of Kentucky's Quality Management program leads the Commonwealth in 24 HEDIS® measures for 2019 and has maintained a two-year NCQA commendable accreditation status in Medicaid. For the past three years, our HEDIS scores for foster care Enrollees have been higher on many measures for our overall Child HEDIS results and the majority if the well-child scores have exceeded the national Medicaid mean. Enhancements to tailor our strong quality management approach to the SKY program include:

Promoting Evidence-Based Practices. We will adopt additional, SKY-specific evidence-based guidelines and approaches such as the higher-intensity AAP/CWLA well-child standards and approaches grounded in SAMHSA's six key trauma-informed principles. We will also adopt and support guidelines on topics like health care for juvenile justice-involved youth; appropriate utilization of psycho-tropics; BH interventions; developmental disabilities including autism; and suicide prevention. We will offer provider incentives, such as value based reimbursement models, to encourage participation and compliance. We will also empower providers to use the holistic High Fidelity Wraparound approach and apply the Annie E. Casey Foundation framework for promoting resiliency.

SKY-Specific Quality Committees. We are enhancing our quality structure by establishing a Collaboration Optimization Committee (focused on the effectiveness of our collaboration with DMS, DCBS, and DJJ to implement the program) and a SKY Enrollee Outcomes Committee to ensure a specialized focus on Enrollee health and other outcomes.

Tailored Metrics and Performance Improvement Topics. In addition to traditional HEDIS measures, we will track and analyze a wide variety of metrics to evaluate our impact on Enrollee outcomes. These metrics will align with measures and reports required by the contract, incorporate key aspects of care for this population, and reflect stability and permanency. We may also use these measures to identify providers with specialized expertise and outstanding performance to recommend to DCBS, Enrollees, and caregivers as preferred providers for SKY Enrollees. We plan to develop a comprehensive reporting dashboard, inclusive of mutually agreed upon metrics, that will be easily interpreted and demonstrate how our services affect Enrollee outcomes. We will also conduct performance improvement projects tailored to population needs such as reduction of seclusion and restraints within residential settings.

WellCare of Kentucky has been National Committee for Quality Assurance (NCQA) accredited since 2014. Since that time, **we have improved our accreditation scores from 79.0 in 2015 to 85.73 in 2018**, have maintained a two-year Commendable NCQA accreditation status, and have the highest NCQA quality ranking in the State Medicaid program at 3.5. In addition to having the highest quality rating, we also have the highest percentage of ratings of a 4 or higher in the 2019 – 2020 report.

e. A summary of the Contractor's strategy and approach for establishing a comprehensive Provider network able to meet the unique physical and Behavioral Health needs of Kentucky SKY Enrollees;

WellCare of Kentucky offers the **largest and most comprehensive network of all Kentucky MCOs**, based on our review of online provider directories**.** Our existing provider network includes 100% of all hospitals, 99% of all eligible PCPs, and 100% of all FQHCs as well as more than 34,500 network providers and 2,300 behavioral health professionals. In addition, all Private Child Care providers with Medicaid numbers are currently in our network.

STRATEGY AND APPROACH

Our strategy for establishing a comprehensive network to meet the unique physical and BH needs of Kentucky SKY Enrollees includes three components.

1. Identify and Contract With Non-Participating Providers Serving enrollees

Gap Analysis to Identify Non-Participating Providers Contracted with Other MCOs. To ensure continuity of care for new Enrollees transitioning from other MCOs, we will use the claim history provided by DMS to conduct a gap analysis, identifying non-participating PCPs who serve SKY Enrollees through other MCOs. We will include those providers in our Network Development work plan with personal outreach to discuss contracting.

Stakeholder Outreach to Identify Additional Non-Participating Providers for Recruitment. We will outreach to stakeholders, including community organizations and key providers, for assistance in identifying providers for contracting.

Recruitment of Specialists Unique to the SKY Population. We are recruiting specialists unique to the Kentucky SKY population such as Level 2 Psychiatric Residential Treatment Facilities (PRTFs) and therapeutic foster care providers. We have already begun the personal outreach to these providers to invite them to upcoming Provider Summits, help them secure a Medicaid number and explain the contracting and credentialing process to them.

2. Expand Access to Key Services That Are Critical But Not Widely Available

BH Crisis Services. WellCare has collaborated with Lifecare Solutions in Louisville to develop a true crisis response team network, which will be expanding into additional Kentucky counties. We are in discussions with providers in bordering states, such as Saint Francis Ministries in Tennessee, to expand services into Kentucky. We are also working with Community Mental Health Centers and Behavioral Health Service Organizations to offer these services.
BH Specialists. Many of the specialties necessary to provide appropriate treatment for this population are in short supply in Kentucky, such as psychiatry, child psychiatry, child psychology, pediatric neurology, neuropsychology, and applied behavioral analysis. To address this, we will build on our current telehealth capabilities to expand access. We will provide telehealth equipment and support to connect foster youth to BH specialists. Through our Virtual Integration Program, we will provide PCPs with a tablet that includes a screening tool and ability to connect to a virtual BH specialist. Virtual visits and follow-up can occur from the youth's home via a device provided to the foster or adoptive parent by WellCare of Kentucky.
Dentists. In addition to integrating our dental vendor into all network development activities to ensure adequate access to a network of dentists and pediatric dentists, we will also use tele-dentistry technology to ensure continuity of care even if the Enrollee needs to move to a foster home outside of the access standards. Using synchronous modalities, we will connect Enrollees with their dental provider by deploying Big Smiles mobile dental providers (able to cover the entire Commonwealth with dental services) to the Enrollee's home, school or other community-based location to ensure continuity of care. We are expanding the network to include mobile sedation dentistry. This will allow Enrollees with special health care needs who require anesthetic to receive care in a dental sedation center or in their dentist's office, rather than in a costlier hospital setting, improving access.

3. Expand Access to Trauma-Informed Care and Other Evidence-Based Practices

Identify Expertise Already Available In Network. Many of our current providers have expertise in trauma-informed care and other relevant evidence-based practices (EBPs), such as trauma-focused cognitive behavioral therapy (TF-CBT). We will use this information to help DCBS, DJJ, and caregivers select providers who can effectively meet Enrollee needs. We will also identify providers with a subspecialty focus such as sexual abuse, physical abuse, domestic violence or human trafficking. When contracting with residential providers we will require evidence they meet the requirements of a Qualified Residential Treatment Provider (QRTP), as required under the Family First Preservation Services Act. We will also ensure that providers follow Building Bridges Initiative (BBI) principles through work plans based on the BBI self-assessment.
Establish A Baseline for Trauma-Informed Care Expertise. Using the National Child Traumatic Stress Network framework for trauma informed care, we will work with DCBS, DJJ Kentucky Partnership for Children and Families, University of Louisville Kent School of Social Work, and our providers and community stakeholders to develop a checklist for trauma-responsive care. We will use results to establish individual provider baselines as well as a network baseline against which we can evaluate improvements in availability of Trauma Informed Care (TIC).
Expand Expertise With Additional Training and Support. We will supplement existing provider expertise with network-wide training and support for an expanded list of EBPs relevant to this population. We are adding training on EBPs such as the American Academy of Pediatrics and

Child Welfare League of America well-care standards for children and youth in foster care, and on appropriate use of psychotropics, treatment for autism spectrum disorder, and health care for youth with juvenile justice involvement. We are partnering with the University of Louisville's Kent School of Social Work to offer TIC training program across the Commonwealth and with our dental benefits administrator to provide TIC training to network dental providers through P.A.N.D.A (Prevent Abuse and Neglect through Dental Awareness). We will offer incentives for providers to deepen their TIC expertise by reimbursing for specified training and certifications and offering preferred provider status to those completing extra trainings. Quality Practice Advisors will provide technical support to providers on TIC and other EBPs including gap analysis, re-training, training for practice staff, and recommendations on external resources.

f. A summary of innovations and Trauma-informed initiatives the Contractor proposes to implement to achieve improved health outcomes for Kentucky SKY Enrollees in a cost effective manner. Include a discussion of challenges the Contractor anticipates, how the Contractor will address such challenges, and a description of the Contractor's experience with addressing these challenges for similar contracts and populations.

INNOVATIONS AND TRAUMA-INFORMED INITIATIVES

WellCare of Kentucky offers a wide range of innovations and trauma-informed initiatives to achieve improved outcomes in a cost effective manner. **Table G.1-1** summarizes some of our most important innovations and trauma-informed initiatives

Table G.1-1 innovations and Trauma-Informed Initiatives

EXPANDING ACCESS AND AVAILABILITY OF SERVICES	
Bring New Providers to Kentucky	To expand access to scarce but critical services such as mobile BH crisis, WellCare of Kentucky will collaborate with providers in border states to expand into the Commonwealth. We have done this with Lifecare Solutions (Tennessee) for mobile crisis and are working with additional providers such as St Francis Ministries.
Telehealth Virtual Integration Pilot	We will provide telehealth equipment and support to PCPs and foster parents to connect youth to BH clinicians through virtual visits and follow up via a tablet-enabled screening tool and telehealth link.
Expand Access to Evidence-Based Practices and Treatment	We will identify, and link Enrollees, to providers who have been formally trained in the use of evidence-based BH assessment and practices like trauma-focused cognitive behavioral therapy (TF-CBT), dialectical behavioral therapy (DBT), parent-child interactional therapy (PCIT), rapid eye movement desensitization and reprocessing (rEMDR), and others.
IMPROVING QUALITY	
Foster Care Medical Home	We will link Enrollees to, and provide additional reimbursement for, PCPs offering enhanced BH coordination practices that conform to the American Academy of Pediatrics/Child Welfare League of America standards for health care for children in foster care.
Evidence-Based Standards for Well-Child Care	We will require PCPs to follow the increased frequency and intensity of well-child services recommended by the American Academy of Pediatrics and Child Welfare League of America.
QTRP Standards	When contracting with residential providers, as part of a BHSO, we will require evidence they meet the requirements of a Qualified Residential

	Treatment Provider (QRTP), as required under the Family First Preservation Services Act.
Building Bridges Initiative	We will ask providers to complete the Building Bridges Initiative (BBI) self-assessment and develop a work plan to move toward BBI improvement. During care coordination, we will promote BBI's youth-guided, family-driven principles.
Members Empowered to Succeed (METS) Program	The METS Program supports provider use of evidence-based approaches and assists Enrollees in stepping down from intensive services or obtaining more specialized or extended services
Preferred Providers	We will identify high-quality providers, including providers who have obtained advanced training in trauma-informed care, for a SKY Preferred Provider designation.
Pilot Program for Transition to Least Restrictive Placement	We are working with Home of the Innocents to provide mental and medical health interventions and intensive assessments to prepare children to transition to the appropriate placement in the least restrictive setting.
Reducing Seclusion and Restraints	We plan to implement a Performance Improvement Project with identified PRTFs and BH hospitals to reduce use of seclusion and restraints and increase alternative methods of addressing behaviors for Enrollees in residential settings.
Grand Rounds with Judges	Judges often order treatment without a full grounding in evidence-based approaches and recommendations. We will offer grand rounds with our clinical experts to inform judicial decision making in the Enrollee's best interests.
Value-Based Purchasing	We are developing value-based purchasing initiatives with PCPs, dentists, key specialists, and foster care residential services to link payment to value and quality.
Case Management Fee and Pay for Quality	We will pay a case management fee to compensate PCPs for the additional responsibilities they are assuming. Our Partnership for Quality (P4Q) incentive program will reward reduction in ER usage, timeliness of initial PCP outreach, and timely assessment completion.
INTENSIVE COORDINATION APPROACH AND SUPPORT	
Co-location of WellCare Staff in DCBS Offices	To expedite access to services as Enrollees enter foster care, we will co-locate staff in regional DCBS offices and DJJ Community Districts. We will also work with DCBS/DJJ to develop a file to alert us within 24 hours of a court order for a child to enter foster care.
Face-to-Face, High Touch Service for All New Enrollees	Under our WellCare At Home field-based fully integrated Care Coordination program, we will conduct a face-to-face assessment of all new Enrollees and presume that all new Enrollees are complex
Enhanced Data for Stratification	Our risk stratification model incorporates SDOH and information from KHIE and we will collaborate with DCBS and DJJ to incorporate data from their systems.
Intensive Placement Support Program	This program will provide intensive clinical and coordination support for children and youth with high and specialized needs preventing DCBS from securing a permanent foster placement.
Clear SKY Solution for Data Sharing	Our ClearSKY solution will provide secure, HIPAA-compliant access to the Medical Passport and other key Enrollee information for authorized DCBS, DJJ, foster and adoptive parent users and former foster care Enrollees.

ENHANCING PROVIDER SUPPORT	
Coding Educator	Beginning four months in advance of program go-live, we will offer support to providers through a coding educator on our Provider Relations staff.
Gold Card Program	Behavioral health and other specialty providers with a demonstrated record of cost efficiency and quality will not be subject to prior authorization requirements.
Regionally-Located Quality Practice Advisors	Regional QPAs will provide a range of technical supports to assist providers in complying with evidence-based practices.
ENROLLEE AND FAMILY SUPPORT	
Transition Age Youth and Young Adults Program	This program uses a youth-led planning model and designated transition staff and peer support resources to encourage youth voice and choice.
Maintain My Medicaid Initiative	This initiative leverages peer support and intensive outreach and education to encourage youth to remain enrolled/re-enroll in Medicaid for their health care.
Kentucky Partnership for Children and Families leadership training	Our partnership with KPCF will expand their leadership training to Enrollees by offering scholarships and developing unique training methods to encourage participation.
Kumanu (JOOL)	This one of a kind smartphone-based application promotes health engagement and personal well-being. The application captures Enrollee-entered data for factors (such as health and life engagement, willpower/self-control, and resilience) that are impacted by ACEs and protective factors, providing insight into SDOH needs.
Youth Peer Support Specialist	We will co-locate Youth Peer Support Specialist on college campuses to provide outreach and support to engage former foster care youth in care and assist with connection to community resources.
Lifetime Access to Community Connections	Former foster care youth will have lifetime access to resources and support through our Community Connections program.
SOGIE program	This program provides evidence-based intervention to address the increased risks among Enrollees of different sexual orientations, gender identities, and gender expressions (SOGIE).
Ensuring Adoption Success for Enrollees (EASE) Program	This program provides intensive education and support to adoptive families to ease the adoption process and promote a successful adoption and family transition.
Human Trafficking Prevention and Healing Program	This program provides education to protect Enrollees from victimization and provide specialized treatment and support resources to those who have been victimized.
MEETING SOCIAL DETERMINANTS OF HEALTH NEEDS	
SDOH Hotspotting	We will analyze z-codes to help us pinpoint and track SDOH needs among our membership and identify 'hotspots' across the Commonwealth where specific resources need to be developed.
Evidence-based SDOH Screening Tool	We use the CMS Center for Innovation's Health-Related Social Needs (HRSN) Screening Tool which asks 10 questions about living situation, food,

	transportation, utilities, and safety. For foster and adoptive parents and for Enrollees age 17 and older, we use additional supplemental questions about financial strain, employment, family and community support, education, physical activity, substance use, and mental health.
Community Connections	We proactively identify Enrollees with unmet social service needs, remove barriers to appropriate access and healthy lifestyles, and build strong community partnerships we can leverage to benefit Enrollees and families.
WellCare Works	This program provides tools, support, and a robust network of more than 190,000 resources (virtual, national, and local community based) to help Enrollees and families take charge of their personal health including social connectivity and employment.
Welcome Home Kits	We will provide kits, including bedding and towels, to help transition age youth and young adults to settle into dorm rooms and apartments.
TRAUMA INFORMED INITIATIVES	
Staff, Provider, and Stakeholder Training and Education	We will provide our Healing Futures comprehensive trauma-informed care training to all WellCare SKY dedicated and shared employees and well as providers and stakeholders. We will supplement this training through a partnership with the University of Louisville Kent School of Social Work to offer additional trauma-informed care training to Enrollee-facing staff, providers, law enforcement, and the courts. We will also provide Mental Health First Aid training for all WellCare Kentucky SKY staff and make it available to providers and community partners including foster and adoptive parents.
Specialized Trauma-Informed Care Training for Dental Providers	We will work with our dental benefits administrator to provide training for dental providers through P.A.N.D.A (Prevent Abuse and Neglect through Dental Awareness). The training includes information about identifying child abuse and neglect, elder abuse, domestic violence and human trafficking.
Trauma-Informed Care Checklist	We will develop a checklist for components of provision trauma responsive care that aligns with the National Child Traumatic Stress Network framework, in collaboration with DCBS, Kentucky Partnership for Children and Families, University of Louisville Kent School of Social Work, providers and community stakeholders.
ACEs Screening	We will incorporate screening for Adverse Childhood Experiences into our comprehensive assessment process and require PCPs to conduct ACEs screening.

CHALLENGES

In implementing the Kentucky SKY program to achieve improved health outcomes for Enrollees, we anticipate the following challenges.

Learning Curve for Providers New to Medicaid. Some of the providers who currently provide vital services for children and youth in foster care, such as therapeutic foster care providers, are new to Medicaid managed care. We will address this by deploying our high-touch Provider Relations team to provide assistance enrolling in Medicaid and with service authorization and billing, and by adding a full-time Coding Educator.

Stakeholder Learning Curve on Kentucky SKY Requirements. It is one thing to receive training and education on ACEs and trauma-informed care, a High Fidelity Wraparound approach, or a framework for strengthening resiliency among children and youth in foster care. It is another to incorporate those guidelines and frameworks into everyday practice. We will address this through education and training opportunities, our high-touch approach to Provider Relations, and structured collaboration with stakeholders, including DCBS and DJJ.

Building a Bridge Between Medicaid and DCBS/DJJ. Our goal is to become a resource for DCBS and DJJ regional staff, aligning our work flows with theirs and identifying ways in which we can assist with information flow and coordination. We will connect with the DCBS and DJJ staff in each region and county office and developing good working relationships with the goal of demonstrating our value to them.

On-boarding 24,000 New Enrollees. At go-live, we will need to quickly complete comprehensive assessments and initiate care planning so that Enrollees quickly get or resume needed services and supports. WellCare already serves many of these Enrollees but we will leverage our successful Kentucky experience with new program implementation as well as our Florida affiliate's recent experience successfully transitioning a large population of children with special needs.

Expanding Access to Critical Services. We will improve access to key but scarce services including mobile crisis, psychiatry, psychology, ABA and trauma therapy. We will do this by expanding our network to include providers in Border States and by leveraging telehealth.

2. Company Background

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G.2. COMPANY BACKGROUND

a. Corporate Experience

i. Describe the Contractor's experience in the provision of managed care services similar to those specified in the Contract for the Kentucky SKY populations specified in this Contract. In addition, include the following information in the response:

a. Experience in coordinating and providing Trauma-informed services, and educating Providers on Trauma-informed Care, ACEs, and evidenced based practices applicable to individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance;

b. Three (3) examples of initiatives the Contractor has implemented for Medicaid managed care programs for individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance that have supported improved outcomes (e.g., greater awareness of Trauma-Informed Care, clinical outcomes, Discharge Planning between levels of care, etc.). Describe whether such initiatives were cost effective and resulted in sustained change;

c. A summary of lessons learned from the Contractor's experience providing similar services to the populations enrolled in Kentucky SKY; and

d. How the Contractor will apply such lessons learned to the Kentucky SKY program

ii. Provide a listing of the Contractor's prior and existing full risk Medicaid managed care contracts serving individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance the previous five (5) years. Include the following information:

a. State name

b. Contract start and end dates

c. Number of covered lives

d. Whether the Contractor provides services regionally or statewide

b. Office in the Commonwealth - For programs similar to Kentucky SKY, has the Contractor co-located staff in an agency regional office? If yes, describe the factors that influenced that decision and summarized the outcome of the co-location in coordinating of services for program participants.

c. Staffing

i. Describe the Contractor's proposed approach to staffing for the Kentucky SKY program under this Contract, including the following information at a minimum:

a. Description of how the organizational structure provides innovative solutions for meeting programmatic goals specific to the Kentucky SKY program and Kentucky SKY Enrollees and supports stakeholder groups (e.g., Kentucky SKY Enrollees, providers, partners, among others).

b. Description of how the organizational structure will support whole-person integrated care, population health, and overall improvement in health outcomes in a cost-effective manner for the Kentucky SKY program.

ii. What prior experience will the Contractor require staff to have had in serving populations similar to Kentucky SKY Enrollees?

iii. Provide a narrative description of the Contractor's approaches to recruiting staff for the Kentucky SKY program, including:

   a. Recruitment sources;

   b. Contingency plans if the Contractor is unable to recruit sufficient numbers of adequately trained staff in a timely basis or if the Contractor's original staffing estimates are too low and for avoiding and minimizing the impact of personnel changes;

   c. How the Contractor will assure the Department that sufficiently experienced, licensed and trained personnel are available to support implementation and ongoing administration of the Kentucky SKY program; and

   d. How the Contractor will seamlessly transition staff, if necessary, from implementation to ongoing operations.

iv. A listing of Full-Time Kentucky SKY Key Personnel identified in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," and as otherwise defined by the Contractor, including:

   a. Individual names, titles, job descriptions, qualifications and full-time equivalents (FTEs) who are dedicated one hundred percent (100%) to the Kentucky SKY program under this Contract with no other responsibilities outside of the Kentucky SKY program, as well as their office locations for this Contract. An FTE is defined as the ratio of the total number of paid hours divided by the total number of working hours in the period. Annually, an FTE is considered to be 2,080 hours.

   b. Whether each Full-time Kentucky SKY Key Personnel position will be filled by a Contractor's employee or a Subcontractor. Identify the number of FTE Subcontractor staff who will be one hundred percent (100%) dedicated to the Kentucky SKY program.

   c. Resumes, including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Include as an Appendix or Attachment to the Proposal.

v. Overview of the Contractor's proposed training of staff to fulfill all requirements and responsibilities of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," for all operational areas. Provide the Contractor's proposed training program and curriculum for all staff specific to areas of responsibility. Include information about the topics for which staff will receive training, how trainings will differ for new staff members versus ongoing trainings and related training schedules.

vi. Overview of Contractor's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

vii. Retention approach for Full-time Kentucky SKY Key Personnel.

viii. Provide a detailed description of the Contractor's organizational structure for the Kentucky SKY program under this Contract, including an organizational chart that displays the following:

a. Management structure, lines of responsibility, and authority for all operational areas of this Contract.

b. How the Kentucky SKY fits into the overall organizational structure of the Parent Company.

c. Where Subcontractors will be incorporated.

ix. A summary of how each Subcontractor will be integrated into the Contractor's proposal performance of their obligations under the Contract to ensure a streamlined experience for the Kentucky SKY Enrollees, Providers and the Department.

x. Identification of staff positions that will be based (1) in the Contractor's Kentucky office(s), (2) in the field, and (3) at a corporate office of the Contractor or Subcontractors. Information should include physical locations for all Contractor operational areas to support this Contract.

xi. Number of proposed FTEs dedicated to the Kentucky SKY program, by position type and operational area and how the Contractor determined the appropriateness of these ratios.

xii. Describe the roles and responsibilities of Care Coordinators and Care Coordination Team. How will the Contractor maintain adequate Kentucky SKY to Kentucky SKY Enrollee ratios and number of Care Coordination personnel and management staff having expertise in Physical Health, Behavioral Health, and the Kentucky SKY Enrollee to build Care Coordination Teams? Provide the Contractor's approach to locating the Care Coordinators areas in which they serve.

G.2. COMPANY BACKGROUND

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 41.1 Scope of Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix,** provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc. (WellCare). On January 23, 2020 WellCare was acquired by Centene Corporation (Centene). WellCare is now a wholly owned subsidiary of Centene. **WellCare of Kentucky's leadership, staff, branding, and model for delivering services to the Commonwealth are not changing and we remain committed to partnering with DMS to ensure Kentucky's Enrollees, communities, providers and other stakeholders receive the integrated, whole-person care and services necessary to address all of their physical, behavioral, and social needs.** With the acquisition, WellCare of Kentucky is now also able to leverage the combined experience and best practices of our Centene affiliate health plans, which is now managing the care of more than 12.9 million Medicaid Enrollees across 30 states.

a. Corporate Experience

i. Describe the Contractor's experience in the provision of managed care services similar to those specified in the Contract for the Kentucky SKY populations specified in this Contract. In addition, include the following information in the response:

OUR EXPERIENCE PROVIDING MANAGED CARE SERVICES FOR THE POPULATION SIMILAR TO KENTUCKY SKY

It has been WellCare of Kentucky's privilege to serve the Kentucky Medicaid program and our Enrollees over the last eight years. Currently, **WellCare of Kentucky is managing the care of approximately 8,100 Foster Care Enrollees, Former Foster Care Youth Enrollees, Adoption Assistance Enrollees, and Juvenile Justice (JJ) Enrollees (hereafter referred to collectively as Foster Care Enrollees), across the Commonwealth**. We also leverage our affiliate WellCare Medicaid health plan's experience and best practices from managing Foster Care Enrollees, which as of year end 2019 include approximately 20,000 enrollees in seven other states. With the acquisition, we are now also able to leverage the experience and best practices of our Centene affiliate health plans, which manage the care of more than 150,000 children in Foster Care across 17 states. This experience includes sole source Foster Care contracts in Florida, Illinois, Texas, and Washington.

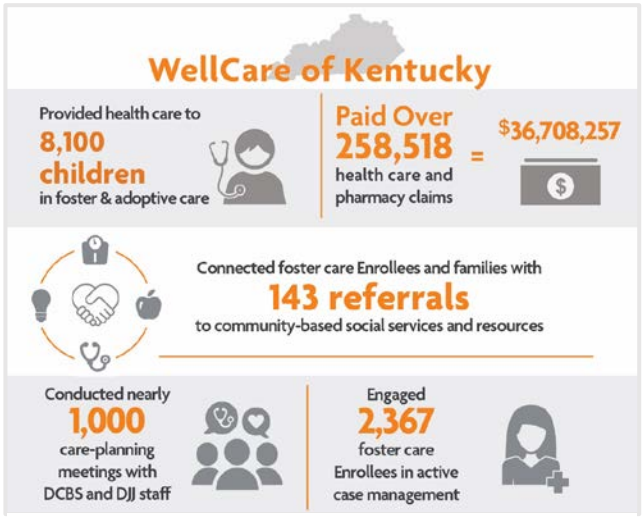


Figure G.2-1 Data for our Foster Care Enrollees

We have embraced our role as a supporter to the Kentucky Cabinet for Health and Family Services, DMS as an agent of change to transform the Medicaid program and to achieve the goal of better health outcomes for Enrollees in the populations we serve. Through the years, we have developed comprehensive, Kentucky-specific, innovative programs that are improving Enrollee health in Kentucky. As an incumbent managed care organization (MCO) with six Regional offices, we currently serve the single largest concentration of children and youth in foster care, receiving adoption assistance and/or involved with the juvenile justice system across the Commonwealth with approximately 8,100 children, relying on our passion for individualized and holistic care to empower them to achieve their unique short-term and long-term goals. Our local Kentucky and national knowledge and experience of this population informs our approach to care coordination of their medical, behavioral, pharmacy, and dental health benefits and their use of social resources. Providing health care for children in the foster care population requires those involved in a child's care to have an in-depth understanding of childhood trauma and its potential negative impact on a child's brain development. It also requires an understanding of their unique physical health, mental health, pharmacy, and social needs as well as the developmental and educational problems children and adolescents in foster care experience. It

is also important to know what it takes to navigate effectively the structure, goals, and mandates of Kentucky's foster care system of care. This knowledge and experience facilitates the provision of appropriate comprehensive care to children and youth in this population. Children in foster care are a uniquely vulnerable population.

The American Academy of Pediatrics (AAP) classifies this population as children with special health care needs because of the high prevalence of chronic medical, developmental, and mental health problems, most of which predate their placement in foster care. In Kentucky, this population has received comprehensive and coordinated services through our existing Kentucky network of more than 34,500 providers since 2011. **On Day 1 of the Kentucky SKY contract, we have the expertise, experience, capability, and proven commitment to providing services to the Kentucky SKY population.**

Children and youth placed in foster care because of abuse or neglect often enter our care with significant behavioral health challenges. Their health issues are often related to poverty or to other at-risk conditions, such as parental substance abuse or mental illness. The actual abuse or neglect (including medical, behavioral, and dental care neglect) is often a contributing factor to their poor health, as noted when they become our Enrollees. The disruption caused by removal from the home and placement in foster care can exacerbate their health issues, if not quickly and appropriately addressed by qualified individuals who understand their needs and know how to navigate and collaborate with those engaged in Kentucky's system of care. Our direct experience with our Kentucky Medicaid children in the foster care population shows these children and youth have high levels of trauma, transiency, psychotropic medication use, and higher rates of hospitalization and readmissions. In April 2019 based on claims data, the most prevalent chronic condition for our Medicaid Enrollees in the foster care population is one or more psychiatric conditions, including depression and substance use disorder (SUD). Our data shows that almost half of our current Enrollees in the foster care population have behavioral health needs, as seen in **Figure G.2-2**, a much higher rate of behavioral health needs than most of the other adult and child Kentucky Medicaid populations we serve today. In fact, their rate of behavioral health issues is more than double the rate for the children and youth we serve in our Kentucky Children's Health Insurance Program (KCHIP) and Temporary Assistance for Needy Families (TANF) child populations. **In 2018, 3,657 foster care children received behavioral health services, with 53,710 unique behavioral health claims for a total $14,149,603.** Many of our foster care children and youth have complex care needs with co-occurring and comorbid conditions, such as gastrointestinal disorders, metabolic disorders, diabetes, asthma, and developmental disabilities. On average, they use twice as many chronic care drugs compared to our KCHIP and TANF child populations. **Our utilization data from 2016 – 2018 for the foster care population shows a positive trend of a 9.54% decrease in Emergency Department visits/1,000 and a 9.51% increase in PCP visits per 1,000 and a 22.22% increase in specialist visits, demonstrating a migration from expensive non-**

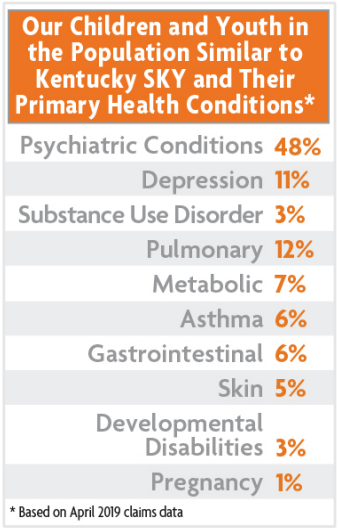


Figure G.2-2 Primary Health Conditions

coordinated Emergency Department visits to a less expensive, highly coordinated place of service.

Children and youth in foster care have more touch points than other Medicaid populations, interacting with foster families, biological and fictive kin relations, medical consenters, child protective services, judges, medical and behavioral healthcare providers, pharmacists, child-placing agencies, advocacy groups, community-based services, and sometimes juvenile justice. This makes care coordination and integration of health care services particularly vital to improving health outcomes for the Kentucky SKY population. Our current population similar to Kentucky SKY is disproportionately clustered in DMS Region 5. For all Enrollee population types, only 17.5% of our total Medicaid population is in Region 5, however in Region 5 the foster care and juvenile justice systems and adoption assistance population is 26% of our total Medicaid population.

Nationwide, as of year end 2019, WellCare managed approximately 28,000 children and youth in the foster care and receiving adoption assistance population in Florida, Hawaii, Michigan, Missouri, Nebraska, New Jersey, and South Carolina. With the acquisition by Centene, WellCare of Kentucky now has access to Centene's industry leading Foster Care experience including 150,000 children in 17 states including Texas and Florida. In Kentucky, we are a market leader and innovator for the foster care and receiving adoption assistance population, collaborating with Department, DCBS, and DJJ staff and other stakeholders, conducting shared decision-making activities that consider an Enrollee's whole person needs and offering initiatives and innovations, like the JOOL health coach program for youth in foster care who are transitioning to adulthood, which we describe later in this response. Transition-age youth and former foster care Enrollees require significant support for self-advocacy, maintain Medicaid, and accessing social determinant resources as they age out. We also recognize the importance and impact of caregiver needs and capabilities on utilization of and lengths of stay in higher levels of care. Our prevention-focused approach includes abuse, neglect, and maltreatment prevention efforts, such as education, training, peer support, and connection to respite for family caregivers. Recognizing children in foster care are at greater risk than the overall population for being victims of human trafficking and sexual exploitation, we offer a population health program to protect Enrollees from victimization through education about risks and how to identify and report potentially dangerous situations and help Enrollees who have been victimized to heal through specialized treatment and support resources.

WellCare of Kentucky demonstrates to the Commonwealth the value of managed care for individuals in the foster care and juvenile justice systems and those receiving adoption assistance. We have a strong commitment to collaboration, transparency, flexibility, and innovation in care delivery for all populations, including the population similar to Kentucky SKY. **In 2018, we conducted nearly 1,000 care-planning meetings with DCBS and DJJ staff.** Today, we offer the following key components required to manage this population, including:

- Complex case management and care coordination
- Psychotropic medication review
- Transition-aged programming focus

- Provider, Enrollee, Department, DCBS, DJJ, and other stakeholder engagement and foster-care related training with an increasing focus on trauma-informed care and services
- Consideration and insight into the geographical and cultural differences throughout all nine DCBS regions and DJJ Community Districts
- Performance-based payment for providers and an Enrollee incentive program

WellCare of Kentucky is currently the largest managed care provider in Kentucky. We have Kentucky Medicaid experience providing covered services, value-added services as well as high-quality population health management program services and care coordination services, including care coordination and specialty case management services for complex and medically fragile populations. On our current Kentucky Medicaid contract, in 2018, we engaged 2,367 foster care Enrollees in active case management.

We use an analytics-driven and locally integrated approach to delivering care and services statewide. In Kentucky, our membership has the highest number of medically fragile Enrollees. Our population health management programs serve all our Enrollees regardless of their diagnosis or where they are on the continuum of health and wellness. We integrate medical and behavioral health, pharmacy, dental, and social services to improve and maintain Enrollee health and wellness through coordinated, interdisciplinary care teams supported by local staff, targeted initiatives, and advanced technology and tools.

NATIONAL EXPERIENCE

As a company responsive to the needs of our Enrollees, providers, state agency staff, and others involved with the care and services for foster care Enrollees, we exclusively serve Enrollees enrolled in government-sponsored health care programs. We react quickly to feedback from Enrollees, providers, state agency staff, and other stakeholders and use our deep knowledge of Medicaid and Medicare to inform problem-solving, shared decision-making, and finding a better way to serve our Enrollees. Between 2014 and 2019, WellCare was the only national Medicaid managed care plan to be re-awarded 100% of rebid contracts and, in multiple states, has been awarded contracts to serve additional populations and regions—many new to managed care. In 2018, WellCare won procurements for new Medicaid business in North Carolina for the Medicaid program statewide and in Florida for Children's Medical Services (CMS) Health Plan, a program offering high-touch services for 68,000 children with special healthcare needs, including 250 foster medically fragile children.

WellCare is a leader in helping Enrollees transition from other MCOs and fee-for-service (FFS) Medicaid programs to our health plans. WellCare's national experience managing transitions of care encompasses Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, and South Carolina and the successful transition of 1,880,000 Enrollees to WellCare, as illustrated in **Figure G.2-3**. Our Kentucky, Florida, Hawaii, Michigan, Nebraska, New Jersey, and South Carolina program implementations included the foster care and adoption assistance populations.

Additionally, with the acquisition we are now able to leverage our affiliate Centene health plans past experience of successful implementations of more than 9.25 million Medicaid Enrollees across 23 states.

WellCare has an extensive array of resources and full scalability to accept large or small groups of transitioning Enrollees, including the Kentucky foster care population, and provide covered services. We designed our standardized processes and advanced platforms to support growth.

WELLCARE IMPLEMENTATION EXPERIENCE

The total is more than **1,880,000** members over 10 years.

Implementation Description	2019	2018	2017	2016	2015	2014	2013	2012	Pre 2012	Number of members Transitioned
WellCare Transition of Florida children with special healthcare needs, including foster care, to our statewide Children's Medical Services (CMS) Health Plan	✓									68,000 members
Staywell Transition of Florida Medicaid members, including the SMI and LTSS populations	✓									78,000 members
Harmony Health Plan Statewide Medicaid expansion into all Illinois counties		✓								190,000 members
Care 1st Health Plan Arizona Transition of Arizona members		✓								100,000 members
Missouri Care Statewide expansion of Medicaid managed care into all 115 counties			✓							179,000 members
WellCare of Nebraska Statewide implementation of Medicaid managed care for Heritage Health			✓							70,000 members
WellCare of South Carolina Transition of Medicaid members from Advicare Corp.				✓						30,000 members
WellCare of New York Statewide carve-in of behavioral health services for adult Medicaid members				✓	✓					71,000 members
WellCare of New Jersey Transition of 46k Healthfirst members & implementation of LTSS program						✓				46,000 members
Staywell Transition of Florida Medicaid members from FFS due to mandated managed care						✓				394,000 members
WellCare of Kentucky Transition of 43k members due to realignment of MCOs (open enrollment): enrollment of 28k members (Reg 3 expansion)							✓	✓		71,000 members
WellCare of Kentucky Transition of members due to realignment of MCOs							✓			63,000 members
`Ohana Health Plan Statewide implementation of the Hawaii QExA, QUEST and CCS programs								✓	✓	30,000 members
WellCare of Georgia Transition of Medicaid members									✓	490,000 members

Figure G.2-3 WellCare Implementation Experience (prior to 2020)

This ability to scale is a key aspect of our operational practices. Our expert national transition team supports local transition activity for large groups. Earlier this year, we completed the implementation of our CMS Health Plan program and transitioned these children to our high-touch program. Like our Kentucky foster care population, our CMS Health Plan Enrollees have special health care needs, many have complex care needs, and some have experienced high levels of trauma, transiency, psychotropic medication use, and higher rates of hospitalization and readmissions. Over the last 20 years in Florida, we have expanded care to more than one million Enrollees across our Medicaid, CMS Health Plan, Healthy Kids, and Medicare plans. This growth is a testament to our proven record of accomplishment providing Enrollees with consistently high quality, comprehensive healthcare solutions. Kentucky SKY Program Key Scope of Work Components WellCare of Kentucky has been fortunate in establishing long-term relationships with its clients, which are indicative of our commitment to our customers and our

ability to provide improve health outcomes and provide quality, cost effective services. In Kentucky, Florida, Hawaii, Michigan, Missouri, Nebraska, New Jersey, South Carolina, we have experience capability to provide the full range of the Kentucky SKY program required scope of services in the Draft Contract, including:

Readiness Review: WellCare of Kentucky is an experienced managed care partner that has successfully completed all required readiness reviews for the Kentucky Medicaid Managed Care Contract as well the successful implementation of new populations and program changes, quickly and efficiently with minimal Enrollee and provider issues and impacts. **Nationally, WellCare has successfully completed and passed every managed care contract readiness review between 2009 and 2019.**

Management Information System: On all of our Medicaid programs, we maintain a single and centralized Enrollee record in CareCentral, our care coordination system. CareCentral houses all behavioral health and medical UM and authorizations into a single Kentucky SKY Enrollee view. Fully integrated with our claims systems, CareCentral shows users a Kentucky SKY Enrollee's integrated health record, health history, diagnosis and treatment, outreach efforts, information received from providers, assistance with scheduling appointments, assessment data, medication history, health-related social resource needs, claims history, authorizations, and care plans. CareCentral has the capability to store and forward information. Authorized WellCare staff and providers have access to a complete picture of a Kentucky SKY Enrollee's needs across the entire spectrum of care when considering authorization decisions and utilization trends. CareCentral offers automated notifications and workflows related to care transitions. It supports transitional care management activities by generating alerts based on ADT feeds, electronic and faxed prior authorization requests, predictive modeling, and other sources. It helps the care coordinator bring together a Kentucky SKY's Enrollee's entire interdisciplinary care coordination team (e.g., providers, behavioral health specialists, pharmacists, Enrollee, family, and Department, DCBS, and DJJ staff). CareCentral's intuitive transitional care management workflows and alerts automate a care coordinator's activities like appointment scheduling, which improves care coordinator efficiency in directing the right transitional care to the right Kentucky SKY Enrollees at the right time. We are updating our system to interface with Subcontractors and other relevant Kentucky systems, including DCBS' TWIST system, DJJ's JORI system and reported data in a format specified by DMS, DCBS, and DJJ.

We recognize the value that our single integrated management information system brings to ensuring visibility into an Enrollee's whole health needs. Through our experience, we have gained a strong understanding of state partner's needs and recognize that if our systems do not function properly we risk our Enrollees not receiving needed care and our providers not getting paid timely and accurately. **Evidence of our commitment to system availability is our recent increase in systems availability metrics from 99.98% in 2017 to 99.99% in 2018.**

Quality Management: Quality is foundational to everything WellCare of Kentucky does for our Medicaid Enrollees. WellCare of Kentucky uses an integrated, collaborative effort on our Medicaid contract to improve Enrollee health outcomes through Enrollee empowerment and provider support and education, we have improved performance in CAHPS scores, provider satisfaction, PCP visits, HEDIS scores, and NCQA accreditation status over the past eight years. WellCare of Kentucky earned high ratings according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2018-2019. NCQA evaluated WellCare's clinical performance based on three areas: consumer satisfaction, prevention, and treatment. Because of targeted and tailored hands-on approach to empowering Enrollees and their families, **we have improved our CAHPS scores from 86.51% in 2014 to 88.3% in 2018** while experiencing significant growth, and have the **highest Enrollee satisfaction in the Commonwealth as measured by the CAHPS survey**. Due to our responsiveness and quick action to provider concerns, our **overall provider satisfaction rate increased significantly (47%) from 2013 to 2018**, and we have ranked **#1 for provider satisfaction in the Commonwealth for 2017 and 2018**. Our programs have increased Enrollee access to providers, resulting in an **increase in PCP visits from 64.5% in 2013 to 70.1% in 2018**. We maintain a focus on closing care needs and encouraging preventive care, **consequently 91% of our HEDIS measures including Well-Child Visit measures and Annual Dental Visits have improved year-over-year from 2013 to 2019**. We currently lead the Commonwealth in 24 out of 70 HEDIS measures for 2019. **Since we became National Committee for Quality Assurance (NCQA) accredited in 2014, we have improved our accreditation scores from 79.0 in 2015 to a projected 85.73 in 2019, have maintained a two-year Commendable NCQA accreditation, and have the highest NCQA quality ranking in the State Medicaid program at 3.5.** In addition to having the highest quality rating, we also have the highest percentage of ratings of a 4 or higher in the 2019 – 2020 report, see **Figure G.2-4**. High NCQA high ratings demonstrate our commitment to our Enrollees, providers, as well as DMS, DCBS, and DJJ and to building on our accomplishments to provide a better healthcare experience for all Kentucky Sky Enrollees. Our investments in quality are helping our Kentucky Enrollees access needed care and services, making sure individuals are receiving the right care at the right time. This reinforces our continued commitment to helping our Kentucky SKY Enrollees live better, healthier lives.

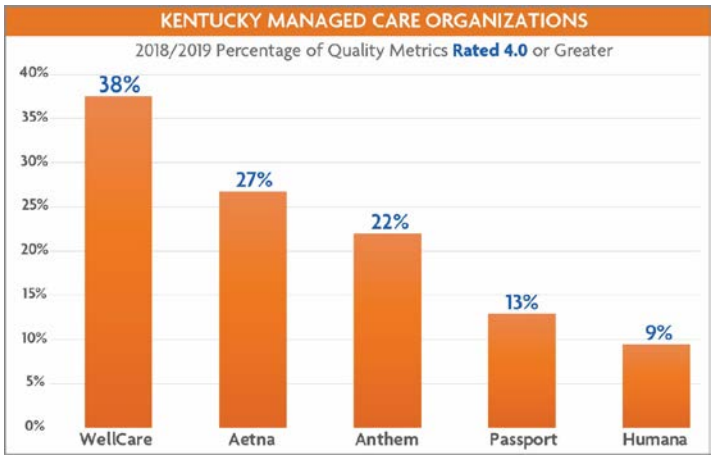


Figure *G.2-4* WellCare of Kentucky Percentage of Quality Metrics

Utilization Management: Because the majority of families involved with child protective services struggle with poverty, they may rely on Emergency Departments for care. Emergency Departments do not provide optimal pediatric preventive care, nor the continuity that is critical

for children in foster care. Fragmented medical care can delay prompt identification of health problems. However, when WellCare of Kentucky, DCBS and DJJ, and medical and behavioral health work together, we can avoid high-cost Emergency Department services by coordinating effective and timely comprehensive health care services for children in foster care.

Today, our Kentucky UM program ensures our Enrollees receive the most appropriate, integrated, and effective treatment to achieve the best clinical outcomes. We accomplish this through the prospective, retrospective, and concurrent assessment of medical necessity and appropriateness of the allocation of medical and behavioral healthcare resources and services given, or proposed services (e.g., discharge planning and care transitions), to meet a SKY Enrollee's needs. **Our focus on shared decision-making means physical and behavioral health providers, pharmacists, Kentucky SKY Enrollees, foster parents, adoptive parents, fictive kin, caregivers, and Department, DCBS, and DJJ staff work together to make decisions and select treatments and care plan interventions based on clinical evidence that balances risks and expected outcomes with Enrollee and family preferences and values.**

Our physical health, behavioral health, and pharmacy guidelines reflect evidence-based recommendations from leading specialty associations, colleges and societies (e.g., American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Diabetes Association), as well as peer-reviewed literature and studies. WellCare's extensive evidence-based practice resources strongly align with the top diagnoses among our foster care and juvenile justice Enrollees. We already use a wide range of evidence-based guidelines relevant to the population, such as for ADHD, antipsychotic drug use, asthma, autism spectrum disorder, depression, epilepsy, lead exposure, and obesity.

Enrollee Services and Support: Through our high-capacity, multimodal Enrollee communication channels and customer service team of dedicated Enrollee Service Representatives (ESRs), we listen to our Enrollees to provide first-call resolutions to their questions and concerns. **Compared to other Kentucky Medicaid MCOs, we have the highest Enrollee satisfaction as measured by the CAHPS survey.** Enrollee outreach includes a suite of digital smartphone applications connecting Enrollees to easily digestible information, access to our online wellness programs that empower self-sufficiency and healthy behaviors, and access to personalized information to help close care needs. We a comprehensive program to provide ongoing education and outreach to Kentucky Medicaid Enrollees and on all of our Medicaid programs. Our training approach includes program descriptions and other relevant information via written and online materials, 1:1 verbal training, mobile education and outreach, digital communications, face-to-face counseling, and home visits when appropriate. We also have an in-state Care Center located in Hazard, Kentucky, and staffed with 40 employees who talk to fellow Kentuckians to ensure Kentucky SKY Enrollees have access to needed resources as they navigate the Medicaid program. We have extensive experience disseminating Enrollee Handbooks (online and written) and ID cards (hardcopy and electronic via MyWellCare mobile app) on the Kentucky Medicaid program. **In 2018, WellCare of Kentucky sent 1,023,416 ID cards to our Enrollees. In 2020, ID cards will be available from the Enrollee portal.**

Grievance and Appeals: Our Enrollee-friendly process leverages more than 30 years of experience resolving grievances, appeals, and state fair hearings in compliance with NCQA,

state, and federal Medicaid requirements using a process designed for rapid and thorough resolution. The program protects Enrollees' rights and employs industry-leading technology to capture, log, document, track, resolve, report, and trend every grievance and appeal from beginning to end. **From 2017 to 2018, WellCare of Kentucky experienced a 3% improvement in first call resolutions.**

Provider Network: Our current Kentucky Medicaid network is fully compliant with RFP-defined Network Access and Adequacy standards and is the largest and most comprehensive network of all Kentucky MCOs, based on our review of online provider directories. **We currently have over 99.9% of all Kentucky Medicaid providers under contract, including 100% of all hospitals, 99% of all eligible PCPs, 100% of all FQHCs, and approximately 2,300 behavioral health professionals.** In Kentucky and on other Medicaid programs, we have experience assigning PCPs as a medical home that serve as a single point of accountability and coordination for primary care, which includes EPSDT screenings and special services. We believe children placed in foster care should have a consistent primary healthcare provider for primary care. Consistency supports the child or youth in developing a relationship with his/her healthcare provider, which is critical for developing their trust. Familiarity with a healthcare practice, its staff, and a team of trusted healthcare providers can help decrease an Enrollee's anxiety regarding health care. These factors are fundamental for children who have experienced trauma. Whenever possible, efforts should be made to maintain children in the same healthcare practice even after changes in placement. We are the only MCO to contract continuously with Appalachian Regional Hospital since inception of our Kentucky Medicaid program, which has been very important for our Enrollees in DMS Region 8.

Provider Services and Support: In Kentucky and on all of our other Medicaid programs, we have a fully functioning provider services function, which serves as the single point of contact for our provider network. **In an independent, external provider satisfaction survey in 2019, we had the highest provider satisfaction—with providers rating WellCare of Kentucky highly on the degree to which we cover and encourage preventive care and wellness.** Provider services produces written and online program-specific educational materials, conducts 1:1 training, and other educational opportunities, **such as our monthly provider training meetings via webinar for CMHCs and DCBS who choose to attend. Our Kentucky leadership team creates an agenda and leads the call to discuss specific topics, such as technical assistance, appeals, and authorizations. Attendance varies from five to 75 attendees.** We have a proven, field-based, provider-facing outreach and education program with 18 Provider Relations representatives (PR reps) and managers established regionally across the Commonwealth. WellCare's PR reps live in the region where they support providers, giving them both proximity to the providers they support and familiarity with their communities. We will build on this foundation to serve the Kentucky SKY program, including hiring a Kentucky SKY dedicated PR Manager and two dedicated PR reps, ensuring we can meet the specific outreach and education needs of its providers. **In 2019, WellCare of Kentucky PR reps made over 6,600 personal visits to provider offices to educate providers and their staff.**

We provide 24/7 provider support through multiple channels. Our provider call center has customer service representatives who are cross-trained on the Kentucky Medicaid program.

Kentucky providers can call Provider Services at (877) 389-9457 with issues related to eligibility verification, claims, UM, Language Line, and provider complaints. In addition, our quality practice advisors (QPAs) support providers in transforming and improving their practices with dashboards and tools. They remind providers about the availability of special program services and value-added services. They work with providers to identify and close care needs related to preventive care visits, provide care gap reports, assist with EMR information through the pseudo-claims process, and provide educational material to remind office staff of the standards of care as outlined in HEDIS specifications (HEDIS Toolkits). **In 2019, WellCare of Kentucky QPAs conducted more than 6,000 visits to provider offices to educate providers and advance the Commonwealth's quality measures.**

Covered Services: By educating and outreaching to Enrollees and families or guardians about the availability of special program services like EPSDT and helping them to effectively use special program services, covered benefits, and other resources available through the Kentucky Medicaid program, WellCare of Kentucky supports DMS' focus on quality goals, closing care needs, and improving health outcomes. We have an established and sophisticated process for closing care needs and increasing EPSDT screening standards and a time-tested process for education and outreach to Enrollees, parents, and providers. We ensure timely completion of required assessments and screenings for our Enrollees within required timeframes. In Kentucky, we collaborate with Kentucky SKY Enrollees, DMS, DCBS, DJJ, other sister state agencies, and families on Enrollee needs.

Pharmacy Benefits: We offer pharmacy benefits and services for foster care, adoption services, and juvenile justice-involved Enrollees as part of whole-person care. We incorporate pharmacy interventions, including medication review and medication reconciliation. We use data to review of the appropriateness of psychotropic medications at the Enrollee and population levels, advocating for our Enrollees and intervening as necessary with providers for instances of suspected overprescribing of psychotropic medications.

Behavioral Health: We know the best path to recovery for children and youth with mental health needs and substance use disorders is a holistic approach that helps Enrollees and their families navigate the broad range of services available to them across the continuum of care. We recognize that Enrollees struggling with chronic health conditions may also experience depression, anxiety, and other disorders secondary to their health diagnoses. We integrate behavioral health into every part of our approach to care, including Enrollee engagement, broad access to care, clinical programs, social programs, and value-added benefits. WellCare of Kentucky aligns with DMS' efforts to significantly improve outcomes for a variety of healthcare chronic conditions and to empower individuals to improve their health and engage in their own healthcare. Nationally, we have developed comprehensive programs to address Opioid Misuse Prevention and Opioid Use Disorder Treatment, Adverse Childhood Experiences (ACEs), and Severe Mental Illness (SMI). Each of these programs includes person-centered supports that focus on addressing whole person needs. As noted above, approximately half of our foster care Enrollees have behavioral health conditions.

Eligibility and Enrollment: DMS has the exclusive and final right to determine an individual's eligibility for the Kentucky Medicaid program and eligibility to become a WellCare of Kentucky

Enrollee not subject to DMS' review nor our appeal. We accept all Enrollees whether they selected us or they were assigned to us through DMS' auto-assignment logic.

Population Health Management and Care Coordination: Our model for Kentucky SKY builds on our Kentucky and national experience working in the field with our current Enrollees similar to Kentucky SKY, their caregivers, state staff (DCBS, DJJ), and other stakeholders to address the unique factors that make population health management and care coordination for this population different than it is for other Medicaid populations. Our population health management programs support the foster care population and include wellness, high-risk OB, chronic disease management, comprehensive psychotropic drug oversight, Pharmacy Toolbox, substance use diversion, dental program, discharge planning, program to address frequent behavioral health-related readmissions, intensive placement support, transition-age youth and young adults, ensuring adoption success for Enrollees, and programs on specialized topics, including sexual orientation, gender identity, gender expression, suicide prevention, abuse and neglect prevention, and human trafficking.

Dental services: We subcontract with Avesis Third Party Administrators, Inc. to provide dental services for eligible Kentucky Enrollees. WellCare of Kentucky is ultimately responsible for the provision of dental services. We educate Enrollees and providers about dental benefits. We facilitate Enrollee use of these services by helping them select a dentist and coordinating their preventive and primary care dental services for oral health conditions or illness. We also encourage providers to refer our Enrollees to dental care. Many of our Kentucky foster care and juvenile justice systems and adoption assistance Enrollees use these services today.

Care Coordination: We have experience improving the health outcomes of our Enrollees through prevention, resiliency, and recovery and preventing further decline in a condition or functioning. Care coordination leadership team focuses on accountability, collaboration, excellence, and innovation and makes a long-term commitment to delivering on the goals of the communities we serve. We will assign all Kentucky SKY Enrollees to a care coordination team of staff who are dedicated to the Kentucky SKY program. Care coordinators and their supervisors are an integral part of the Kentucky SKY Program, a local and high-touch program. Care coordinators comprehensively address the needs of our complex, high-risk Enrollees and provide the personal 1:1 interaction and engagement to improve outcomes, resiliency and recovery, self-management skills, and decision-making capability desired for this population. **Nationally, we recently added 200 additional local care coordinators to our programs and as a result experienced a 20% decrease in inpatient admissions per 1,000 Enrollees, a 13% decrease in readmission per 1,000 Enrollees, and a 13% decrease in Emergency Department utilization.** We have significant experience assigning care coordination staff to an Enrollee, making assignments based on an Enrollee's primary needs and the skills and experience of our care coordination staff. They coordinate the Enrollee's end-to-end medical, behavioral, pharmacy, and social needs across the system of care. In Kentucky, our care coordinators assist our foster care and juvenile justice systems and adoption assistance population with navigating the healthcare system, coordinating health assessments within RFP-defined timeframes, and help coordinate provider appointments along with NEMT or community-based transportation to meet timeliness requirements.

For the last two years, WellCare of Kentucky made the list of Best Places to Work in Kentucky. We placed 10th in the Large Company category in 2018 and 8th in the Large Company category in 2019. Our designation as one of the Best Places to Work in Kentucky will be important as we attract, recruit, and hire a significant number of dedicated care coordinators for the Kentucky SKY Program. In Florida for the CMS Health Plan program, we recently undertook a significant statewide recruiting effort to hire 300+ care coordinators with experience serving children with special health care needs. As the Kentucky SKY contractor, we will leverage our CMS Health Plan's best practices for the recruiting effort in Kentucky.

Program Integrity: WellCare has more than 30 years of experience monitoring Program Integrity in Medicaid healthcare delivery across the nation, safeguarding public funds and overall financial stability to protect every dollar spent on Enrollees' services. **In 2018, of the $4.3 million our Special Investigative Unit recovered, $56,462 was attributed to Kentucky Medicaid claims and of the $32.2 million in cost avoidance, $2.8 million was attributed to Kentucky Medicaid claims. From January to May of 2019, for the $2.5 million recovered, $305,205 is attributed to Kentucky Medicaid claims and are responsible for a cost avoidance of $502,542 in Kentucky.**

Reporting: WellCare of Kentucky has a long history of ensuring timely submission, accuracy, and completeness of all regulatory reports and compliance requests with our government partners. **All of our 2018 and 2019 report submissions were delivered timely and in accordance with DMS' required specifications.**

Social determinants of health: Our Community Connections program considers the social and economic factors of all Enrollees and their families or guardians. **Since launching the Community Connections Program in Kentucky, we have connected 31,000 people to 165,000 services across the Commonwealth and have seen a direct impact in utilization of high-cost services for Enrollees engaged in the program including a 26% reduction in Emergency Department visits, a 53% decrease in inpatient spending (Robert Wood Johnson study of our Community Connections Program, 2016).**

The Community Connections program integrates social resource needs into every element of care coordination and management through the following features:

- An up-to-date registry of community resources available across more than 70 domains used by WellCare staff and providers to link Enrollees directly to needed services. This database encompasses more than 335,000 resources, including community-based public assistance organizations, services, and health-related activities and events. We recently redesigned our Community Connections platform to enhance community data sharing.
- Community Connections Help Line that provides telephonic episodic social service coordination support through peer coaches and liaisons with lived experience to help screen for eligibility for service, identify additional needs, connect callers to appropriate services, and follow up.
- WellCare of Kentucky places our community engagement partner staff in every region of the Commonwealth to identify emerging needs of the communities in which they live to solve for social service gaps and support care management activities.

- Use of closed-loop referrals to social services, whereby our staff tracks the outcomes of referrals that are made through the Community Connections program and provides Enrollees with additional help, as needed.
- To advance community health outcomes through our Community Connections program, WellCare's strategic plan includes investing in existing community resources and implementing new Community Health Investment Programs. This proprietary contracting and investment model supports social service resource organizations by sharing data and targeting investments that have proven efficacy for the Medicaid populations we serve.

Since launching our Community Connections social resource program, **we have assisted 117 foster care Enrollees and their families with 475 referrals to community-based social services and resources, with their greatest needs being school-based supports, food pantry and similar nutrition programs, and financial assistance with utilities.** Through our Community Connections program, if a care coordinator identifies an Enrollee with an urgent need for a social resource need like food or shelter, a care coordinator may make a referral to a community-based organization prior to engaging that Enrollee in care management activities. The Robert Wood Johnson Foundation and the University of South Florida have evaluated our Community Connections model. It has demonstrated quality improvements in the overall health of individuals. **Enrollees receiving referred services are 4.8 times more likely to complete their annual PCP visit, while also reducing the total cost of care. Enrollees who have had their social resource needs met show an annual $2,400 savings in health care expenditures.**

a. Experience in coordinating and providing Trauma-informed services, and educating Providers on Trauma-informed Care, ACEs, and evidenced based practices applicable to individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance;

EXPERIENCE COORDINATING AND PROVIDING TRAUMA-INFORMED SERVICES

WellCare of Kentucky recognizes the prevalence and impact of ACEs and trauma experienced by children/youth in the foster care, juvenile justice, and adoption assistance populations. We understand the importance of trauma-informed principles in all aspects of care for Enrollees who experience ACEs and trauma. Our approach to trauma-informed care incorporates knowledge of the impact of early trauma into our policies and programs. Trauma-informed approaches require a culture shift. We have extended the principles of a trauma-informed approach into other areas of our operations, including population health management, care coordination, utilization management, prior authorization, and pre-certification, discharge planning, care coordination and management, and crisis intervention services.

Trauma is not easily observable; therefore, we recently updated our Comprehensive Needs Assessment tool to include questions related to Adverse Childhood Events (ACEs) and trauma. We have experience identifying and addressing childhood ACEs and trauma in individuals who experienced one or more of the following: recurrent and severe physical abuse and/or severe emotional abuse; neglect (physical and/or emotional); alcoholic or SUD in family; imprisoned family member; unstable behavioral health, depressed, or institutionalized family member; parent treated violently; parental separation or divorce; and sexual abuse. Screening individuals

for ACEs and trauma has implications for holistic care and services, including social supports and SUD and/or mental health services. In North Carolina, we collaborate with Community Care of North Carolina's, our partner in delivery of healthcare services to North Carolina Medicaid Enrollees, national subject matter experts whose experience indicates the number of ACEs an individual experiences is key, not which ACEs. Further, data shows individuals who have experienced four or more ACEs results in:

- Seven times the rate of alcoholism
- Two times the rate of cancer
- Four times the rate of emphysema
- Adults with six or more ACEs results in a 30 times increase in suicide rate

Our care coordination staff use pediatric behavioral health and trauma screening and assessment tools to identify possible trauma and the need for a referral for trauma-focused services. Our care coordination staff share with DCBS, DJJ, or the adopted parent a list of providers who have indicated specialization in trauma, working to refer Enrollees to the guardian or parent's provider of choice. WellCare has identified over 350 behavioral health clinicians who indicate specialization in post trauma therapy.

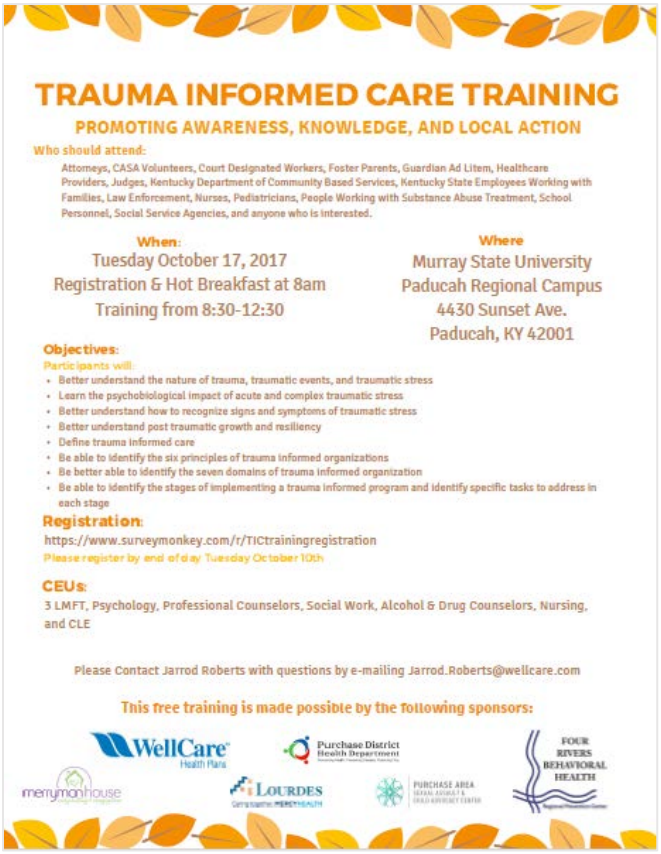
We know that every individual, regardless of age, reacts to and presents the effects of their traumatic experiences in diverse and unique ways and these experiences frequently influence their health in a negative way. We have network providers, including PCPs, behavioral health specialists, and child psychologists, who provide trauma-informed care services. Our care coordinators have experience coordinating care for children and youth in the foster care and juvenile justice systems or receiving adoption assistance and connecting children and youth to providers who provide trauma-informed care.

EXPERIENCE EDUCATING PROVIDERS ON TRAUMA-INFORMED CARE, ACES, AND EVIDENCE-BASED PRACTICES APPLICABLE TO ENROLLEES IN THE FOSTER CARE AND JUVENILE JUSTICE SYSTEMS OR RECEIVING ADOPTION ASSISTANCE

Today we offer online training via the provider web portal to support Enrollees and families. We offer providers interactive face-to-face training and educational opportunities, our popular and well-attended bi-weekly Webinar targeted training sessions for providers on specific topics, including evidence-based practices, screening for behavioral health issues like ACEs and trauma, and providing trauma-informed care or providing referrals to providers or specialists who do. We sponsored or offered the following trauma-informed care educational opportunities:

- In October 2017, WellCare sponsored an in-person provider educational summit at Murray State University in McCracken County to train more than 200 providers about providing trauma-informed care, see **Figure G.2-5**.
- In September 2018, WellCare sponsored a Protective Factors Approach conference focused on ACEs and trauma-informed care and the Strengthening Families initiative to help caregivers build protective factors.

Community Impact Councils proactively identify the need to address the effect of ACEs and trauma. WellCare of Kentucky's Community Connections team leads multiple Community Impact Councils around Kentucky each year. These councils are a creative and innovative vehicle to breakdown silos and work together as a community to strengthen the social safety net. In 2016, our Daviess County Community Impact Council focused on foster care service gaps. **Through a facilitation process, the group agreed that the most urgent need was to address foster children who transfer from one foster care home to another in rapid succession based on behavioral issues, often resulting from ACEs and trauma. This meeting led to the creation of a foster parent support group supported by a $5,000 sponsorship from WellCare.** The funds provided food, childcare, and incentives to grow the group for twelve months. This support group provided an organic way to create a mentorship model where seasoned foster parents could guide newer foster parents. If there were normal behavioral issues occurring, the foster parents could reach out to their developed support network for assistance, giving the opportunity for more stable foster care placements.


TRAUMA INFORMED CARE TRAINING

PROMOTING AWARENESS, KNOWLEDGE, AND LOCAL ACTION

Who should attend:

Attorneys, CASA Volunteers, Court Designated Workers, Foster Parents, Guardian Ad Litem, Healthcare Providers, Judges, Kentucky Department of Community Based Services, Kentucky State Employees Working with Families, Law Enforcement, Nurses, Pediatricians, People Working with Substance Abuse Treatment, School Personnel, Social Service Agencies, and anyone who is interested.

When:
Tuesday October 17, 2017
Registration & Hot Breakfast at 8am
Training from 8:30-12:30

Where
Murray State University
Paducah Regional Campus
4430 Sunset Ave.
Paducah, KY 42001

Objectives:
Participants will:
- Better understand the nature of trauma, traumatic events, and traumatic stress
- Learn the psychobiological impact of acute and complex traumatic stress
- Better understand how to recognize signs and symptoms of traumatic stress
- Better understand post traumatic growth and resiliency
- Define trauma informed care
- Be able to identify the six principles of trauma informed organizations
- Be better able to identify the seven domains of trauma informed organization
- Be able to identify the stages of implementing a trauma informed program and identify specific tasks to address in each stage

Registration:
https://www.surveymonkey.com/r/TICtrainingregistration
Please register by end of day Tuesday October 10th

CEUs:
3 LMFT, Psychology, Professional Counselors, Social Work, Alcohol & Drug Counselors, Nursing, and CLE

Please Contact Jarrod Roberts with questions by e-mailing Jarrod.Roberts@wellcare.com

This free training is made possible by the following sponsors:

WellCare Health Plans, Purchase District Health Department, merrymanhouse, Lourdes, Purchase Area Drug Advocacy Council, Four Rivers Behavioral Health

Figure G.2-5 Trauma Informed Training

Telehealth/Telemental Health increases access to behavioral health services: We will educate providers on the new telehealth regulations and provide versions of our in-person educational presentations in a variety of forums, including breakout sessions at our annual Provider Summits, on both our public website and provider web portals, and through bi-weekly Webinar series. We will encourage provider-to-provider consultations to expand trauma-informed care.

Today, our providers, local Community Mental Health Centers (CMHC), and Federally Qualified Health Centers (FQHC) already use telemedicine/telehealth to connect their Enrollees to specialists and behavioral health providers, such as psychiatrists and mental health counselors, to help address their patients' whole-person needs. **In 2018, we paid claims to providers for over 6,800 telemedicine/telehealth services for over 20 different types of services.**

Partnership

Telehealth/telemental services have great potential to improve access to care for Kentucky SKY Enrollees in rural areas without a pediatric psychiatrist, those who have behavioral health conditions requiring specialty services, or those who have challenges with transportation, or who simply prefer the convenience or privacy afforded by telehealth access. Today WellCare has an established telehealth

presence in the Commonwealth. We are identifying, partnering, and contracting with specialty providers to expand access to specialty services (e.g., applied behavioral health analysis, neuropsychology, trauma therapies, and mobile crisis). By using telehealth to meet with a certified juvenile sex offender treatment provider, an Enrollee receives a full risk assessment that identifies the potential for future acting out and determines the appropriate level of care—taking into consideration the safety of the individual, those around them, and the community. This specialized training is a critical need for a child or youth dealing with the emotional difficulties of trauma and requires learning correct behaviors from a trusted professional.

Expanding Trauma-Informed Education – University of Louisville/Kent School of Social Work Partnership: We are partnering with the University of Louisville/Kent School of Social Work to implement a statewide trauma-informed care training program across the Commonwealth, targeting providers, community-based organizations, and first responders. The University of Louisville has a well-regarded trauma-informed training program through the Kent School of Social Work. This partnership includes curriculum development, building capacity, launch, and evaluation. Training sessions will be available via Webinar or in person. University of Louisville has experience providing trauma-informed training for state agencies like DCBS, Kentucky Cabinet for Health and Human Services, and Volunteers of America. The outline for trauma-informed training includes:

- Welcome and goal of training
- Self-assessment
- Trauma-informed care (System)
- What is trauma
- What is traumatic stress
- Types of trauma (incidence, prevalence)
- What does trauma look like, feel like, sound like to a person victimized by trauma
- Factors that determine the impact of trauma
- Effects of trauma exposure (short term; long term)
- Trauma and PTSD
- Trauma and brain development
- Trauma and social, behavioral, emotional development
- Trauma and culture
- Responding to trauma
- Screening, assessing, and treating trauma
- Impact of trauma on the service provider
- Types of trauma impact on service provider-vicarious trauma, burnout, secondary trauma stress, compassion fatigue, compassion satisfaction

- Resilience and post-traumatic growth
- Self-care (physical, social, emotional, psychological, spiritual)

"It is my pleasure to write this letter of support and partnership with WellCare of KY to address the needs Kentucky's SKY population. We applaud your efforts to deliver holistic, comprehensive, and integrative services to the most vulnerable in our society. We look forward to partnering with you to accomplish this critical need in Kentucky."
– Quote from Bibhuti K. Sar, MSW, PhD, Professor Director of Doctoral Program, June 18, 2019.

Care Coordination Training: In addition to training providers, we educate care coordinators on the principles of trauma-informed care. Core elements of our training for care coordination staff include:

- How to identify trauma and ACEs
- How it impacts care delivery and the way our Enrollees engage in their own health care
- Providing guidance on preventing re-traumatization
- Empowering Enrollees to realize their individuality that extends beyond their trauma experiences

b. Three (3) examples of initiatives the Contractor has implemented for Medicaid managed care programs for individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance that have supported improved outcomes (e.g., greater awareness of Trauma-Informed Care, clinical outcomes, Discharge Planning between levels of care, etc.). Describe whether such initiatives were cost effective and resulted in sustained change;

WellCare of Kentucky implements creative initiatives that result in sustained positive change, improved outcomes, and promote cost effectiveness. The following are three initiatives we have implemented that benefit our Enrollees, including individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance

INITIATIVE #1: WELLCARE AT HOME FIELD-BASED CARE COORDINATION PROGRAM

WellCare of Kentucky has implemented and successfully operates our WellCare at Home field-based care coordination model for all of the populations we serve in Kentucky. The WellCare at Home field-based care coordination is a critical component of our fully integrated, person-centered, community-based care coordination model. This program originated in Kentucky, and our initial efforts proved the value in a high-touch approach brings to increasing Medicaid Enrollee satisfaction and improving health outcomes. Our care coordination program is fully integrated and tailored to each Enrollee's needs by considering their whole-person needs. In 2015, we expanded our WellCare at Home field-based care coordination program nationwide to all of our other WellCare Medicaid affiliates. Today, all of our Medicaid programs serving foster care and juvenile justice systems or receiving adoption assistance use field-based, integrated care coordination.

As we continue to enhance our care coordination capabilities, we expanded our high-touch approach in Kentucky to include an innovative Field Outreach Coordinator (FOC) program with

non-clinical FOCs who reach out telephonically to Enrollees with high utilization based on claims data, diagnosis, and Emergency Department use. Prior to calling an Enrollee, FOCs review an Enrollee's centralized record in CareCentral, our care management program. Their mission is to use evidence-based motivational interviewing skills to understand and help remove an Enrollee's barriers to accessing care and services. Our FOCs demonstrate empathy and support for the Enrollee's situation and connect the Enrollee to care coordination staff who can remove identified barriers and assist with newly identified needs.

Our Kentucky care coordination team comprises a fully integrated team of local and national staff, including registered nurses, licensed clinical social workers, social workers, care coordinators, and FOCs. Our care coordinators work in all nine DCBS regions and the four DJJ Community Districts. They frequently work in DCBS and DJJ offices to support a collaborative approach with state staff. An advantage of co-locating in DCBS and DJJ is that we can hear about new Enrollees prior to receiving the 834 file. This early notification of new Enrollees facilitates early, shared decision making about an Enrollee's total care needs.

WellCare's fully integrated data platforms, CareCentral and the Provider Portal, upload data in real-time from internal and external systems, including claims (pharmacy, medical, and behavioral health), encounters, eligibility, health information exchange (HIE) and admission, discharge, and transfer (ADT) feeds, encounters. Care coordinators use CareCentral to view a holistic view of each Enrollee and to document all interactions with Enrollees. Providers have access to our comprehensive Member Care Compass, including all Enrollee data, such as personal goals, care plans, assessments, and medical history. With Enrollee or parent/guardian consent, care coordination staff and providers have access to this complete picture of individual Enrollee needs across the entire spectrum of care when considering authorization decisions and utilization trends. CareCentral includes advanced reporting tools that share meaningful and actionable Enrollee data to support physical and behavioral providers as they facilitate integrated services. , and our Community Connections social resource database

CareCentral supports effective care coordination: CareCentral pushes system alerts to care coordinators in real-time, allowing them to take action regarding Emergency Department visits, hospitalizations, provider messages, and Enrollee communications and make necessary updates to an Enrollee's care plan. CareCentral's comprehensive Enrollee 360 view includes the Enrollee's care plan, care needs (gaps in care), interventions, medication utilization, and utilization history. Network providers can review Enrollee-specific data and update care plans using the provider portal. The Enrollee's centralized record includes Health Risk Assessment (HRA) and Comprehensive Needs Assessment results. CareCentral offers automated workflows and triggers for care coordinators to perform specific tasks for specific Enrollees. For example, CareCentral supports HRA and comprehensive needs assessment and reassessment completion through sophisticated workflows and system-generated notifications. CareCentral functionality automatically generates care authorizations upon care plan completion and any updates thereto. We fully integrate and embed into all aspects of our operations, including CareCentral, our evidence-based disease-specific medical and behavioral health clinical practice guidelines. Further, we align our metrics and reporting capabilities to track and analyze integrated, whole-person services and metrics for utilization, HEDIS measures, claims data (e.g., medical,

behavioral, pharmacy), readmissions, Emergency Department use for all diagnoses, cost of care, and shared savings metrics.

Foster Care Opioid Use Disorder (OUD) Pilot: WellCare of Kentucky leadership team conducted focus groups to design an innovative a pilot program for coordination of care for foster youth with OUD. We met with a foster care youth who went into residential care because of her OUD and other substance use issues. This individual shared her experience and suggested we work with Court Appointed Special Advocate (CASA) volunteers. We conducted three focus groups that included CASA volunteers in Louisville and Lexington to understand issues. CASA volunteers shared their observations related to youth and family issues with OUD. We plan to expand focus groups to include providers and DCBS staff. WellCare of Kentucky and the Kentucky CASA Network are teaming up to help children in foster care who have felt the impact of opioid addiction. WellCare of Kentucky will sponsor and present at the CASA conference in November 2019. This effort demonstrates our focus on innovation and collaboration, which extends beyond engaging DCBS and providers to involving courts and other stakeholders involved with the foster care system of care.

Outcomes: After moving to the WellCare at Home high-touch, in-person model, **our Enrollees experienced a 26% reduction in inpatient admission and an 8% reduction in preventable Emergency Department visits.** In Kentucky, we continue to sustain improvements in the reduction in inpatient readmissions. In 2018, WellCare's Kentucky plan readmission rate for the number of Enrollees readmitted to the hospital within 30 days of a discharge was just under 3% from 2016.

WellCare at Home CC/CM for high-risk Enrollees has resulted in an average savings of $500 pm compared to historic controls, mostly due to reductions in hospital admisstions and readmissions.

INITIATIVE #2: KEY ASSETS – HELPING YOUTH WITH AUTISM

In 2012, WellCare of Kentucky identified Enrollees with a diagnosis for autism and who were housed in facility levels of care, both inside and outside of Kentucky. These Enrollees, through conversations with DCBS, did not have options for community-based placement. One of our Enrollees had been in a facility in Texas for three years. Through a unique collaboration, we worked with DCBS and a provider to outline a potential program to meet these Enrollees' needs. Not only did we need to develop the place where the Enrollees were to live, but also the system of care and services needed for these individuals had to be developed. We collaborated with DCBS, DMS, and Key Assets, along with the current facility providers, care providers, behavioral health providers, and medical providers to develop a home for these individuals.

Service Development and Planning: WellCare of Kentucky worked with the current providers and Key Assets to identify the Enrollees' current treatment needs and identify the types of services that would need to be available in the home and in the community for the Enrollees to be successful. WellCare identified CPT codes for services that were not currently available on the Medicaid fee schedule in Kentucky and engaged Key Assets in planning the process to develop the identified CPT codes into services. We developed service definition and service parameters along with frequency, intensity, and duration based on current Enrollee need. While the current fee schedule did not support these CPT codes, WellCare of Kentucky

committed to Key Assets, DCBS, and DMS that we would cover these services for these specific Enrollees under a single case agreement.

Service Transition Planning: To prepare for transition from a facility level of care into a community level of care, careful planning, and development of a transition place was required. This took a creative approach on to how to cover and pay for services from multiple providers. We were dedicated to developing single case agreements that allowed for multiple service billing from multiple providers in one day. This allowed Key Assets to go into these facilities and work side-by-side with the current provider to learn about the Enrollee's current treatment and intervention plan. This allowed the Enrollee to get to know the Key Assets staff and the foster parent caregiver. Key Assets even traveled to Texas and met with the treatment team there for a week in preparation for transition. To ensure continuity of care was consistent with all care providers, the ABA provider in the facilities worked directly with the ABA provider through Key Assets. The ABA providers worked together to develop the behavior plans needed to assist the Enrollee and the staff through transition. WellCare covered the majority of these services through transition, offering the continuity of care services needed for this to be successful.

Service authorization and concurrent review: Because the services and program for Key Assets were different than the existing Medicaid approved services and fee schedule, we had to develop a specialized medical necessity review and authorization process for this program. Our UM team identified the needed components of medical necessity criteria to use for authorization and concurrent review. We educated Key Assets staff on the criteria needed and held special concurrent live reviews to ensure all information needed for continued approval of services was available. Because this was a step in service provision that Key Assets had never done as a private childcare provider, we paid special attention to documentation, treatment planning, and service review, with WellCare of Kentucky hand holding the process. Despite the uniqueness of this program, the requirement to meet medical necessity under the mandates of our contract had to be met.

Outcomes: In January 2014, James, our first Key Assets Enrollee, transitioned from Our Lady of Peace to Key Assets. The first week in his home, James experienced being outside and swinging. Key Assets staff stated they could not get him out of the swing easily. They also discovered how much he enjoyed running through the frozen food section of the grocery store and rearranging food in refrigerators. Within a couple of months, our second Enrollee transitioned from Texas and into his home. The Key Assets program is continuing today. Overall, 11 of our Enrollees have been in the Key Assets program. The primary outcome is that these individuals have been able to live in the community and have not required a higher level of care. James would have lived in facilities all of his life, based on conversations with state-level medical directors. However, James has remained at Key Assets since 2014 in a home in the community, graduated the 8th grade, learned how to swim, attends public school, and is preparing to transition into adulthood today. Out of the 11 Enrollees in the program, only two required a higher level of care and left Key Assets as a result.

INITIATIVE #3: JOOL (REBRANDED AS KUMANU) LIFE COACH FOR TRANSITION AGE YOUTH

Transition age youth in foster care are young people who are at high risk of unsuccessful transitions into independent adulthood due to the complexity of their needs, the many challenges they face, and the lack of a support system to assist them. We initiated JOOL in October 2018 as a pilot program ending in September 30, 2019.

In 2018, WellCare of Kentucky held a focus group with young adults who recently aged out of the Kentucky Foster Care program. These adults shared their experiences and made recommendations for a tool that included incentives for reaching certain milestones during the aging out process.

The JOOL Life Coach engages and improves purpose in life of young adults (transition-aged youth) that are aging out of the Kentucky State Medicaid Foster Care program. WellCare is collaborating with JOOL Health to offer a one of a kind smartphone-based application that promotes health engagement and personal well-being. Think of a personal, digital life coach based on one's defined life purpose. The anticipated outcomes are health and life engagement, energy (vitality), willpower (self-control), resilience, lifestyle change, as well as potential impact to health care costs.

The program targets WellCare Medicaid Enrollees who are 17 years old and are part of the Kentucky Foster Care program. For Enrollees engaged with the JOOL Life Coach program, a care coordinator, the Enrollee's state-appointed caseworker and their foster parent or private childcare representative jointly provide an overview of the JOOL Life Coach program. If an Enrollee has a personal smartphone, we encourage them to use it, if possible. If the Enrollee does not have access to a smartphone, we issue the Enrollee a smartphone with limited capabilities. The care coordinator works with the Enrollee to download and set up the JOOL application on the smartphone. The Enrollee interacts with the JOOL application in the multiple ways.

The JOOL application introduces the Enrollee to the program with several onboarding steps. Onboarding walks the Enrollee through the following:

- *Core Values –* The user chooses their top core values. Examples include tradition, responsibility, expertise, kindness, independence, etc.
- *Purpose Composer –* This step asks the Enrollee to identify four purposes, a personal purpose, a family purpose, a work/school purpose, and a community purpose. An example of a school purpose could be "I want to be on time to school every day and exceed the expectations of my teachers."
- *Health Risk Assessment (HRA) –* The Enrollee then participates in a very basic HRA. For instance, the app asks the Enrollee to provide information about his/her age, gender, height, weight, stress level, and questions about diabetes and feeling depressed.

Once the onboarding is complete, the Enrollee begins charting on a daily basis in three areas:

- *Alignment with their purposes for that day –* For example, an Enrollee may be less aligned with the work/school purpose if he or she was late to school or reprimanded by a teacher.

- *S.P.A.C.E. –* Sleep, presence, activity, creativity, and eating.
- *Personal outcomes –* Changes to the Enrollee's personal outcomes.

The JOOL application "learns" about the Enrollee through charting. After five days of charting, the application establishes a baseline so that it can track how often the individual meets targets. After 10 days of charting, the application begins to give interactive visuals of what factors impact S.P.A.C.E., willpower, and the Enrollee's outcomes the most. After 15 days of charting, the application begins to forecast S.P.A.C.E, willpower, and personal outcomes and then provides tips to improve the outcome.

The JOOL Life coach program includes some small incentives that make sure as many Enrollees as possible reach the important milestones of the application. We use the following incentives:

- Age appropriate, no cost, mobile phone games. Popular games, such as Candy Crush, Sims, Farmville, Angry Birds, or many other family friendly titles.
- Gift card incentives for individuals who reach certain milestones in the program. The following incentives will be available:
    - $25 gift card for program Enrollees who use their own phone.
    - $25 gift card for finishing the program (12 months).
    - $10 gift card each at three months, six months, and nine months

We do not require the Enrollee to return a smartphone to WellCare at the end of the 12-month program. However, we discontinue the cellular service for the phone at the end of the program. The care coordinator provide the Enrollee with contact information on the Lifeline cell phone program.

Lastly, the application provides "Daily JOOLS" to the Enrollee. Daily JOOLs are machine learning intelligent tips that get smarter over time. The tips are targeted messages that address executive functioning, S.P.A.C.E., outcomes, and other factors that may help drive Foster Care kids towards a healthier lifestyle. For example, Foster Care young adults, many times, inadvertently allow their Medicaid health coverage to lapse. The JOOL application, through the Daily JOOL functionality, educates individuals on the importance of the need to re-certify their Medicaid status.

Outcomes: We ask all participating Enrollees to take a pre-test at enrollment and a post-test at 30 days and 90 days. Because the program is still open and occurring, the outcomes from the pre and post-tests are not available. The following preliminary outcomes, in **Figure G.2-6** and **Figure G.2-7** are available for our Enrollees using JOOL:

Figure G.2-6. This JOOL dashboard show the areas our uses have improved since starting to use the tool. The results in blue highlight shows a statistically significant improvement for Work Alignment.

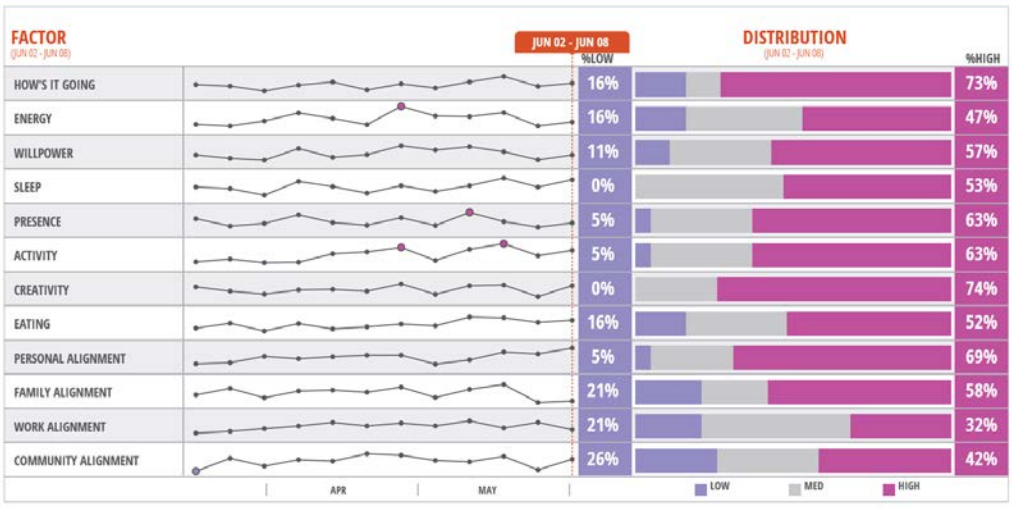


Figure G.2-7. This graph shows us the distribution related to Enrollee use of JOOL factors for a specified timeframe.

c. A summary of lessons learned from the Contractor's experience providing similar services to the populations enrolled in Kentucky SKY; and

WellCare has a proven record of successful operations for the foster care and juvenile justice and adoption assistance population, both in Kentucky and nationally. And while every state is unique, we have learned through experience that some lessons learned can be applied universally as part of developing an effective strategy for managing the foster care population. We tailor our operations and programs to fit the priorities and delivery systems within each state and effectively address specific challenges. The continued application of lessons learned reinforces our commitment to help our Kentucky SKY Enrollees live better, healthier lives.

Table G.2-1 presents lessons learned from our experience providing similar services to the populations enrolled in the Kentucky SKY program.

Table G.2-1 Lessons Learned

Lesson Learned	Description
The Kentucky system of care is too focused on facility-based care for high-risk foster care Enrollees and a fully integrated, field-based care model works best	Our foster care youth do not want to be housed in residential treatment facilities, especially for long periods of time. We have a strong focus on community-based care. Utilization data from 2016 – 2018 for the foster care population shows a positive trend of a 9.51% increase in PCP visits per 1,000 and a 22.22% increase in specialist visits, demonstrating a migration from expensive non-coordinated Emergency Department visits to a less expensive, highly coordinated place of service. Our experience is grounded on putting our Kentucky Enrollees first; providing whole-person, fully integrated care using a collaborative shared decision-making approach; delivering services locally and statewide; connecting Enrollees and their families to community-based social resources; comprehensive education for Enrollees, families, network providers, and Department, DCBS, and DJJ staff, and ensuring Enrollee access to collaborating with network providers and Department, DCBS, and DJJ staff. We establish and maintain collaborative relationships with network providers and with DMS, DCBS, and DJJ. WellCare of Kentucky has made significant investments in quality and process improvements to help our more than 8,000 Kentucky Enrollees in the foster care and juvenile justice and adoption assistance population better access needed care and services. This model increases permanency; increases access to community-based care; reduces spending on inappropriate utilization; uses data-driven and informed shared decision making;
Training is not a once and done process	During the preparation for the anticipated Waiver transition we learned we needed to strengthen provider training to include longer-term refresher training via webinar in addition to short-term, focused training sessions.
Collaboration is more than just bringing stakeholders together	Communication and collaboration is key. We learned the value and benefits of shared decision-making, giving all stakeholders, including the Enrollee and foster parents/guardians, a strong voice and a real opportunity to contribute during care and service planning. Our staff goes to Building Bridges. Our leadership staff goes to numerous meetings, state interagency councils, and conferences related to foster care to develop relationships and help address gaps in the system of care. We meet with faith-based organization leadership.
The importance of assigning a PCP to children in foster care	We learned a “gatekeeper” model does not work for the foster care population. We applaud the Commonwealth’s decision to assign PCPs on the new contract.

Lesson Learned	Description
Need to increase partnerships with stakeholder regarding psychotropic medications	Due to the increasing trend of psychotropic usage among youth in foster care, we have increased and will continue to increase our outreach and engagement of PCPs, pharmacists, Enrollees and their foster parents and guardians, and DMS, DCBS, and DJJ staff regarding appropriate utilization of psychotropic medications by the foster care population. We anticipate a positive outcome in curbing increased use of psychotropic medications.
Need specialized staff expertise	WellCare of Kentucky hired staff, including a Pharm.D., with pharmacy expertise and engages this staff on interdisciplinary care team meetings, as needed. We need to hire a child psychiatrist to assist with the Kentucky SKY population. Today in Kentucky, we can engage a corporate child psychiatrist, as needed, to consult with interdisciplinary care team members. We anticipate the expansion of telehealth and telemental health will increase access to individuals with needed specialty expertise, particularly in rural areas.
Need to gain greater insight into appropriate prior authorization and ongoing concurrent review for residential treatment	We learned the value of conducting weekly meetings for Enrollees in residential treatment or at risk of inpatient facility-based care. During these meetings, our UM staff walks through the needs of every youth in residential treatment. Our staff discusses each Enrollee's whole person needs and the care and services the Enrollee needs to be able to transition to a community-based lower level of care. These collaborative joint staff meetings have identified provider-training needs. We are strong advocates for our foster care Enrollees experiencing an in-state or out-of-state residential treatment. Increased collaboration reduces reliance on high-cost residential treatment facilities and promotes Enrollee satisfaction and less expensive, yet highly coordinated community-based care and services.
Need to educate providers on our new discharge planning form for Enrollees with complex care needs post hospital discharge	We learned that providers did not use our new discharge planning form until we educated them about how to complete the form. Today, after our training sessions, our providers, including Our Lady of Peace and The Ridge, tell us they like the newly developed discharge planning form. It collects more in-depth information about Enrollees so UM staff can make better-informed decisions about medical necessity, and care coordinators can coordinate more appropriate clinical interventions based on current and future needs. Details about the totality of an Enrollee's situation need to be included on the form, which requires collaborative input from DCBS, hospital discharge planning staff, and the Enrollee and foster parent. A result of this collaboration was the need for criteria around sexual abuse. We escalated this issue to DCBS and national experts and helped the Commonwealth develop sexual abuse-related criteria. We implemented best practices for improved provider training and making better care decisions around whole-person needs based on a combination of collaborative shared decision-making and InterQual criteria.
Need to engage CASAs in improving	We learned that CASAs provide valuable insight into our Enrollees involved with the juvenile justice system. CASAs can serve as a single point of contact and provide valuable information and insight that helps us provide more timely

Lesson Learned	Description
outcomes for juvenile justice-involved foster care youth	interventions.
Need to engage DCBS staff to increase Enrollee access to the new JOOL educational tool	Having the right skills to transition from adolescence to adulthood and not having these skills is a barrier to success for our transition-age foster care Enrollees. We rolled out our new JOOL tool in 2018. During the last six months, we have only filled 40% of the slots available in this program. We learned that we need to work with DCBS caseworkers to help engage our Enrollees in this new educational and skill-building tool. We anticipate filling additional slots by being purposeful on how we collaborate with DCBS caseworkers who work with many youth and connecting Enrollees to this tool.

d. How the Contractor will apply such lessons learned to the Kentucky SKY program

We apply our lessons learned to inform our actions to improve or enhance Enrollee-level and system-level processes, quality initiatives, and the system of care, with a focus on improving Enrollee health outcomes and Enrollee, foster parent/caretaker, and provider as well as Department, DCBS, and DJJ satisfaction. We have learned that creating new service access, enhancing current service access, and collaborating with quality providers is key.

We have applied our lessons learned to:

- *Improve collaboration and shared decision-making* across the continuum of care, involving biological and fictive kin relations, medical consenters, child protective services, judges, medical and behavioral healthcare providers, child-placing agencies, advocacy groups, CASAs, and community-based services as well as DMS, DCBS, and DJJ staff.
- *Increase and enhance multi-modal opportunities for education and training* for Enrollees, providers, and Department, DCBS, and DJJ staff.
- *Fully integrate our care teams and promote increased collaboration between UM and care management staff* improves Enrollee access to care and services as well as improves Enrollee and foster parent and caregiver satisfaction.
- *Improvements in discharge planning processes* led to system-level processes that resulting in enhanced opportunities to address an Enrollee's whole-person needs.
- *Find creative solutions and use our thought leadership* to address gaps in access and barriers to success to care and services in the system of care.

LESSON LEARNED – THE SYSTEM OF CARE NEEDS THOUGHT LEADERSHIP AND CREATIVITY

WellCare of Kentucky learned that **approaching the care and service needs for foster children, adopted children, and children under the DJJ umbrella must be done purposefully, carefully, and thoughtfully**—with a focus on enhancing a child's quality of life.

In 2011, after contract go-live, DCBS assigned James to WellCare of Kentucky as a foster child. James was inpatient in Our Lady of Peace, a behavioral health hospital. James had an autism diagnosis and was mostly non-verbal and very active. We immediately began working on discharge planning for James and quickly discovered that James did not have options for a place to live outside of the hospital. All the foster care providers in Kentucky had refused to take James into their care and our staff worked on finding options for James.

James was 11 years old and very interested in running and getting into refrigerators. He was on high AWOL precautions because he had a knack of getting out of the locked unit. Our Lady of Peace staff loved him because he had lived there so long. He was on a lot of medication and had a behavior plan. During his long-term placement at Our Lady of Peace, he did not receive consistent dental services, as such his assigned WellCare of Kentucky Care Coordinator coordinated dental services. James was very small for his age—some guessed due to medication, others guessed due to the continual facility living. DCBS tried to place James in a foster home, but placements never worked out due to his high energy and need for a high level of supervision.

His Care Coordinator realized immediately that the placement services that James needed did not exist. He needed a home with highly trained foster parents and options for supervision, even in the middle of the night. Additionally, he needed experts in behavior planning, speech, occupational therapy, and psychotropic medication. He needed a place that would not give up on him just because James was being James. Through multiple meetings with state officials, they gave us permission to look for a placement and develop a program to meet his needs. After outreaching to several providers to discuss James' needs, Key Assets emerged as the right provider and the right setting at the right time for James. (Refer to Initiative #2 in G.02.a.i.b.)

James entered into the Key Assets community-based residential group home program in January 2014. It was a cold, snowy day and school was out. Quickly, Key Assets staff learned that the cancellation of school led to staffing and supervision issues for James. Our UM staff immediately approved increased the service hours to make up for the increased need. Even though it was cold, James felt he must go outside and swing; Key Assets staff took him swinging every day, and he loved it. Key Assets staff soon learned that James was not trying to run away when he would run—he just liked to run and loved being outdoors. He also loved running through the frozen section of the grocery store, opening all the doors to the frozen food. He went to school and began showing great improvement with interacting with others. He began to grow and eventually began to look his age instead of five years younger. By the end of his first year with Key Assets and his foster mom, he was communicating with words and began saying "I love you," to his Key Assets foster mom. Many never expected James to live outside of an institution, to talk, or to go to public school. Others thought he would never smile, laugh, and have fun. Yet, he proved all of the experts to be wrong.

James is just one example of WellCare of Kentucky's compassion for our Enrollees and how our Enrollees needs always come first, above all else. WellCare of Kentucky associates have permission to be creative and think beyond what is typical. Through James, we learned the importance of collaboration with everyone involved in his care, and how just talking about it does not get the work done. We know we need help from all stakeholders in all areas to change how the current system of care works, and that often medical necessity reviews for treatment have to go beyond the medical necessity review criteria and look at the Enrollee as a whole person.

Other lessons learned include the need to engage the foster care, adoption, and DJJ system of care into system transformation. To continue to do business as usual is not going solve the problem for children similar to James. We know that children do better and are happier in homes. We had to overcome a reliance on residential treatment and find a home for every child, and support existing all stakeholders involved in caring for foster children in addition to working to prevent a child from leaving their family because of safety issues.

ii. Provide a listing of the Contractor's prior and existing full risk Medicaid managed care contracts serving individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance the previous five (5) years. Include the following information:

a. State name

b. Contract start and end dates

c. Number of covered lives

d. Whether the Contractor provides services regionally or statewide

We have current experience providing full Risk Medicaid Managed Care Medicaid contracts that include serving Enrollees in the foster care and juvenile justice systems and those receiving adoption assistance populations. As of December 31, 2019, WellCare of Kentucky and our affiliate WellCare Medicaid health plans managed approximately 28,000 Foster Care Enrollees i across the continuum of care as part of our contracts in the following states:

- Kentucky
- Florida
- Hawaii
- Michigan
- Missouri
- New Jersey
- Nebraska
- South Carolina

Table G.2-2 through **Table G.2-9** provides the requested information on WellCare's full risk Medicaid managed care contracts that include Foster Care Enrollees.

Table G.2-2 Kentucky

Kentucky Medicaid	
Contract Start and End Dates	Cabinet for Health and Family Services **Initial Contract Start Date:** July 6, 2011 **Current Contract End Date:** June 30, 2020
Number of Covered Lives	430,874 Total Covered Lives includes **8,152 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-3 Florida

Florida Medicaid	
Contract Start and End Dates	Agency for Health Care Administration (AHCA) Department of Health **Medicaid:** **Initial Contract Start Date:** July 1 2002 **Current Contract End Date:** December 31, 2024 **Florida CMS Health Plan:** **Initial Contract Start Date:** February 1, 2019 **Current Contract End Date:** December 31, 2024
Number of Covered Lives	1,027,370 Medicaid Total Covered Lives includes **10,285 Foster Care** Enrollees 68,000 CMS Health Plan Total Covered Lives includes **250 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	**Florida Medicaid Contract**: Regional **CMS Health Plan Contract**: Statewide

Table G.2-4 Hawaii

Hawaii Medicaid	
Contract Start and End Dates	State of Hawaii Med-QUEST Division (MQD) Quest Integrated Program: **Initial Contract Start Date:** March 8, 2012

Hawaii Medicaid	
	Current Contract End Date: December 2020 with two option years
Number of Covered Lives	40,837 Total Covered Lives includes **190 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-5 Michigan

Michigan Medicaid	
Contract Start and End Dates	Department of Health and Human Services (DHHS) **Initial Contract Start Date:** April 1, 1999 **Current Contract End Date:** December 31, 2020
Number of Covered Lives	494,682 Total Covered Lives includes **1,881 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Regional

Table G.2-6 Missouri

Missouri Medicaid	
Contract Start and End Dates	Missouri HealthNet Division, Managed Care **Initial Contract Start Date:** March 1, 1998 (since 2013 as a WellCare company) **Current Contract End Date:** June 30, 2020 – contract was divested on January 23, 2020 as part of the acquisition
Number of Covered Lives	218,488 Total Membership includes **2,663 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-7 Nebraska

Nebraska Medicaid	
Contract Start and End Dates	Nebraska Department of Health and Human Services **Initial Contract Start Date:** April 14, 2016 **Current Contract End Date:** December 13, 2021 – contract was divested on January 23, 2020 as part of the acquisition
Number of Covered Lives	79,185 Total Covered Lives includes **2,773 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-8 New Jersey

New Jersey Medicaid	
Contract Start and End Dates	Division of Medical Assistance & Health Services (DMAHS) **Initial Contract Start Date:** November 13, 2013 **Current Contract End Date:** June 30, 2020 with automatic annual renewal options
Number of Covered Lives	74,265 Total Covered Lives includes **4,351 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-9 South Carolina

South Carolina Medicaid	
Contract Start and End Dates	South Carolina Department of Health and Human Services **Initial Contract Start Date:** January 2013 **Current Contract End Date:** June 30, 2021 with optional annual renewal
Number of Covered Lives	81,146 Total Membership includes **65 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Regional

With the acquisition, we are now also able to leverage the experience and best practices of our Centene affiliate health plans, which manage the care of more than 150,000 children in Foster Care across 17 states. **Table G.2-10** through **Table G.2-26** provides the requested information on our Centene affiliate full risk Medicaid managed care contracts that include Foster Care Enrollees.

Table G.2-10 Arizona

Arizona Medicaid	
Contract Start and End Dates	Arizona Health Care Cost Containment System **Initial Contract Start Date:** Oct 1, 2015 **Current Contract End Date:** Sept 30, 2021
Number of Covered Lives	224,065 total covered lives, includes **4,100 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	South Region

Table G.2-11 California

California Medicaid	
Contract Start and End Dates	Department of Health Care Services - Medi-Cal **Initial Contract Start Date:** Jan 1, 2013 **Current Contract End Date:** Jun 30, 2020
Number of Covered Lives	1,907,444 total covered lives, includes **1,673 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Los Angeles County

Table G.2-12 Florida

Florida Medicaid Foster Care	
Contract Start and End Dates	Florida Agency for Health Care Administration **Initial Contract Start Date:** May 1, 2014 **Current Contract End Date:** Sept 30, 2023
Number of Covered Lives	**41,306 Foster Care** (Out-of-Home, Kinship, Adoption Assistance, In-Home), and Former Foster Care
Whether the Contractor provides services regionally or statewide	Statewide Sole Source Contract

Table G.2-13 Illinois

Illinois Medicaid Foster Care	
Contract Start and End Dates	Department of Healthcare and Family Services **Initial Contract Date:** January, 1 2018 Implementation Phase 1: Feb 1, 2020 Implementation Phase 2: April 1, 2020 **Current Contract End Date:** Dec 31, 2021, with optional renewals for up to four additional years
Number of Covered Lives	**Implementation Phase 1:** 15,956, Former Youth in Foster Care **Implementation Phase 2:** 16,600 (projected), Youth in DCFS Custody
Whether the Contractor provides services regionally or statewide	Statewide Sole Source Contract

Table G.2-14 Indiana

Indiana Medicaid	
Contract Start and End Dates	Indiana Family and Social Services Administration **Initial Contract Start Date:** Apr 1, 2015 **Current Contract End Date:** Mar 31, 2021
Number of Covered Lives	245,032 total covered lives, includes **4,427 Foster Care** Enrollees

Indiana Medicaid	
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-15 Iowa

Iowa Medicaid	
Contract Start and End Dates	Iowa Department of Human Services **Initial Contract Start Date:** Jan 1, 2019 **Current Contract End Date:** Dec 31, 2022
Number of Covered Lives	264, 567 total covered lives, includes **2,500 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-16 Kansas

Kansas Medicaid	
Contract Start and End Dates	Kansas Department of Health and Environment (KDHE) **Initial Contract Start Date:** Jan 1, 2013 **Current Contract End Date:** Dec 31, 2023
Number of Covered Lives	135, 891 total covered lives, includes **6,336 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-17 Louisiana

Louisiana Medicaid	
Contract Start and End Dates	Louisiana Department of Health **Initial Contract Start Date:** Feb 1, 2012 **Current Contract End Date:** Dec 31, 2020
Number of Covered Lives	451,587 total covered lives, includes **6,780 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-18 Mississippi

Mississippi Medicaid	
Contract Start and End Dates	Mississippi Division of Medicaid **Initial Contract Start Date:** Jan 1, 2011 **Current Contract End Date:** Jun 30, 2020 with optional renewals
Number of Covered Lives	195,801 total covered lives, includes **6,333 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-19 Missouri

Missouri Medicaid	
Contract Start and End Dates	Missouri Department of Social Services **Initial Contract Start Date:** July 1, 2012 **Current Contract End Date:** June 30, 2020 with optional renewals
Number of Covered Lives	203,522 total covered lives, includes **14,047 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-20 Nebraska

Nebraska Medicaid	
Contract Start and End Dates	Nebraska Department of Health and Human Services **Initial Contract Start Date:** Jan 1, 2017 **Current Contract End Date:** Dec 31, 2022 with optional renewals
Number of Covered Lives	80,363 total covered lives, includes **2,864 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-21 New Hampshire

New Hampshire Medicaid	
Contract Start and End Dates	New Hampshire Department of Health and Human Services **Initial Contract Start Date:** Dec 1, 2013 **Current Contract End Date:** Aug 31, 2024
Number of Covered Lives	76,656 total covered lives, includes **1,673 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-22 New Mexico

New Mexico Medicaid	
Contract Start and End Dates	New Mexico Human Services Department **Initial Contract Start Date:** Jan 1, 2019 **Current Contract End Date:** Dec 31, 2022
Number of Covered Lives	61,154 total covered lives, includes **685 Foster Care** Enrollees

New Mexico Medicaid	
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-23 Ohio Medicaid

Ohio Medicaid	
Contract Start and End Dates	Ohio Department of Medicaid **Initial Contract Start Date:** Jan 1, 2016 **Current Contract End Date:** Jun 30, 2020 with automatic annual renewals
Number of Covered Lives	335,948 total covered lives, includes **2,600 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Statewide

Table G.2-24 Oregon

Oregon Medicaid	
Contract Start and End Dates	Department of Human Services - Oregon Health Authority **Initial Contract Start Date:** Jan 1, 2014 **Current Contract End Date:** Dec 31, 2024
Number of Covered Lives	93,401 total covered lives, includes **300 Foster Care** Enrollees
Whether the Contractor provides services regionally or statewide	Lane County

Table G.2-25 Texas

Texas Medicaid Foster Care	
Contract Start and End Dates	Health and Human Services Commission of Texas **Initial Contract Start Date:** April 1, 2008 **Current Contract End Date:** Aug 31, 2021

Texas Medicaid Foster Care	
Number of Covered Lives	32,770
Whether the Contractor provides services regionally or statewide	Statewide Sole Source Contract

Table G.2-26 Washington

Washington Foster Care	
Contract Start and End Dates	Washington State Health Care Authority **Contract Start Date:** July 1, 2015 **Current Contract End Date:** Jun 30, 2020
Number of Covered Lives	23,969
Whether the Contractor provides services regionally or statewide	Statewide Sole Source Contract

b. Office in the Commonwealth - For programs similar to Kentucky SKY, has the Contractor co-located staff in an agency regional office? If yes, describe the factors that influenced that decision and summarized the outcome of the co-location in coordinating of services for program participants.

WELLCARE OF KENTUCKY WILL CO-LOCATE KENTUCKY SKY FIELD OUTREACH COORDINATORS IN AGENCY REGIONAL OFFICES.

Collaboration and partnerships between WellCare of Kentucky staff and DMS, DCBS, and DJJ staff are essential. Today, our Kentucky field-based care coordinators serving the foster care and adoption services population are local and work physically in DCBS and DJJ offices statewide. On the Kentucky SKY program, we will build upon existing relationships with DMS, DCBS, and DJJ staff and continue in-person outreach in local DCBS and DJJ offices.

Co-location enhances collaboration and coordination, problem solving, and information sharing with DCBS and DJJ staff. Today our regional teams of associates live and work in the regions and districts where DCBS and DJJ offices are located. We assign a local WellCare of Kentucky care coordinator to each DCBS Service Region. This care coordinator meets with his or her assigned Service Region and county level offices to establish and maintain internal relationships with DCBS and DJJ staff.

On our current Kentucky Medicaid contract, we conducted monthly meetings in each DCBS Service Region at contract go-live, with meetings occurring quarterly today. Care coordination staff conducts similar meetings with DJJ East and West Service Districts. Care coordinators conduct frequent Enrollee-specific treatment planning meetings with Service Region, county level, and Community District staff, collaborating to ensure each Enrollee in the foster care and adoption services population can access physical, behavioral health, pharmacy, and social services and is receiving the care he or she needs across the care continuum. We leverage established relationships during these meetings as we gain insight into Enrollees with existing care coordination and access needs. We collaborate with DCBS and DJJ staff to connect the Enrollee with needed services without duplicating them. We seek recommendations from DCBS and DJJ staff regarding provider and state agency educational needs. Often our collaboration consists of specific Enrollee issues, addressing access to care, referrals to providers, discharge planning from one level of care to another, or just sharing ideas that can help Enrollees. Our current collaboration has allowed training sessions to occur within multiple regions across the Commonwealth and opportunities to provide training to DCBS foster parents.

As part of the Kentucky SKY program implementation and ongoing, we will expand upon existing relationships with regional staff in the Service Regions and Community Districts to address concerns, problem resolution, provider and state agency educational needs, and risk management for the Kentucky SKY program. As an example, WellCare of Kentucky developed a tip sheet with helpful hints and information for DCBS/DJJ staff and foster parents. This tip sheet outlined information around how to request services, what information WellCare of Kentucky could help track down on an Enrollee's medical/behavioral health history, and who to call with specific questions. Because of this tip sheet, state staff could resolve questions and concerns quickly. Recently, a DCBS worker outreached the contact name on the tip sheet because the pharmacy could not fill an Enrollee's medication. The DCBS worker stated the pharmacy was

showing the Enrollee having inactive status with WellCare of Kentucky. That direct contact from DCBS allowed WellCare of Kentucky staff to outreach to the pharmacy--with the DCBS worker on the phone--and confirm the Enrollee's active status. As a result, the pharmacy filled the Enrollee's medication immediately.

c. Staffing

i. Describe the Contractor's proposed approach to staffing for the Kentucky SKY program under this Contract, including the following information at a minimum:

WellCare of Kentucky will comply with DMS' expectations and requirements as specified in Section 9.2 Administration/Staffing of the Draft Medicaid Managed Care Contract and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

PROPOSED APPROACH TO STAFFING THIS CONTRACT

WellCare of Kentu cky understands that building and deploying the correct staffing model is critical to our ability to meet the operational requirements of the Kentucky SKY program and deliver on its mission to improve health outcomes and strengthen the support to families in crisis. As noted in our response to a.i, WellCare of Kentucky is now subsidiary of Centene. **WellCare of Kentucky's leadership and staff is not changing and remains committed to partnering with DMS to ensure Kentucky's Enrollees, communities, providers and other stakeholders receive the integrated, whole-person care and services necessary to address all of their physical, behavioral, and social needs.** WellCare of Kentucky manages the care of approximately 8,100 Foster Care Enrollees, across the Commonwealth. We also leverage the experience and best practices of our affiliate WellCare Medicaid health plans' experience managing the care of approximately 20,000 Foster Care Enrollees across seven other states(as of year end 2019). With the acquisition, we are now able to leverage the experience and best practices of our Centene affiliate health plans, which manage the care of more than 150,000 children in Foster Care across 17 states. This experience includes sole source Foster Care contracts in Florida, Illinois, Texas, and Washington.

We understand that Children/youth in foster care typically have more intensive health care needs than other children and may lack access to regular primary care, dental care, or behavioral health care. We know these children/youth may have been exposed to Adverse Childhood Experiences (ACEs) because of trauma, significant stress, abuse, and neglect and may require care for chronic physical problems. Further, we know these children/youth tend to have more behavioral health problems and require more psychosocial services than other children/youth receiving Medicaid services.

With this in mind, and building on our eight years of experience in providing Medicaid services in Kentucky, we have built a staffing model that is focused on improving the quality of life and health outcomes for Kentucky SKY Program Enrollees by meeting their complex physical, social, pharmacy, and behavioral health needs. We will expand our team of highly qualified and trained associates and maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties as identified in RFP Attachment C Draft Medicaid

Managed Care Contract and Appendices. We will continue to develop and maintain our WellCare of Kentucky SKY team by utilizing the following best practices:

- Leveraging our extensive experience of operating a locally driven health plan within the Commonwealth to create a staffing plan that addresses the complex challenges specific to the Commonwealth's health care landscape as well as the diverse cultural needs of the Kentucky SKY population.
- Identifying, recruiting, and retaining experienced executives and associates who understand the distinct needs and cultural nuances of our SKY Enrollees, who live in our operating communities, and are familiar with our collaborative programs and community partners.
- Giving our local leaders and associates closest to our Enrollees, providers and stakeholders the autonomy to make decisions regarding the Kentucky SKY program with support and feedback from our Commonwealth leadership team.
- Providing our associates with the training, tools, and resources needed to provide the highest level of service to our Enrollees and providers.
- Continue to grow our relationship with the Commonwealth, DMS for Community Based Services (DCBS), and the Department of Juvenile Justice (DJJ) through frequent, effective, and transparent communication.

WellCare of Kentucky's SKY program is led by a skilled group of health plan executives that serve as our SKY Executive Team and are responsible for oversight of all WellCare of Kentucky SKY operations. WellCare of Kentucky today serves the single largest concentration of Foster Care, Adoption and Adult Guardianship children across the Commonwealth with approximately 8,100 children relying on our passion for individualized and holistic care to empower them to reach their unique goals. Led by our Kentucky SKY Executive Director, Lori Gordon, who personally champions on behalf of our foster care children and their caregivers, our dedicated teams of professionals have worked closely for nearly a decade with our agency partners to ensure the highest quality of service to our most vulnerable Kentuckians and assure all children have nurturing communities of care. As DMS places its trust in a single point of accountability for its Foster Care youth, WellCare is uniquely positioned as a leader among provider partners and families to bring the vision of Families First Prevention Act to life.

Every associate serving on WellCare of Kentucky's SKY Executive Team will live in Kentucky. WellCare of Kentucky's SKY executives are experienced in implementing innovative care delivery systems for individuals similar to those enrolled in Kentucky's SKY Program and they bring diverse sets of clinical and operational expertise. Each has a deep understanding of the challenges specific to the Commonwealth's healthcare landscape as well as institutional knowledge of our collaborative programs, network providers, and community partners in all nine DCBS regions across the Commonwealth. All full-time Kentucky Sky key personnel are dedicated full-time to the Kentucky SKY population and shall be available to meet at the location requested by DMS, DCBS, and DJJ within 24 hours' notice from DMS.

WellCare of Kentucky employs more than 300 associates, all of which are dedicated to serving people in Kentucky and will be crucial to the success of the Kentucky SKY program. We plan on

deploying an additional 220 associates located within the Commonwealth that will be solely dedicated to serving the SKY program. This approach to staffing this Contract is critical to our success as these locally-based employees perform a variety of key functions including, but not limited to care coordination, population health, utilization management, grievances and appeals, quality improvement, provider service (including provider relations, network development, and enrollment), pharmacy enrollee services, compliance, finance, and enrollee and provider complaints. We shall provide DMS, DCBS, and DJJ with a staff roster every 90 days during the Term of the Contract unless otherwise specified by DMS. This roster shall set forth the names, titles, and physical location of our Kentucky SKY staff (including Subcontractors), their areas of responsibility and the number of hours they are required to dedicate to the Kentucky SKY program.

a. *Description of how the organizational structure provides innovative solutions for meeting programmatic goals specific to the Kentucky SKY program and Kentucky SKY Enrollees and supports stakeholder groups (e.g., Kentucky SKY Enrollees, providers, partners, among others).*

WellCare of Kentucky is a thought leader within the Commonwealth and our drive for developing and providing innovative solutions permeates all aspects of our organization from executive leadership to every WellCare associate. WellCare of Kentucky is the only Managed Care Organization in the state with a completely integrated team and service capabilities. Under the umbrella of our health plan leadership, and leveraging the support and resources of WellCare Health Plans, Inc., our operational structure and processes fully support the integrated delivery of services, including WellCare staff, contractors, systems, and call centers. Building on WellCare of Kentucky's achievements and experience operating within the Commonwealth, we support DMS' goal of enhancing its current Medicaid managed care system with a focus on quality goals and improving health outcomes.

'ONE TEAM' APPROACH

WellCare of Kentucky's innovative organizational structure and practices support integrated delivery of services across our staff, contractors, systems, call centers, and all available resources to provide a unified, streamlined managed care experience for our Enrollees, physicians, the DCBS, the DJJ and DMS. Our operations structure and processes were developed and continue to evolve based on industry needs with integration in mind—ensuring that our support teams, contractors, and call centers leverage standardized WellCare of Kentucky procedures for open communication, Enrollee support, and continuous improvement.

Our approach to integrated service delivery begins with our 'One Team' philosophy—which has been the cornerstone of our organizational culture and the culmination of WellCare's 30 years' experience building toward a fully integrated, holistic approach to Enrollee care. One Team means that our philosophy applies to every aspect of our organization, from the executive leadership staff led by our Executive Administrator, Lori Gordon, to the fully integrated care management team, and across all entities that support our Enrollees, including our local subcontractors and the Enrollee call center staff trained to support the Commonwealth through the Enrollee Call Center, Nurse Advice Line (NAL), and our Behavioral Health Crisis Line.

Because of our streamlined operational structure, processes, and staff, our health plan can focus on providing comprehensive, holistic care management that focuses on proactively leveraging services that treat the whole-person. As a fully integrated health plan, we implement person-centered goal setting and care planning, address social determinants of health (SDOH), and ensure that Enrollees have reliable access to services that treat more than a specific diagnosis or condition, such as physical health, behavioral health, and pharmacy. Our whole-person care approach includes guidance assisting Enrollees with access to carved-out services when necessary, or to our suite of valued-added services that address non-medical needs and serve to improve health outcomes.

DEDICATED CARE COORDINATION TEAMS IN EACH OF THE NINE DCBS REGIONS AND FOUR COMMUNITY DISTRICTS

WellCare of Kentucky today serves the single largest concentration of Foster Care, Adoption and Adult Guardianship children across the Commonwealth with approximately 8,100 children relying on our passion for individualized and holistic care to empower them to reach their unique goals. WellCare already locates Care Coordinators and Care Coordination Teams in the areas they serve and because our Care Coordination staff is field based, it offers increased flexibility to work in any environment; DCBS/DJJ offices, PCP offices, provider offices, foster homes, and family homes. Currently, our Care Coordination staff are assigned to one of our six offices across the Commonwealth, but they work from the field. Building on our successful field-based Care Coordination approach, we have developed a regionally based care coordination model that places Care Coordinators and Care Coordination Team staff in each of the nine DCBS regions. The following staff will be deployed regionally throughout the Commonwealth:

- Masters level licensed Behavioral Health Clinicians
- Care Coordinators
- Behavioral Health Specialists
- Nurse Care Managers: Medically Complex Children
- Nurse Case Managers
- Care Management Supervisors
- Coordinator Supervisors
- Case Management Managers

These associates will serve all Service Regions and Community Districts throughout the Commonwealth. Placing our Care Coordination Teams in each of the nine DCBS regions allows for better coordination of care and services for each Kentucky SKY Enrollee in collaboration with DMS, DCBS, and DJJ. A WellCare of Kentucky local Care Coordinator is assigned to each DCBS Service Region/DJJ Community District and responsible for meeting with his or her assigned Service Region and county level offices to establish internal relationships. These regional staff meetings occurred monthly at program go-live and are now held quarterly.

Similar meetings have occurred with DJJ East and West Service Districts since the beginning of the program.

Our Care Coordination staffing model aims to meet the unique needs of Kentucky SKY Enrollees in support of DMS' objectives to:

- Enhance the coordination of care and access to Trauma-informed services, including physical health, mental and behavioral health, dental care, social services, and wraparound services
- Improve coordination of care and continuity of care between CHFS agencies, health care providers, and community resources, as needed
- Ensure required assessments and health services within the mandated timeframes
- Foster collaboration and coordination with CHFS agencies and health care providers to share key health records in a timely manner and reduce duplication of services
- Foster collaboration and coordination with hospitals, treatment facilities, residential providers, physical and behavioral health providers, and others on the discharge planning needs of the Enrollee for all levels of care
- Safely reduce the number of children entering OOHC
- Improve timeliness to appropriate permanency
- Reduce Caseloads

Additional information regarding our innovative care coordination model can be found in our response to section G.2.c.xii.

DEDICATED REGIONALLY BASED TEAMS

In order to provide a streamlined managed care experience for our Enrollees, Adoptive Parent(s), Foster Care Parent(s), Caregivers, Fictive Kin, providers, the DCBS, the DJJ and DMS, we have developed an organizational structure that includes separate and distinct regional teams of operational and clinical staff in each of our six regional offices throughout the Commonwealth. WellCare of Kentucky's Foster Care and Adoption Program has met both regionally and locally with DCBS staff and DJJ staff since the award of the Kentucky Managed Care Organization contract in 2011. Placing regional teams and associates throughout the Commonwealth, including within regions and districts where DCBS and DJJ offices are located, will allow us to continue building these relationships through constant communication. We have a state-level executive leadership team to anchor each regional staff team, and a local regional leader to manage the team's day-to-day activities. This innovative staffing model ensures our regional team leaders engage in daily, weekly, and monthly interactions with their teams to ensure adherence to escalation protocols and to ensure associates are making timely, accurate, and proactive decisions.

DEDICATED ENGAGEMENT TEAM - PROVIDING TRAINING FOR SKY STAKEHOLDERS

In order to ensure we provide targeted communications and training to providers, law enforcement, the judicial system, advocates, and other stakeholders on the managed care

program, we are proposing adding several positions to our organizational structure. These positions include a Training Specialist that is responsible for providing education and training of DMS, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel and a Department of Juvenile Justice Liaison that serves as the interagency liaison with the Kentucky DJJ, KY DCBS, Kentucky Department of Corrections (KDOC), and Administrative Office of Courts (AOC).

Training Specialist

WellCare of Kentucky's training specialist is responsible for providing education and training of DMS, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel. This role is also responsible for providing quarterly training for law enforcement officials, judges, district, and county attorneys, including the Kentucky Administrative Office of the Courts and the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy.

The associate fulfilling this role is required to have a Bachelor's Degree in a related field or equivalent work experience. It is preferred that this associate has one of the following licenses/certifications: Licensed Bachelor Social Worker (LBSW), Licensed Master Social Work (CSW), or Licensed Professional Counselor (LPC). The associate within this role must possess thorough knowledge of Kentucky SKY contract requirements, SKY business processes and workflows and specific tools/assessments required by contract. This associate must also possess comprehensive understanding of the roles and responsibilities of DMS, DCBS, and DJJ. This associate is required to have 4 plus years of experience in design and delivery of training programs using strong facilitation and communication skills, evaluation of learner needs, assessment of training programs and implementation of learning solutions for performance enhancement or 3+ years of experience in clinical practice in a hospital, clinic or other provider setting specific to foster care and/or juvenile justice.

Department of Juvenile Justice Liaison

WellCare of Kentucky's DJJ Liaison coordinates with the Department of Juvenile Justice for evaluations and treatment specific to the disposition for eligible Enrollees. This associate collaborates with the interdisciplinary team to achieve optimal resource outcomes. The DJJ Liaison serves as the interagency liaison with the Kentucky DJJ, KY DCBS, KDOC, and AOC. This role serves as the single point of contact for information specific to the DJJ disposition for eligible Enrollees. This role communicates DJJ related follow-up/requirements to the interdisciplinary team and collaborates with the interdisciplinary team to achieve optimal resource outcomes. This role is responsible for ensuring required DJJ paperwork is complete and submitted in a timely manner. This role provides support to care and case managers regarding the coordination of care plans for members by utilizing social service expertise to evaluate the members need for alternative services and third party intervention. This role also assists in coordinating transfers for Enrollees under DJJ treatment. Provides and/or coordinates trainings, as needed or requested (i.e., substance abuse treatment).

The associate fulfilling this role is required to have a Social Work (BSW), Psychology, Counseling, Rehabilitation, or other relevant field or equivalent work experience in managed care directly related to assisting Enrollees to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health. It is preferred that

this associate has one of the following licenses/certifications: LBSW, Licensed Master Social Work CSW, or LPC. This associate must also have six months of experience in a health care environment with client care coordination responsibilities via assisting clients to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health.

Dedicated Provider Network Team – Supporting Our Network of Providers

As an incumbent managed care organization within the Commonwealth, we currently serve the single largest concentration of Foster Care, Adoption and Adult Guardianship children across the Commonwealth with approximately 8,100 children relying on our passion for individualized and holistic care to empower them to reach their unique goals with services delivered through an existing network of more than 34,500 providers. As we expand our network to support Kentucky SKY, we will build on this expertise to ensure a comprehensive network that meets the unique needs of Kentucky SKY Enrollees in support of DMS' objectives to:

- Enhance the coordination of care and access to Trauma-informed services
- Provide appropriate statewide provide network with 24 hour emergency access and crisis services
- Ensure required assessments and health services are delivered within the mandated timeframes
- Promote the sharing of key health records in a timely manner to reduce duplication of services

Executive Director, Lori Gordon, Bonnell Irvin, Provider Network Director, Tim Houchin, Behavioral Health Director with board certifications in Psychiatry, Child and Adolescent Psychiatry and Forensic Psychiatry, and Candice Bowen, Senior Director, Network Management lead our Kentucky SKY network development activities.

To support the unique needs of Kentucky SKY Enrollees and this contract we will utilize our dedicated provider network teams to perform outreach to each stakeholder, including DMS, DCBS, DJJ, and foster parents, to identify specific providers who are not already in our network that we need to recruit. We will also expand the network by adding new services around mobile crisis, in home services, telehealth, child-psychologists, child-psychiatrists, and other key specialty providers. Specifics of our approach include

Dedicated Provider Engagement Teams – Supporting Our Providers

WellCare of Kentucky is focused on creating the highest level of provider satisfaction with our health plan and eliminating problems for providers who serve our Enrollees. As such, in 2016, we evolved our innovative provider engagement organizational structure to include a dedicated Commonwealth-based provider engagement team, employing local representatives who live and work in the communities they support and are better equipped assist our providers in moving along the value-based continuum.

WellCare Kentucky will build on the foundation of its extensive MMC Provider Relations functions, establishing a separate Provider Engagement Team to serve the Kentucky SKY

program, creating a provider services function that will act as the point of contract specifically for providers serving SKY Enrollees. WellCare will establish this separate Provider Engagement Team to best serve the new providers, including 30+ private childcare providers who will be new to a managed care system and may need extra assistance learning new systems and resolving any issues that arise at intervention.

We will support our SKY network of providers with a regional team of experts in the Kentucky SKY program who live in the communities they serve. Our provider engagement team will wrap supports around Kentucky SKY providers and assist them in all aspects of contracting and delivering services to Kentucky SKY Enrollees. Anthony Piagentini, WellCare of Kentucky's Provider Services Manager, leads our provider engagement team. Anthony is responsible for managing our provider relations team for WellCare of Kentucky including all institutional, professional, and behavioral health providers. Our SKY provider engagement team includes our SKY Provider Relations Liaison, LeAnn Magre, who is responsible for supporting the resolution of Provider access and availability issues and Patricia Russell, our Director, Provider Operations, who has been with WellCare of Kentucky since 2011 and provides additional stability to the team. Our Provider Services Manager, Provider Relations Liaison, Director of Provider Operations, and regional SKY Provider Relations representatives will have detailed knowledge of Kentucky providers, including behavioral health providers, patterns of care/referral in Kentucky, the Kentucky SKY program, provider contracting, billing, authorizations, and claims submission. In support of the Kentucky SKY program, our SKY Provider Engagement Team also includes a coding educator will also work directly with SKY providers on coding practices beginning four months in advance of program go-live.

Currently, WellCare of Kentucky has the largest and most active field-based provider relations team amongst our competitors, comprised of over 26 associates to conduct provider relations and engagement in full support of DMS' goals. With this dedicated provider engagement team, WellCare of Kentucky is able to provide the highest frequency of face-to-face and overall interactions from provider support staff among our competitors. **WellCare of Kentucky averages 736 contacts with providers each month from the Provider Relations Team. Of these interactions, on average that includes 476 face-to-face meetings in provider's offices per month.** This is supported by four Hospital Specialists calling on institutions, and 15 Provider Relations Representatives who call on primary care and behavioral health providers across the state. These interactions focus on multiple objectives including resolving existing issues, educating providers on current programs like pay-for-quality, and executing Joint Operating Committee meetings with a variety of participants including quality and pharmacy as an example.

b. Description of how the organizational structure will support whole-person integrated care, population health and overall improvement in health outcomes in a cost-effective manner for the Kentucky SKY program.

AN ORGANIZATIONAL STRUCTURE THAT SUPPORTS WHOLE PERSON INTEGRATED CARE, POPULATION HEALTH, AND IMPROVING HEALTH OUTCOMES

WellCare of Kentucky's infrastructure provides integrated accountability with behavioral, social, pharmacy and physical health staff aligned through our clinical, administrative, and operational

structure. This ensures that integration of services begins at the top of WellCare of Kentucky's management structure and flows down into our regional and local service delivery at the Enrollee level. Our governance and decision making model ensures that these local leaders engage in daily, weekly, and monthly interactions with our local staff to address Kentucky specific issues, to ensure challenges are being addressed, to ensure adherence to escalation protocols, and to guarantee our associates are making timely, accurate, and proactive decisions. Examples of these interactions include weekly meetings with leadership, weekly interdepartmental meetings, weekly and monthly report reviews, and monthly town halls.

Figure G.2-8 Integrated Care Team

WellCare of Kentucky's organizational structure and practices support integrated delivery of services across our staff, systems, call centers, and all available resources to provide a unified, streamlined managed care experience for our Enrollees, physicians, and DMS. WellCare does not subcontract Behavioral Health and our integrated clinical, behavioral, pharmacy and social work teams are co-located to optimize team work and collaboration to the benefit of the Enrollee. We believe in leveraging one integrated care team covering all care needs including physical, behavioral, pharmacy and unmet social needs.

Our Enrollees benefit from one point of contact in their integrated care team, see **Figure G.2-8**, one card to carry, and one phone number to call, which simplifies the understanding, access, and coordination for the majority of their services. For those services that we provide oversight for, we work closely with and trust our local partners, such as Avesis, who follow WellCare of Kentucky guidelines and standards to provide support for our Enrollees based on our One Team philosophy. For DMS, this provides a clear and transparent view into the operational and clinical approach that WellCare of Kentucky delivers and for which we remain singularly accountable.

In addition, for our physician and care management partners, it serves to deliver a comprehensive set of Enrollee data through CareCentral, our web-based care management platform that pushes Enrollee information to the provider portal. And perhaps most importantly, our people and our systems integrate with WellCare's Community Connections database, which connects Enrollees to tens of thousands of local services with the help and guidance of our care coordinators to address social barriers and improve their quality of life.

A TEAM WITH EXPERIENCE PROVIDING WHOLE-PERSON INTEGRATED CARE

Our eight years of experience in providing Medicaid services in Kentucky has taught us that the best way to ensure whole-person integrated care is to employ culturally diverse individuals who live in our operating communities, have a deep understanding of challenges specific to the Kentucky healthcare landscape, and who have lived experience that reflects the experience of the Enrollees we serve. We are proud to have several Executive Team leaders in place with expertise in the serving approximately 8,100 Foster Care, Adoption, and Adult Guardianship

children across the Commonwealth and experience providing whole-person integrated care. WellCare of Kentucky's Executive Administrator, Lori Gordon, has full accountability for overseeing all operations, strategic direction and administration of our Kentucky SKY Program plan.

Working closely with our Executive Director is our Commonwealth-based leadership team, comprised of key leaders, each of whom are responsible for overseeing specific functional areas within WellCare of Kentucky's organization. Together, our Commonwealth-level leadership team and support staff will anchor each regional staff team. Our dynamic team of local leaders is responsible for making decisions for WellCare of Kentucky. This decision-making responsibility extends downward to the teams deployed throughout the Commonwealth to ensure that associates closest to our Enrollees, providers, and stakeholders are empowered to make decisions with support and feedback from our Commonwealth leadership team. For example, the scope of decision-making authority of our local team in Kentucky includes, but is not limited to, how staff and resources are deployed throughout the local market to support our Enrollees and providers, the authority to administer the execution and management of our provider network, the ability to make decisions about Value-Based Purchasing with our providers, and the capability to make local decisions regarding claims adjudication and prior authorization issues.

A TEAM WITH EXPERIENCE ADDRESSING POPULATION HEALTH AND IMPROVING HEALTH OUTCOMES FOR ENROLLEES

WellCare of Kentucky today serves the single largest concentration of Foster Care, Adoption and Adult Guardianship children across the Commonwealth relying on our passion for individualized and holistic care to empower them to reach their unique goals. Our dedicated team of field-based Care Coordination professionals have a true passion for helping these Enrollees improve health outcomes, build resiliency, maintain stability, and achieve their permanency goals. WellCare is the only Kentucky Medicaid MCO that has already implemented a field-based model for these Enrollees, having recognized several years ago that effectively managing this population requires a high touch approach and strong relationships and processes with DCBS, DJJ, and other stakeholders. As a result, we have improved outcomes such as the following for our foster care, juvenile justice, and adoption assistance Enrollees.

- From 2017 to 2019 HEDIS scores for well-child visits in the third, fourth, fifth and sixth years of live increased 10%. Adolescent well-care visits increased 28%. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents had a significant increase for all ages and is in the top 75 percentile and had a 68% increase. The use of first-line psychosocial care for children and adolescents on antipsychotics increase (12-17 years) 9%. HEDIS scores for all five Immunizations for Adolescents measures, Adolescent Well Care, Timeliness of Prenatal Care, and Chlamydia Screening increased from 2017 to 2019.
- Among those with co-morbid physical and behavioral health (BH) issues, inpatient admissions/1000 decreased by 11%, ER visits/1000 decreased by 13%, and specialist visits/1000 increased by 29% from 2016 to 2019.

- Among those with co-occurring mental health and substance use issues, ER visits/1000 decreased by 14%, inpatient mental health admits/1000 increased by 3%, PCP visits/1000 increased by over 3%, and specialist visits/1000 increased by 7% from 2016 to 2019.

As DMS places its trust in a single point of accountability for its Foster Care youth, WellCare is uniquely positioned as a leader among provider partners and families to bring the vision of Families First Prevention Act to life.

ii. What prior experience will the Contractor require staff to have had in serving populations similar to Kentucky SKY Enrollees?

ENSURING PROSPECTIVE ASSOCIATES HAVE NECESSARY EXPERIENCE

As mentioned throughout this response, we have an established recruiting and hiring process in place to ensure all current and potential WellCare of Kentucky associates have sufficient experience with populations similar to Kentucky SKY Enrollees. When it comes to recruiting, we ensure applicants have a clear understanding of their responsibilities and what requirements the position for which their applying entails. Our internal and external job descriptions provide a thorough list of key duties and responsibilities as well as minimum requirements in the areas of education, work experience, skills, licenses, and certifications. The minimum requirements vary from position to position. **At a minimum, all SKY staff positions require two years of child welfare experience.** For example, our Care Coordinators are required to have five plus years of experience in a health care environment with client care coordination responsibilities and four plus years of experience working with children and families involved with foster care, adoption or juvenile justice while our Peer Support Specialists must be a certified Kentucky Peer Support Specialist with experience as a foster and/or adopted parent in the Kentucky Child Welfare system or a former foster youth with lived experience. In addition to the mandatory SKY staff position requirements, WellCare of Kentucky looks for the following skills when identifying prospective candidates for our SKY positions:

- Empathy and self-awareness
- Ability to effectively present information and respond to questions from foster families, biological and fictive kin relations, medical consenters, child protective services, Enrollees, and providers
- Ability to work independently
- Ability to multi-task
- Demonstrated time management and priority setting skills
- Demonstrated interpersonal/verbal communication skills
- Knowledge of healthcare delivery, specifically the Kentucky child welfare system, agencies, providers, and resources
- Knowledge of community, state and federal laws and resources
- Demonstrated written communication skills

- Demonstrated customer service skills
- Ability to effectively present information and respond to questions from peers and management
- Demonstrated problem solving skills
- Ability to work in a team environment

Prospective candidates are carefully selected through written application, personal interview, reference checks, and skills testing. Both the recruiting team and the hiring manager utilize behavioral based interview guides that assess candidates in a fair and unbiased manner. Recruiters have access to HI revue video interviewing technology for live, recorded, or panel interviews. Applicants complete a predictive index survey upon applying to WellCare that identifies a candidate's behaviors and personality traits relative to their desired role. Prior to award, we will screen all potential candidates to ensure they have the required licensure and experience to fulfill the role for which they are applying. Criminal and general employment background checks and drug screens are required following a conditional offer of employment. Our screening protocol also ensures these have not been excluded from participation in Federal health care programs. This thorough vetting process ensures that all prospective applicants have the necessary prior experience in serving populations similar to Kentucky SKY Enrollees.

iii. Provide a narrative description of the Contractor's approaches to recruiting staff for the Kentucky SKY program, including:

RECRUITING STAFF FOR THE KENTUCKY SKY PROGRAM

As shown in the **Figure G.2-9** below, **we have identified candidates for 16 of 19 key leadership positions leveraging individuals who live and work in the Commonwealth**; we are ready to work with DMS, DCBS, DJJ and other stakeholders to implement this exciting enhanced program.

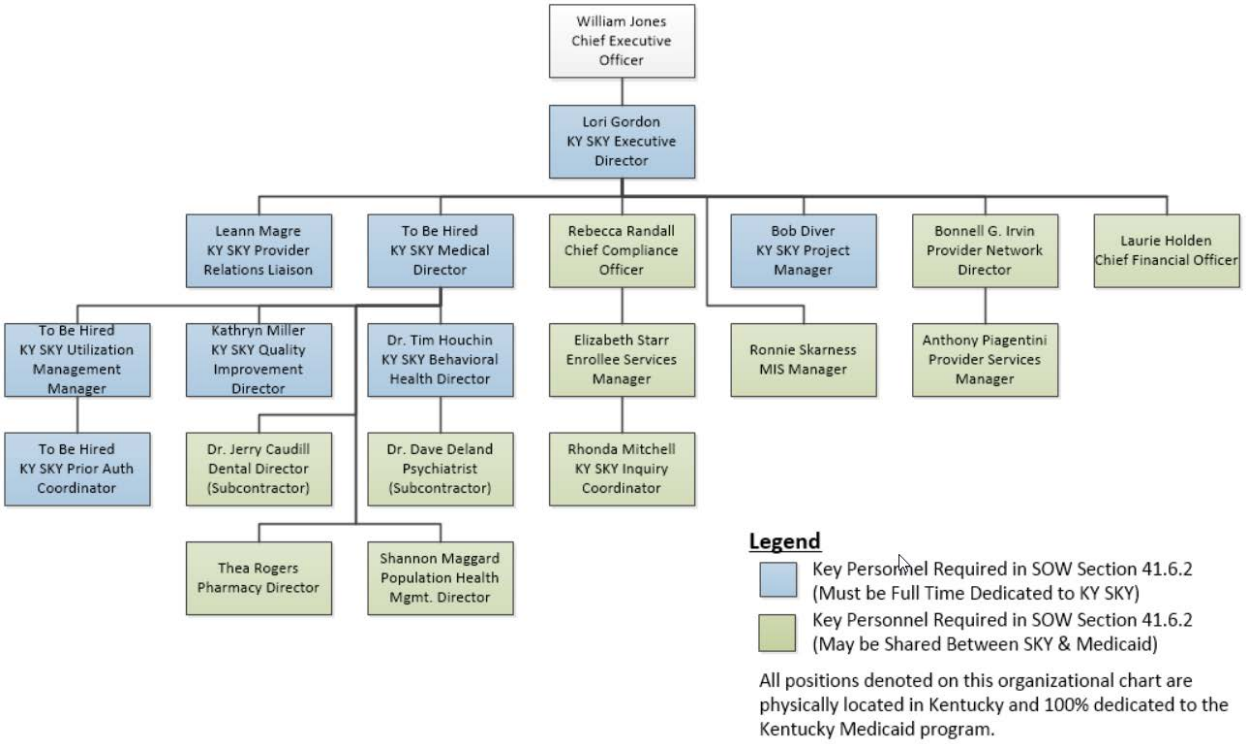


Figure G.2-9 WellCare of Kentucky SKY Organizational Structure

We have consistently demonstrated a strong commitment to offering a locally staffed plan with the Commonwealth and during our time serving people in Kentucky, we have shown a unique ability to recruit local, high-performing executive leaders and associates who understand the diverse needs and cultural nuances of our Enrollees. We are confident our proven internal and external recruiting methodologies will allow WellCare of Kentucky to add the necessary key personnel to complement our existing team to serve Enrollees covered under the new Kentucky SKY program.

In order to develop a staffing plan to fulfill the requirements of the Kentucky Sky Program, WellCare conducts a detailed and thorough information gathering process to ensure that the necessitated staffing levels for the Kentucky SKY program are accurately captured and planned for over time. We achieve this through a series of structured review sessions with functional area leaders that span all functions of the organization to ensure a clear understanding of the contract requirements, deliverables, and the strategy in place to effectively achieve and execute those deliverables. Following these review sessions, each functional area is responsible for providing a detailed staffing plan that includes the number and type of FTEs as well as the anticipated dates of hire, over time, including the time leading up to contract implementation. Senior level leadership reviews, revises (if needed), and approves the plan to ensure strategic direction is achieved and the inputs are appropriate to meet the established requirements.

Within 30 calendar days, WellCare of Kentucky will submit a detailed staffing plan that includes activities WellCare of Kentucky will conduct to fill any staffing needs to have sufficient support for Contract implementation and ongoing operations. The staffing plan will provide timelines for conduct of activities and for filling all staff positions.

a. Recruitment sources;

RECRUITMENT SOURCES

Our Talent Acquisition Team, comprised of specialized recruiters well positioned to leverage our ongoing pipelines, innovative sourcing tools and technologies, is responsible for executing our staffing plan. **Our Talent Acquisition Team includes 11 Talent Acquisition leaders at varying levels, one College Recruiting Program Manager, 56 recruiters (five specialized executive recruiters, 26 FTEs, 25 temporary positions), six Sourcing Specialists, and 12 Staffing Assistants.** We also have the ability to hire temporary/FTE recruiters in order to support influx of new Kentucky positions. Our Talent Acquisition Team has already begun developing and executing targeted recruiting strategies in each region of the Commonwealth. WellCare's Talent Acquisition Team has a variety of innovative and interactive recruitment tools to enhance candidate quality and experience. To ensure we are identifying a diverse pool of applicants for leadership and associate positions that reflect the diverse population of Kentucky and the specific staffing needs of the Contract, we are leveraging several different recruiting solutions that directly outreach to members of the disabled and aging community, members with lived experience similar to our Enrollees, and individuals of varying ethnic and cultural backgrounds. Our outreach efforts target a network comprised of major job board aggregators national outreach career sites, diversity sites, veteran's sites, LGBT sites, disabled sites, and local community-based organizations.

Our Talent Acquisition Team is currently involved in the following recruitment strategies to ensure we have the adequate staff in place to carry out the requirements of the Kentucky SKY program.

Advertising and Marketing

Associate Referral Program

WellCare of Kentucky leverages our Associate Referral Program as a key to recruiting talented associates who are highly motivated and committed to excellence. Through this program, we encourage our associates to refer qualified candidates to apply for open positions. Should that referred individual become hired and complete 90 days of continuous employment, the associate will receive a monetary bonus. We offer highly competitive referral bonuses including $500 for Non-Exempt associates, $1,500 for Exempt associates and $2,500 for Director-level and above associates. For positions that need to be filled quickly due to growth or unexpected attrition, we enhance the associate referral bonus to offer a stronger incentive to our associates to refer qualified candidates to open positions. Since January of 2018, WellCare of Kentucky has identified, hired, and on boarded 29 associates through our Associate Referral Program.

Job Boards

Our Talent Acquisition Team ensures that the available positions are posted on free online job boards and that they review the postings weekly to ensure accuracy. We post our positions on traditional online job boards including eQuest Advantage, Glassdoor, Google PPC, HealtheCareers, Indeed, LinkedIn, Professional Diversity Network, Programmatic, and Monster.

Targeting the Competition and Existing Healthcare Companies

WellCare is the employer of choice within the health care industry and we have built an organization that has become an attractive place to work for experienced health care executives, people leaders, and individual contributors. We provide a comprehensive benefits package, promote work life balance with flexible schedules, opportunities to work remotely (15% of our workforce work from home full time and a large percentage telecommute anywhere between one to four days per week), and tuition reimbursement. Additionally, we are committed to diversity and inclusion, and create an environment in which associates bring their authentic selves to the work place. **This has resulted in WellCare of Kentucky receiving recognition as one of Best Places to Work in Kentucky for the last two years. In 2019, we placed 10th in the Large Company category in 2018 and 8th in the Large Company category. The Best Places to Work in Kentucky survey and awards program, sponsored by the Society of Human Resource Management and the Kentucky Chamber of Commerce, is dedicated to identifying and recognizing the Commonwealth's best employers.** We will leverage our status as one of the Best Places to Work in Kentucky to attract top-level talent from our competitors and existing healthcare companies throughout the Commonwealth.

Community Engagement

Partnering with local Universities

As a part of our recruitment process, our University team researches universities to collaborate with in Kentucky, specifically universities that provide nurse accreditations, and below is what they found.

- University of Kentucky
- University of Louisville
- Murray State
- Morehead State
- University of Cumberlands
- Western Kentucky University
- Northern Kentucky University
- Easter Kentucky University
- Kentucky State University

When our University Team looks to establish a partnership with a university, they utilize a 3x3 method (career services, student groups, and faculty). They begin with reaching out to career services, who will put them in touch with student groups (nurse's student organization, analytics student organization, IT Student organizations, and business fraternities/sororities) to build relationships. Then, they work with the faculty on becoming guest presenters within their classes to discuss WellCare's culture, job opportunities, our involvement in the community, and mission of the organization.

Career Fairs / Interview Blitz Events: Establishing interview blitz calendar for Tampa and Kentucky based positions

Our Talent Acquisition Team conducts open houses and job fairs throughout the Commonwealth to expedite recruitment in particular geographic and functional areas of need.

We also collaborate with colleges and universities within the Commonwealth who hold career fairs in the state. We attend these fairs to publicize our available positions in conjunction with our recruiting timeframes and geographic areas of needs. Our interview blitzes typically run from 10:00 am – 7:00 pm EST, and the Talent Acquisition team will invite in a list of qualified individuals to meet with the hiring managers for face-to-face interviews for open roles. These events allow us to interview multiple candidates in one day, and execute offers quickly.

Partnering with Organizations throughout the Commonwealth

WellCare of Kentucky has an established track record of collaborating with organizations throughout the Commonwealth in order to recruit and train talent individuals to support our Enrollees. We will build on these established partnerships to recruit and train a talented team to support the Kentucky SKY program. One such example of this collaboration involved partnering with the Kentucky Community & Technical College System (KCTCS) and the Eastern Kentucky Concentrated Employment Program (EKCEP) to establish a call center within the Commonwealth.

In order to support the Kentucky 1115 waiver which was slated to go live on 7/1/18, WellCare of Kentucky decided to stand up a care center (call center) in Hazard, Kentucky (an area with high unemployment and in need of additional industry.) Originally, 40 positions were to be hired which included a Supervisor, Community Programs, Operations Supervisor, Enrollee Engagement Representatives, and Community Liaisons. We partnered with the Hazard Community & Technical College Workforce Development team to evaluate the ability to find qualified candidates to fill the roles in order to be able to locate the center in Hazard, Kentucky. These individuals would be responsible for fielding both incoming and outgoing calls from Enrollees who have questions about their benefits under the waiver, are having difficulty paying their monthly premiums and meeting work requirements. When Enrollees within the Commonwealth are calling about these issues, it was important to us that they speak with someone from their own communities that can relate to their issues and geographic challenges.

WellCare of Kentucky, in partnership with the KCTCS and the EKCEP hosted a job fair on 6/26/18 at the Kentucky Career Center in Hazard. The Eastern Kentucky Concentrated Employment Program assisted us with advertising the event as well as helped us man the event. Leaders from WellCare's Operations and Community Advocacy departments participated in on-site interviews along with HR and Talent Acquisition. 293 people attended and interviewed for 40 spots. The partnership with the KCTCS and EKCEP was key in getting this message out. Although the waiver did not end up going live, WellCare of Kentucky still hired a contingency of associates since we had already made that commitment to bring jobs to this community. These associates worked on other projects such as contacting Enrollees to close care gaps and make sure Enrollees completed their attestations.

Scholarship Programs

Recognizing the need for quality primary care in rural areas of the Commonwealth, WellCare of Kentucky funded two new scholarship programs aimed at increasing the number of doctors and nurses working in primary medicine and psychiatry in Eastern Kentucky. Access to doctors, nurses, and other health care providers directly affects health outcomes. When health care is in

short supply or located far away, people are less likely to get routine screenings, tests, and vaccinations – the type of care that can catch problems early or even prevent illness all together. Anything WellCare of Kentucky can do to encourage more providers to locate in underserved areas will be a direct benefit to health of the Commonwealth.

Despite the importance of rural primary and psychiatric care, communities in rural Kentucky, particularly in the eastern part of the state, have struggled to attract and retain an adequate number of primary care providers – both doctors and advanced practice nurses. In order to address these shortages, WellCare of Kentucky funded scholarship programs in conjunction with the University of Kentucky Medical School and College of Nursing. WellCare's support funded up to 16 scholarships for medical and nursing students at various stages of their studies. We are considering providing additional scholarship programs to increase access to doctors, nurses, and other health care providers within in rural areas of the Commonwealth.

"Physicians for the Commonwealth" Scholarship

"The WellCare Physicians for the Commonwealth Program" awarded ten $10,000 one-year scholarships to incoming medical students in 2017 who have a strong interest in the UK Rural Physician Leadership program and are interested in serving an underserved population within Kentucky. The Rural Physician Leadership program offers students opportunities to gain two years of clinical experience with a rural, underserved Eastern Kentucky population. Data show that physicians who train in more rural areas are more likely to stay in those areas to practice.

College Of Nursing Scholarships

In 2017, WellCare of Kentucky partnered with the University of Kentucky College of Nursing to provide $8,000 per semester scholarships, as well as over the next two years to nurses who are in their final year of study and plan on practicing in primary medicine or behavioral health in rural Kentucky. The nurses receiving the scholarships were in their final year of the school's Doctorate in Nursing Practice Program, which focuses on preparing graduates to lead the at the highest clinical and executive ranks.

b. Contingency plans if the Contractor is unable to recruit sufficient numbers of adequately trained staff in a timely basis or if the Contractor's original staffing estimates are too low and for avoiding and minimizing the impact of personnel changes;

CONTINGENCY PLAN

In the event WellCare of Kentucky is unable to recruit sufficient numbers of adequately trained staff in a timely basis or if our original staffing estimates are too low we are prepared to implement a rapidly deployable contingency plan in order to minimize abrasion to our Enrollees and providers. WellCare of Kentucky's methodology to internal succession planning as well as our corporate supplied resources, leadership and associates at the national, state and market level, allows us the confidence and capabilities to serve our Enrollees and be responsive to Department regardless of the circumstances. We are always prepared for the unexpected, and we will have associates in place to fulfill our responsibilities as identified in RFP Attachment Draft Medicaid Managed Care Contract and Appendices.

Internal Succession Planning

To ensure we continue to provide an optimized level of care to our Enrollees, we have a pipeline of internal candidates who have expertise serving populations similar to those included within the Kentucky SKY program. Our organizational and talent development team will continuously work with our Commonwealth leaders to craft thorough and actionable succession plans for positions with WellCare of Kentucky to ensure we have a "bench" of leaders and associates that we can deploy at any time. These succession plans include a proactive internal 'candidate search' for positions instrumental to the successful operation of WellCare of Kentucky's SKY program. WellCare's Executive Leadership Team, including Ken Burdick, WellCare's CEO, the Board of Directors, and WellCare of Kentucky leaders regularly reviews our succession plans.

By aligning identified key and developing leaders and associates with a suite of carefully developed curricula targeted at closing development gaps, we are able to efficiently groom a team of 'ready now' key leaders and associates. We have a series of learning roadmaps tailored for each level of management ensuring we continuously develop a body of outstanding leaders. Using these learning roadmaps, we provide necessary training and professional development aimed at increasing potential successor competencies and skills. WellCare of Kentucky has an internal training organization that continually and proactively provides best-in-class learning and development to existing staff in core areas. Our philosophy around continuous learning fosters an environment where all associates are provided with the training they need to effectively perform not only their current roles, but also growth roles. We are committed to providing all associates with effective learning in the necessary business and development skills to expand the skills and knowledge essential to their roles and ensure we have a stable of associates that are prepared to assume vacated roles should the need arise.

Leveraging Associates from Corporate and Other Markets

WellCare of Kentucky can easily leverage and mobilize associates in our shared services (corporate) functions as well as locally in our markets in the event of inability to meet a performance standard or an expected/unexpected staffing gap. WellCare has successfully launched and currently runs Medicaid programs in multiple states across the country, including proximate regional states of Missouri and Illinois. As such, WellCare has teams of incumbent associates who deliver best in class performance in their areas of focus including clinical, network development, community advocacy, provider relations, etc. As needs arise, our organization is prepared to re-allocate targeted individuals and functional groups from other state offices or from our corporate office to support critical functions. WellCare draws on a workforce of over 13,000 associates that serve WellCare's Medicaid and Medicare markets, which we can readily leverage in the event of an unexpected staffing gap (vacancy), minimizing abrasion to Enrollees, government partners, and providers. We are prepared to leverage the skills and abilities of our teams to support the evolving needs of our Enrollees.

Avoiding and Minimizing the Impact of Personnel Changes

WellCare of Kentucky understands that associate turnover is unavoidable but we utilize proven practices to avoid and minimize the impact of personnel changes through rapid identification

and replacement of associate as well as onboarding staff and bringing personnel replacements up to speed.

Avoiding and Minimizing Impact of Personnel Changes through Rapid identification of Key Personnel Replacements

In the event of an expected or unexpected vacancy of a key position, our Executive Administrator will work with state leadership to appoint a qualified interim leader within 30 calendar days of departure to minimize disruption to our Enrollees and provides. Drawing from our leadership at the national, state and market level we will quickly identify the necessary key leader and transition them into the role as expeditiously as possible. This key individual will remain in this position until we find a permanent replacement. This individual immediately begins shadowing the departing key leader to get a better understanding of their day-to-day responsibilities and to ensure a seamless transition. Simultaneously, the departing associate, with assistance of other leaders in their specific functional area, will develop a transition plan document that outlines the necessary processes, responsibilities, current projects, key meetings, etc. for that key position. The interim associate is responsible for familiarizing himself or herself with this document to understand what they are accountable for within this role. Once we identify a long-term associate, it is the responsibility of the interim associate to bring them up to speed.

WellCare of Kentucky's Chief Compliance Officer in the Commonwealth, Rebecca Randall, will notify DMS and FAC in writing of any change in our Executive Management key personnel, department managers, and point of contact for this Contract within three Business Days of WellCare of Kentucky learning of a change, including a change in duties or time commitments, resignation, or of WellCare of Kentucky notifying an individual of planned changes for the key position (e.g., promotion, termination). Simultaneously, our Executive Administrator will engage with our Talent Acquisitions team to identify both external and internal candidates for the vacated position using a combination of internal and external sourcing strategies. Our Talent Acquisition Team will prioritize the recruiting of the vacated position in order to fill the role within (30) calendar days of departure, unless the Commonwealth approves a different timeframe.

Avoiding and Minimizing Impact of Personnel Changes through our Efficient and Effective Training Program

It is imperative that we bring all replacement associates and new associates up-to-date regarding the Kentucky SKY contract efficiently and effectively in order to minimize the impact of personnel changes on our Enrollees and providers. Upon contract award, staff training will focus on two primary tasks.

Our associates must have the requisite knowledge and skills to understand and navigate our managed care operations, information systems, and tools in order to provide a high level of consistent service. We have a well-positioned training program in place to meet established and evolving learning needs. Our corporate training program establishes training parameters including: methodology for training delivery, required attendees, tracking of course completion, evaluation of content, and knowledge assessments. We have developed and refined our

training program utilizing our Subject Matter Experts and the **ADDIE** Model (Analyze, Develop, Design, Implement, and Evaluate) to ensure our training program prepares our newly hired staff to understand the unique nuances of the Kentucky SKY program. We have dedicated clinical trainers and curriculum developers in place and our targeted curricula ensures associates have the requisite knowledge and skills to understand and navigate our managed care operations, information systems and tools. Our comprehensive Training Program ensures that new associates receive training on content specific to their individual roles as well as material necessary to understand requirements as identified in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices.

WellCare University (WCU), our learning management system, stores, deploys, assesses, and reports all training requirements by role and function across the enterprise. Within WCU, we will have all training material stored in this system and defined by role and function so any new associate or transitioning associate will have immediate access to the appropriate training and assessments to begin their job. This ensures that training and program specific knowledge is stored within our plan is not at risk when an associate leaves or transitions to another role.

We evaluate all associates, whether new hire or currently employed with WellCare, for their understanding of Kentucky SKY contract and program requirements. WellCare does not take mandatory training lightly. Any associates who fail to complete mandatory training in a timely fashion are subject to disciplinary action. We ensure all WellCare of Kentucky associates complete all mandatory Kentucky SKY contract-related training no later than the required timeframes established by DMS.

Additional information regarding our proposed training program, frequency and curriculum is located in our response to section G.2.c.v.

c. How the Contractor will assure the Department that sufficiently experienced, licensed and trained personnel are available to support implementation and ongoing administration of the Kentucky SKY program; and

EXPERIENCE AND LICENSED STAFF TO SUPPORT IMPLEMENTATION OF THE KENTUCKY SKY PROGRAM

Our Implementation Plan supports the successful implementation of all the requirements outlined in the Kentucky MMC RFP and Contract requirements for Medicaid and SKY including ensuring sufficiently experienced, licensed, and trained personnel are available to support implementation and ongoing administration of the Kentucky SKY program.

We understand that one of the most important first steps in our implementation process is identification and establishment of our Kentucky SKY Governance Team. The Kentucky SKY Governance Team has overall accountability for the Implementation Plan and reports weekly on the progress and status of all activities, risk, and issues. Bob Diver, Project Manager, and Chief Operating Officer, Ben Orris, lead WellCare of Kentucky's locally-based Kentucky SKY Governance team and they assume overall responsibility for the Kentucky SKY Implementation Plan activities and readiness review requirements. They will lead our Kentucky Executive Leadership Team along with other dedicated leaders across the organization assigned to the Kentucky SKY Implementation.

The Kentucky SKY Governance Team, in **Table G.2-10**, has overall accountability for the Implementation Plan for the SKY program and meets at least weekly to discuss the status of all activities, due-dates, action-items, risk, and issues. The Kentucky SKY Governance Team includes the following participants, forums, responsibilities & purpose, and meeting frequency:

Table G.2-10 WellCare of Kentucky SKY Governance Team

Participants	Forum	Responsibility and Purpose	Meeting Frequency
SKY Executive Leadership in Collaboration with our Core Medicaid Team	Program Steering Committee	• Final point of escalation • Organizational level contract resolution • Senior Executive Program Oversight	Weekly
SKY Team Program Leaders in Collaboration with our Core Medicaid Team	Program Leadership	• Key Executives liaison with KY • Executive program oversight • Accountable for overarching process / project success • Review Weekly Synopsis for project status updates	Weekly
Dedicated SKY Project Manager in Collaboration with our Core Medicaid Project Manager and Readiness Review Manager	Program Management	• Project oversight, leadership, and strategy • Strategic/Tactical direction • Point of escalation / conflict resolution • Cross-pillar coordination and project reporting	Weekly
SKY Project Leads and Business Leads/SMEs	SKY Program Ownership, Management, and Project Execution	• Hands on project management organized by Business Area • Maintenance of project schedules and work plans • State project status reporting	Weekly as Needed

Additional information regarding our implementation support staff can be found in our response to Section G.03. Kentucky SKY Implementation.

EXPERIENCE AND LICENSED STAFF TO SUPPORT ONGOING ADMINISTRATION OF THE KENTUCKY SKY PROGRAM

Because WellCare of Kentucky has over 300 current employees and has served the Kentucky MMC program for over eight years, we have the confidence to assure DMS that sufficiently

experienced, licensed, and trained personnel will be available to support implementation and ongoing administration of the Kentucky SKY program.

Increases in staffing necessary to manage to SKY Enrollees are already anticipated in our implementation plan. Staffing analysis was performed using a base market staffing model employed by all WellCare markets. This model is based on potential membership and set staffing ratios for all geographic and functional areas. Adjustments are then made based on an assessment of new contract requirements and Kentucky SKY goals and priorities. The Kentucky SKY leadership team will review and finalize estimated staffing. Our goal is to have all necessary associates hired in the second quarter of 2020. Associates will have all necessary training completed and will be ready for go live by January 1, 2021.

Our implementation plan features the addition of 220 staff located throughout the Commonwealth to support the Kentucky SKY program. Our proven experience in implementing and staffing new Medicaid programs across the country will allow us to quickly identify, hire, onboard, and train the necessary associates to support the Kentucky SKY program. As mentioned throughout this proposal, we will utilize a variety of local recruiting strategies to ensure we have proper staff in place. Direct recruiting will focus locally on positions crucial to the success of the SKY program and interviews will be done locally within those areas. Offers will be extended based on business need and timing required.

d. How the Contractor will seamlessly transition staff, if necessary, from implementation to ongoing operations.

TRANSITIONING STAFF FROM IMPLEMENTATION TO ONGOING OPERATIONS

Throughout the implementation process, our implementation team provides guidance, decision-making, authority and accountability, which provides a streamlined process to address any concerns as they arise. As the plan is launched, these local leaders are empowered to assume day-to-day operations and strategic direction with support as needed. This includes continue engagement with the DCBS and DJJ to ensure the needs of each SKY Enrollee are being met.

Prior to go live all associates tasked with performing functions within the Kentucky SKY program will have the requisite training, knowledge and skills to understand and navigate our managed care operations, information systems and tools to ensure a smooth transition from implementation to ongoing operations

Upon contract award, staff training will focus on two primary tasks. The first task is training current staff on the benefits under the contract to ensure all associates have intimate knowledge of Kentucky SKY program requirements. We will review and revise current training content and curricula to reflect the benefits and other requirements of the Kentucky SKY contract. We will provide total comprehensive training and education to all of our staff members to ensure current associates are fully equipped to provide unparalleled service. It is critical that all employees understand the Kentucky SKY contractual details as well as WellCare's vision and goals, our Enrollee-centered approach and the criticality of the Enrollee experience.

The second task is training new staff hires. New staff training will focus on requirements of the contract along with additional training for external facing associates. All of WellCare of

Kentucky associates begin with a foundation of training at onboarding that includes specific market training, corporate training, and detailed compliance courses. Further, all associates are engaged in on-going annual training on a variety of topics including program changes compliance, and professional development. Much of that training is mandatory, regardless of how long an employee has been with WellCare of Kentucky. This ongoing training reinforces critical information and such training helps improve performance, compliance, and morale.

Our rigorous training regimen for both current and new associates will ensure a seamless transition from implementation to ongoing operations.

iv. A listing of Full-Time Kentucky SKY Key Personnel identified in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," and as otherwise defined by the Contractor, including:

a. Individual names, titles, job descriptions, qualifications and full-time equivalents (FTEs) who are dedicated one hundred percent (100%) to the Kentucky SKY program under this Contract with no other responsibilities outside of the Kentucky SKY program, as well as their office locations for this Contract. An FTE is defined as the ratio of the total number of paid hours divided by the total number of working hours in the period. Annually, an FTE is considered to be 2,080 hours.

FULL-TIME KENTUCKY SKY KEY PERSONNEL

WellCare of Kentucky's SKY program is led by a skilled group of health plan executives that will serve as our SKY Executive Team and will be responsible for oversight of all WellCare of Kentucky SKY operations. Our leaders have a depth of experience providing services and supports in a variety of settings including institutional clinical settings, Out of Home Placement settings, behavioral health treatment facilities, and acute care settings. This experience has informed our evidence-based, innovative care delivery models to positively impact Kentucky's SKY Program. **Table G.2-11** below includes the names, titles, and fulltime equivalents (FTEs) 100% dedicated to this Contract, as well as their office locations for this Contract.

Table G.2-11 Full Time Kentucky Sky Key Personnel

Title	Name	Office Location	Employee or Subcontractor	FTEs
Project Manager	Bob Diver	Louisville	Employee	1.0
Executive Administrator	Lori Gordon, LCSW, MBA	Bowling Green	Employee	1.0
Medical Director	To be hired upon contract award	TBD	Employee	1.0
Quality Improvement (QI) Director	Kathryn Miller, LCSW, CCM	Louisville	Employee	1.0

Title	Name	Office Location	Employee or Subcontractor	FTEs
Behavioral Health Director	Timothy Houchin, MD, MHCDS	Louisville	Employee	1.0
Utilization Management Manager	To be hired upon contract award	TBD	Employee	1.0
Prior Authorization/Pre-Certification Coordinator	To be hired upon contract award	TBD	Employee	1.0
Provider Relations Liaison	Leann Magre, MSSW, MBA, LCSW, CCM	Louisville	Employee	1.0
Nurse Case Managers	To be hired upon contract award	TBD	Employee	14.0

In addition to the required Full-Time Kentucky SKY Key Personnel listed above, WellCare of Kentucky will employ experienced professional staff to participate in Care Coordination Teams serving all Service Regions and Community Districts throughout the Commonwealth. We will build individual Care Coordination Teams for Kentucky SKY Enrollees based on their specific needs and will assign the Care Coordination Team within one (1) Business Day of Enrollment in Kentucky SKY. The Care Coordination Team will involve and include the preferences of the Kentucky SKY Enrollee, Adoptive Parent(s), Foster Care Parent(s), Caregivers, and Fictive Kin in Care Coordination processes, care planning, and Care Plan implementation. We will update our Care Coordination Teams as necessary as determined by the Kentucky SKY Enrollee's Service Plan. These teams will include at a minimum:

- Masters level licensed Behavioral Health clinician;
- Nurse Care Manager to assist Kentucky SKY Enrollees designated as Medically Complex Children;
- Behavioral Health Specialist with at least five years of Behavioral Health experience;
- Family Peer Support Specialist and/or Youth Peer Support Specialist; and
- Care Coordinators

Table G.2-12 below includes the titles and fulltime equivalents (FTEs) dedicated to this Contract, as well as office locations for these Care Coordination Team members. Additional information regarding the roles and responsibilities of Care Coordinators and Care Coordination Team is located in our response to Section G.02.c.xii.

Table G.2-12 Full-Time SKY Key Personnel Care Coordination Teams

Title	Name	Office Location	Employee or Subcontractor	FTEs
Masters level licensed Behavioral Health clinician	To be hired upon contract award	Field-Based	Employee	20.0
Nurse Care Manager to assist Kentucky SKY Enrollees designated as Medically Complex Children	To be hired upon contract award	Field-Based	Employee	8.0
Behavioral Health Specialist with at least five years of Behavioral Health experience	To be hired upon contract award	Field-Based	Employee	37.0
Family Peer Support Specialist and/or Youth Peer Support Specialist -	To be hired upon contract award	Field-Based	Employee	2.0
Care Coordinator	To be hired upon contract award	Field-Based	Employee	64.0

SHARED KENTUCKY SKY KEY PERSONNEL

In addition to the required full-time Kentucky SKY key personnel, WellCare of Kentucky has the appropriate, qualified staff in place to fulfill the shared Kentucky SKY Personnel roles identified in Section 42.6.2.B.2 in Attachment C - Draft Medicaid Managed Care Contract and Appendices. **Table G.2-13** below includes the names, titles, and fulltime equivalents (FTEs) dedicated to this Contract, as well as office locations for these shared Kentucky SKY personnel. The positions noted in **Table G.2-13** are shared between the Kentucky MMC and Kentucky SKY programs.

Table G.2-13 Shared Kentucky SKY Personnel

Title	Name	Office Location	Employee or Subcontractor	FTEs
Psychiatrist	Frank Deland, MD	Lexington	Employee	1.0
Pharmacy Director	Thea Rogers, Pharm.D.	Louisville	Employee	1.0
Dental Director	Jerry Caudill, DMD, FAGD, MAGD, CDC, CTCP, FPFA, FICD, FACD	Campbellsburg	Subcontractor	0.25
Provider Network Director	Bonnell Gustafson Irvin, MPA	Lexington	Employee	1.0
Provider Services Manager	Anthony Piagentini	Louisville	Employee	1.0
Population Health Management Director	Shannon Maggard, RN, CCM	Louisville	Employee	1.0
Enrollee Services Manager	Elizabeth Starr, LCSW	Louisville	Employee	1.0
Inquiry Coordinator	Rhonda Mitchell	Louisville	Employee	1.0
Chief Financial Officer	Laurie Holden, MBA	Louisville	Employee	1.0
Chief Compliance Officer	Rebecca Randall	Louisville	Employee	1.0
Management Information Systems Director	Ronnie Skarness	Louisville	Employee	1.0
Hospital Based Care Managers	To be hired upon contract award	Hospital-Based	Employee	2.0

ADDITIONAL LEADERSHIP - THOMAS JAMES III, M.D.

WellCare of Kentucky recently hired Thomas James III, M.D. Dr. James has extensive leadership experience with government programs, population health, health policy and quality measurement. Dr. James also has over 25 years of experience in Kentucky within the managed care industry as well as extensive direct patient care specifically in the areas of internal medicine and pediatrics. Prior to joining WellCare of Kentucky, Dr. James held the position of Senior Medical Director, Medical Management and Quality with Highmark, Inc. Within this role, Dr. James was responsible for clinical oversight of quality, clinical quality in care transition of Highmark members from UPMC, and provided support for wellness and preventive services initiatives. Dr. James has also served as Chief Medical Officer with Baptist Health. Within this role, Dr. James was responsible for Population Health for Baptist Health, an integrated delivery network (IDN) in Kentucky. He coordinated the analytics units of Baptist Health, Evolent Health,

and other partners while achieving NCQA interim accreditation for the first time for this health plan. In addition to his time spent with Highmark and Baptist Health, Dr. James has held Medical Director positions with other various managed care organizations including, AmeriHealth Caritas, Humana, and Anthem Health Plans of Kentucky. Dr. James has an active medical license in the state of Kentucky as well as certifications from the American Board of Internal Medicine, the American Board of Pediatrics, and the American Board of Medical Management.

WellCare of Kentucky will submit job descriptions and required qualifications, and a description of the qualifications of each individual with key management responsibility for any mandatory function to DMS for approval within 30 days of signing the Contract, annually, prior to material revisions and upon request by DMS.

Job descriptions and qualifications for the key personnel identified in **Table G.02-11 and Table G.02-12** begin on the following page.

b. Whether each Full-time Kentucky SKY Key Personnel position will be filled by a Contractor's employee or a Subcontractor. Identify the number of FTE Subcontractor staff who will be one hundred percent (100%) dedicated to the Kentucky SKY program.

As denoted **in Table G.2-11 and Table G.2-12**, all WellCare of Kentucky Full-Time Kentucky SKY Key Personnel positions will be filled by a WellCare of Kentucky employee.

c. Resumes, including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Include as an Appendix or Attachment to the Proposal.

Please refer to **Attachment G.02. Company Background – Key Personnel Resumes** for resumes including information such as degrees, credentials, clinical licensure as applicable, years and type of experience for the key personnel listed in **Table G.2-11 and Table G.2-12.** We have provided job descriptions in lieu of resumes for those Full Time Kentucky SKY Key Personnel positions for which we are currently recruiting and will be hired post-award.

PROJECT MANAGER

WellCare of Kentucky's SKY Project Manager leads the Kentucky SKY program planning and implementation, and facilitates ongoing operations until such time DMS and Kentucky SKY Contractor mutually agree to discontinue the project management services. The project manager shall be located at the Kentucky SKY MCO's Kentucky office and be onsite at DMS and DCBS offices in Frankfort, Kentucky at times specified by DMS and DCBS during the planning, implementation and deployment phases of the Contract.

PRIMARY RESPONSIBILITIES:

- Provides leadership to the management team to ensure the organization's strategic plan is translated into tactical goals and objectives that guarantee performance objectives are met or exceeded
- Directs and manages the organization's financial performance. Takes appropriate actions to increase revenue, leverage resources, manages and/or minimizes expenses and ensure compliance with all business and administrative regulations.
- Assist and leads where appropriate, with aspects of state and federal government relationships, including dealing with regulators, as necessary, to establish and continue effective working relationships. Ensures that all state and federal regulations are met
- Ensures WellCare of Kentucky compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance
- Receiving and responding to all inquiries and requests made by Department related to the Agreement, in the time frames and formats specified by Department
- Attending and participating in regular meetings or conference calls with Department
- Making best efforts to promptly resolve any issues identified either by the WellCare of New Kentucky or DMS that may arise and are related to the Agreement
- Meeting with Department at the time and place requested by Department, if Department determines that WellCare of New Kentucky is not in compliance with the requirements of the Contract

EDUCATION:

- A Bachelor's Degree in Business Administration, Finance or a related field is required
- A Master's Degree in a related field is preferred

WORK EXPERIENCE:

- 10+ years of experience in overall Managed Care, Network Management and/or Business Operations
- 5+ years of experience in Senior management with P&L accountability for an MCO
- Successful track record in: provider relations, provider contracting, ownership of top and bottom line P&L responsibility with a successful HMO (government program experience preferred), growing membership and revenue, and improving the MLR)
- Experience with implementation of new programs or products for a population of a similar size and complexity as Kentucky SKY

EXECUTIVE ADMINISTRATOR

WellCare of Kentucky's Executive Administrator develops and drives the policies, operational planning, and execution of performance for the State's foster care program. Develops and maintains relationships across the State with key stakeholders that are critical to the performance of the SMI program, including State agencies, behavioral health providers, community organizations, and advocacy groups. Oversee behavioral and medical health functions for the Foster Care program for the assigned business unit. Ensure effective management of care to all foster children under contract. Oversee the development and implementation of core business strategy. Collaborate with system stakeholders such as DCBS, DJJ and DMS, State Medicaid Departments, Foster Parents, Judges and others to represent health needs and issues and identify ways to collaborate for better member outcomes. Serves as internal and external subject matter expert on the foster care and adoption populations.

PRIMARY RESPONSIBILITIES:

- Drives, manages and executes the strategy and program performance for the SKY program.
- Liaises across multiple key internal functional areas (Clinical, Network, Quality, etc.) to drive decisions and initiatives critical to the plan.
- Engages with external constituents such as DCBS, DJJ, community and advocacy groups, key providers and other stakeholders to build strong working relationships that deliver results.
- Effectively partners to organize resources and integrate processes to optimize program performance, program effectiveness, profitability and outcomes
- As a result of collaborative partnerships, shares responsibility for program Quality Improvement and accreditation initiatives in the assigned market.
- Proactively monitors appropriate metrics to ensure positive health outcomes, program results and improve efficiency.
- Directs work assignments, measures results and initiates personnel actions as required.
- Develops, implements and manages process improvement initiatives.
- Ensures compliance with all state and federal regulations as well as Corporate guidelines in day-to-day activities including contractually required reports.
- Assists in establishing effective organizational practices and works closely with various health plan departments and regulatory agencies to ensure contracts meet operating, financial and legal standards.

EDUCATION:

- A Master's Degree in a related field is required

WORK EXPERIENCE:

- 8+ years of experience in Healthcare or health insurance industry
- 5+ years of experience in Product management/development roles
- 7+ years of management experience Leadership, leading teams
- Broad knowledge of the Managed Care industry and proven experience leading governmental programs
- At least 2 years experience in child welfare

MEDICAL DIRECTOR

WellCare of Kentucky's Medical Director is actively involved in all major health programs of the Kentucky SKY Contractor. All clinical directors, including those employed by Subcontractors, shall report to the Medical Director for all responsibilities of the Kentucky SKY Contract. The Medical Director shall also be responsible for treatment policies, protocols, Quality Improvement activities, Population Health Management activities, and Utilization Management decisions related to the Kentucky SKY program and devote sufficient time to ensure timely clinical decisions. Available for after-hours consultation, if needed.

PRIMARY RESPONSIBILITIES:

- Manages day-to-day quality improvement and medical management activities of the Kentucky SKY program plan
- Oversees and is responsible for all clinical activities, including but not limited to the proper provision of Covered Services to Enrollees, developing clinical practice standards and clinical policies and procedures. Substantial involvement in QAPI Program activities.
- Oversight of all utilization review techniques and methods and their administration and implementation.
- Collaborates with the organization's senior leadership to ensure medical compliance with all customer, regulatory, and accreditation requirements for clinical services
- Establishes professional working relationships with providers and provider organizations to support the development of the highest possible provider partnerships
- Works with other Kentucky SKY Program Medical Directors/clinical services staff to attain and/or maintain compliance with customer, accreditation and regulatory requirements
- Provides clinical expertise needed to effectively and efficiency resolve complex, controversial and/or unique administrative circumstances
- Provides medical leadership for development and attainment of the organization's goals.
- Collaborates with corporate service coordination to establish and implement clinical programs to support and meet care management goals

EDUCATION:

- A Doctor in Medicine (MD) or D.O. from an accredited school of medicine recognized by national medical regulatory bodies in the United States

WORK EXPERIENCE:

- 5 years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).
- 5+ years of experience in Direct Patient Care
- Substantial expertise in the development of medical policies, procedures and programs
- Demonstrated success implementing Utilization and Quality Improvement strategies / techniques and experience with physician behavior modification

LICENSES AND CERTIFICATIONS:

- The Medical Director must be a physician licensed to practice in Kentucky
- Pediatrician certified by the American Board of Pediatrics

QUALITY IMPROVEMENT DIRECTOR

WellCare of Kentucky's SKY Quality Improvement Director is responsible for the operation of our SKY Quality Improvement (QI) Program. Provides leadership necessary to achieve national best practice performance levels in quality improvement while implementing evidence based medicine / practices. Ensures quality of healthcare services rendered meets or exceeds professionally recognized community standards. Interfaces with a diverse range of clinical and administrative professionals, resolves complex policy / service issues within the group, and directs data analytic / reporting activities that are prescribed by customers and regulators in a complex environment. Ensures compliance with state, federal and accreditation requirements.

PRIMARY RESPONSIBILITIES:

- Develops and implements our Kentucky SKY Program's quality improvement plan in accordance with the mission /strategic goals of the organization, federal and state laws and regulations, and accreditation standards. Ensures systemic and individual quality of care.
- Identifies / implements process improvements. Integrates quality throughout the organization. Ensures a network of credentialed providers.
- Establishes professional relationships with Kentucky, stakeholders and community agencies to facilitate quality process internally and externally
- Develops / implements systems, policies, and procedures for identification, collection, and analysis of performance measurement data
- Assists in strategizing and facilitating various committee structures and functions to best address the QI process and oversees Quality Committees. Serves as a member of the our QAPI Committee and member/ad hoc member of other quality related committees
- Oversight/interface internally/externally with pay for performance programs and initiatives
- Have and Maintain Training And Experience In Rapid Cycle Improvement.

EDUCATION:

- A Bachelor's Degree is required and Master's Degree in Social Work, Psychology, HealthCare, Nursing, Public Health, Health Administration or related field is preferred

WORK EXPERIENCE:

- 2+ years of experience in Quality Improvement/Strategic Planning
- 5+ years of experience in Managed Care and 4+ years of management experience
- 5+ years of experience working with foster care and/or juvenile justice system(s)
- Experience With The Foster Care And Juvenile Justice Systems, And Trauma-Informed Care
- Excellent knowledge of JCAHO, URAC, AAAHC, and NCQA standards
- Relevant experience in quality management for physical and/or behavioral health care

LICENSES AND CERTIFICATIONS:

- State License as a Registered Nurse (RN), physician, or physician's assistant
- Certified Professional in Healthcare Quality (CPHQ), Certified by the National Association for Health Care Quality, or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers is preferred

BEHAVIORAL HEALTH DIRECTOR

WellCare of Kentucky's Behavioral Health Director is actively involved in all programs or initiatives relating to behavioral health for Kentucky SKY Enrollees. Coordinates efforts to provide Behavioral Health Services by the health plan or any Behavioral Health Subcontractors.

PRIMARY RESPONSIBILITIES:

- Works directly with staff and Enrollees to assess, plan, implement, coordinate, monitor, and evaluate services and outcomes to maximize the health of the Enrollee. Implements utilization and/or case management workflows and policies and procedures for integrated behavioral health programs. Proactively monitors appropriate metrics to drive efficiency
- Provides leadership and support to front-line staff / supervisors of behavioral health services in Kentucky. Function as SME for behavioral health processes, mental health services and psychosocial programs
- Serves as an instrumental partner in monitoring and tracking key performance indicators to include identification of over/under utilization and/or case management patterns and/or deviation from expected results for Kentucky
- Assists with development of clinically-focused training associated with behavioral health assessment, care plan development and behavioral health services in Kentucky
- Performs audits of assessments, case plans and service notes to verify cases are properly established and that coordination activates are occurring/appropriately documented
- Provides training and guidance to new and current behavioral health associates regarding policy and procedure, systemic tools, workload and care plan development
- Ensures regulatory requirements/accreditation standards are applied to all activity/reporting. Ensures compliance with all state and federal regulations as well as corporate guidelines in day-to-day activities.

EDUCATION:

- A Master's Degree in Social Work, Psychology, Counseling, Rehabilitation, or other relevant field that provides a foundation to receive a license as required of the position

WORK EXPERIENCE:

- 5+ years of experience in behavioral health management or acute behavioral health care setting focusing on outpatient/inpatient utilization, case management and discharge planning
- 3+ years of experience in a managed care environment
- Experience working with the needs of vulnerable populations who have chronic or complex bio-psychosocial needs
- At least 2 years experience in child welfare

LICENSES AND CERTIFICATIONS:

- Behavioral health practitioner licensed in Kentucky
- One of the following is required: Licensed Clinical Social Worker, Licensed Clinical Mental Health Counselor, Licensed Clinical Marriage & Family Therapist, Licensed Clinical Professional Counselor, Licensed Clinical Psychologist

UTILIZATION MANAGEMENT DIRECTOR

WellCare of Kentucky's Utilization Management Director is responsible for oversight of the Utilization Management functions for the Kentucky SKY program and any Subcontractors performing services relevant to Utilization Management (UM). Accountable for providing vision and strategy for inpatient utilization and prior authorization management activities designed to achieve quality and service-driven objectives. Oversees all phases of development, organization, planning, and implementation of projects / initiatives / workflows / processes to enhance quality-driven outcomes. Ensures that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

PRIMARY RESPONSIBILITIES:

- Provides direction and oversight to ensure effective management of inpatient care, discharge planning, and prior authorizations. Responsible for all UM activities
- Optimizes processes and workflows to achieve successful quality outcomes and benefit maximization within the scope of responsibility
- Serves as a partner in development of KPIs. Monitors and tracks KPIs to independently identify over/under utilization patterns and/or deviation from expected results
- Develops processes and procedures to ensure department-wide compliance with contractual, regulatory (Federal/State) and accreditation entities
  Promotes and improves environment of provider and Health Plan partnership
- Ensures monitoring and tracking tools are in place to adequately link and assess production and quality driven work products and outcomes to individual performers
- Develops formal policies, procedures and workflows that effectively guide work activity
- Develops formal department-specific new employee orientation and training programs

EDUCATION:

- A Bachelor's Degree in Nursing (BSN), Health Administration, Nutrition or business related field is required
- A Master's Degree in Business, Public Health or Healthcare administration is preferred

WORK EXPERIENCE:

- 7+ years of experience in acute clinical/surgical experience and/or behavioral health clinical setting is required.
- 3+ years of management experience in a managed health care setting is required
- Current experience in UM to include pre-authorization, utilization review, concurrent review, discharge planning, and/or skilled nursing facility reviews is required
- Current experience with Behavioral Health Services, Foster Care and juvenile justice systems, Crisis Intervention Services, and Trauma-informed Care

LICENSES AND CERTIFICATIONS:

- Licensed Registered Nurse (RN) is required
- Utilization review/management certification, or equivalent professional certification is preferred

PRIOR AUTHORIZATION COORDINATOR

WellCare of Kentucky's Prior Authorization Coordinator is responsible for coordinating Prior Authorizations and Pre-certifications. Responsible for convening meetings with DCBS and DJJ professionals at the Service Region and Community District level, as needed, to ensure appropriate and timely care for Kentucky SKY Enrollees.

PRIMARY RESPONSIBILITIES:

- Ensures that staff reviews and collects medical information in order to determine the medical necessity of services requested by applying specific medical criteria.
- Monitors staff work product to ensure that services provided to eligible Enrollees are within benefit plan, and appropriate contracted providers are being utilized.
- Ensures that staff initiates and continues direct communication with health care providers involved with the care of the Enrollee to obtain complete and accurate information. Ensures that staff identify appropriate clinical settings for services being requested.
- Ensures that staff identify and refer cases appropriate for case management.
- Ensures that staff identify potential quality of care issues and refers to Quality Department.
- Determines appropriate utilization management of services requested and ensures that staff are able to do same.
- Assists with implementation of health care initiatives in market.
- Assists in the implementation of specific strategies that improve the quality and outcomes of care.
- Acts as a subject matter expert within the team.
- Handles escalated issues at management's request.
- Acts as a team educator on new processes and/or policies.
- Performs and represents department and clinical duties at the request of management.
- Reviews and collects data to identify patterns and trends for Enrollee service utilization.
- Trains and mentors staff to ensure compliance with departmental regulations, policies, and procedures.

EDUCATION:

- A Bachelor's Degree in Business Administration, Business Management or similar business related field is required

WORK EXPERIENCE:

- 4+ years of experience in an acute clinical/surgical position(s), current experience in utilization management to include pre-authorization, utilization review, concurrent review, discharge planning, and/or skilled nursing facility reviews
- Experience in the delivery of Behavioral Health Services.
- Care management experience in a managed health care setting
- At least 2 years experience in child welfare

LICENSES AND CERTIFICATIONS:

- Licensed Practical Nurse (LPN) in the Commonwealth of Kentucky

PROVIDER RELATIONS LIAISON

WellCare of Kentucky's Provider Relations Liaison is responsible for supporting the resolution of Provider access and availability issues. Position plans, provides resources, and directs activities in provider operations, provider contracting/negotiation and provider service functions for the Kentucky SKY program. Responsible for provision of all provider services activities. Plans, provides resources, and oversees provider relations representatives and provider operations coordinators, provider claims issues and provider service functions. Acts as a mentor to Provider Relations Representatives. Manage relationships with key provider groups, facilities, or large IPAs. Uses extensive provider Relations experience to provide an account management experience as the "Go To" person for those providers. Services include provider education, claims research and resolution, confirmation of proper system load and any other services needed by these key external partners.

PRIMARY RESPONSIBILITIES:

- Oversees the management physician network by developing and maintaining relationships to drive business results within a specific geographic area
- Oversees service and education to network physicians/ provider
- Achieves company targets through implementation of Network Improvement plans
- Sets goals for their area and works closely with Managers/Representatives to drive performance and to ensure provider satisfaction metrics are met or exceeded
- Conducts field rides with Provider Relations Representatives to gauge their performance and provide coaching and development in order to improve the business results
- Plans, conducts and directs provider contracting/negotiations and provider servicing
- Develops practices to assist risk partners in managing financial risk
- Performs data analysis and develops specific actions to manage medical cost trends
- Plans, provides resources and directs activities, network development, provider contracting/negotiation and provider service functions
- Develops provider contracting and service strategies and ensures maximum efficiencies in the utilization of human and financial resources
- Strategizes for membership growth, retention, and to affect sophisticated or complex Provider relationships

EDUCATION:

- A Bachelor's Degree in a related field or equivalent work experience directly related to the level and duties of the job is required

WORK EXPERIENCE:

- 7+ years of experience in provider relations or similar background
- 4+ years of management experience
- Knowledge of Kentucky provider, including Behavior Health provider, and patterns of care/referral in Kentucky
- Prior experience with individual physicians, provider groups and facilities

NURSE CASE MANAGERS

Coordinates the care and services of KY SKY Enrollee populations across the continuum of Health. Promotes effective utilization and monitors health care resources. Assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works with the Supervisor / Manager of Case Management to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Enrollee.

PRIMARY RESPONSIBILITIES:

- In conjunction with the PCP and Enrollee, completes a comprehensive assessment and develops a care plan utilizing clinical expertise to evaluate the Enrollee's need for alternative services. Assess short-term and long-term needs and establishes case management objectives.
- Manages active cases based on case intensity and acuity.
- Interacts continuously with Enrollee, family, physicians, and other providers utilizing clinical knowledge/expertise to determine medical history and current status. Assess the options for care including use of benefits and community resources to update the care plan.
- Acts as liaison and Enrollee advocate between the Enrollee/family, physician, and facilities/agencies.
- Maintains accurate records of case management activities in the Care Central System using clinical guidelines.
- Coordinates community resources with emphasis on medical, behavioral and social services. Applies case management standards and maintains HIPAA standards and confidentiality of protected health information. Reports critical incidents and information regarding quality of care issues.
- Ensures compliance with all state/federal regulations and guidelines in day-to-day activities.
- Schedules or facilitates scheduling appointments and follow-up services
- Requests consultation and diagnostic reports from network specialists.
- Contacts Enrollees to remind them about upcoming appointments and/or missed appointments. Participates in monthly chart audits.

EDUCATION:

- A High School or GED is required and a Bachelor's Degree in nursing or related field is preferred

WORK EXPERIENCE:

- 2+ years of experience in a clinical acute care position(s), preferably in home health, physician’s office or public health
- 1+ year of experience in current case management experience
- At least 2 years experience in child welfare

LICENSES AND CERTIFICATIONS:

- Licensed Registered Nurse (RN)
- Certified Case Manager (CCM)

MASTERS LEVEL LICENSED BEHAVIORAL HEALTH CLINICIAN

Coordinates the care and services for SKY enrollees across the continuum of care. Promotes effective utilization and monitors health care resources. Assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works with the Supervisor / Manager of Case Management to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Enrollee.

PRIMARY RESPONSIBILITIES:

- Interviews clients and their families and coordinates programs and activities to meet their social and emotional needs.
- Provides support to care and case managers regarding the coordination of care plans for Enrollees by utilizing social service expertise to evaluate the Enrollees need for alternative services and third party intervention.
- Outreaches to Enrollees telephonically and/or in-person to provide health coaching and consultation and by providing guidance regarding barriers to managing health conditions.
- Assists Enrollees to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health. Reviews benefits options, researches community resources, coordinates services, trains behavioral routines, and enables Enrollees to be active participants in their own healthcare.
- Provides telephone follow-up to ensure Enrollees have seen their PCP and are completing their treatment plan or preventive care services a defined by the PCP or guidelines.
- Coordinates community resources with emphasis on the development of natural support system. Coordinates benefits, regulations, laws, and public entitlement programs.
- Acts as a liaison and Enrollee advocate between the Enrollee/family, physician, and facilities/agencies. Assists in obtaining benefits for Enrollees through community resources when benefits are exhausted or not available.

EDUCATION:

- A Master's Degree in Social Work, Psychology, Counseling, Rehabilitation, or other relevant field that provides a foundation to receive an independent license as required

WORK EXPERIENCE:

- 5+ years of experience in behavioral healthcare setting with responsibility for treatment planning and intervention
- 4+ years of experience working with children and families involved with foster care, adoption, or juvenile justice.
- Experience in a managed care environment

LICENSES AND CERTIFICATIONS:

- One of the following is required: Kentucky Certified Peer Support Specialist, LCSW, Licensed Mental Health Counselor (LMHC), Licensed Clinical Marriage & Family Therapist (LCMFT), Licensed Clinical Professional Counselor (LCPC), LCP

NURSE CARE MANAGER (MEDICALLY COMPLEX CHILDREN)

Coordinates the care and services of KY SKY Enrollee populations (including Medically Complex Children) across the continuum of Health. Promotes effective utilization and monitors health care resources. Assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works with the Supervisor / Manager of Case Management to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Enrollee.

PRIMARY RESPONSIBILITIES:

- In conjunction with the PCP and Enrollee, completes a comprehensive assessment and develops a care plan utilizing clinical expertise to evaluate the Enrollee's need for alternative services. Assess short-term and long-term needs and establishes case management objectives.
- Manages active cases based on case intensity and acuity.
- Interacts continuously with Enrollee, family, physicians, and other providers utilizing clinical knowledge/expertise to determine medical history and current status. Assess the options for care including use of benefits and community resources to update the care plan.
- Acts as liaison and Enrollee advocate between the Enrollee/family, physician, and facilities/agencies.
- Maintains accurate records of case management activities in the Care Central System using clinical guidelines.
- Coordinates community resources with emphasis on medical, behavioral and social services. Applies case management standards and maintains HIPAA standards and confidentiality of protected health information. Reports critical incidents and information regarding quality of care issues.
- Ensures compliance with all state/federal regulations and guidelines in day-to-day activities.
- Schedules or facilitates scheduling appointments and follow-up services
- Requests consultation and diagnostic reports from network specialists.
- Contacts Enrollees to remind them about upcoming appointments and/or missed appointments. Participates in monthly chart audits.

EDUCATION:

- A High School or GED is required and a Bachelor's Degree in nursing or related field is preferred

WORK EXPERIENCE:

- 2+ years of experience in a clinical acute care position(s), preferably in home health, physician’s office or public health
- 1+ year of experience in current case management experience
- At least 2 years experience in child welfare

LICENSES AND CERTIFICATIONS:

- Licensed Registered Nurse (RN)
- Certified Case Manager (CCM)

BEHAVIORAL HEALTH SPECIALIST

Coordinates the care and services for SKY enrollees across the continuum of care. Promotes effective utilization and monitors health care resources. Assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works with the Supervisor / Manager of Case Management to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Enrollee.

PRIMARY RESPONSIBILITIES

- Interviews clients and their families and coordinates programs and activities to meet their social and emotional needs.
- Provides support to care and case managers regarding the coordination of care plans for members by utilizing social service expertise to evaluate the members need for alternative services and third party intervention.
- Outreaches to members telephonically and/or in-person to provide health coaching and consultation and by providing guidance regarding barriers to managing health conditions.
- Assists members to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health. Reviews benefits options, researches community resources, coordinates services, trains behavioral routines, and enables members to be active participants in their own healthcare.
- Provides telephone follow-up to ensure members have seen their PCP and are completing their treatment plan or preventive care services a defined by the PCP or guidelines.
- Coordinates community resources with emphasis on the development of natural support system. Coordinates benefits, regulations, laws, and public entitlement programs.
- Acts as a liaison and member advocate between the member/family, physician, and facilities/agencies.
- Assists in obtaining benefits for members through community resources when benefits are exhausted or not available.

EDUCATION:

- A Bachelor's Degree in Social Work (BSW), Psychology, Counseling, Rehabilitation, or other relevant field or equivalent work experience in managed care directly related to assisting members to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health

WORK EXPERIENCE:

- 5+ years of experience in behavioral healthcare setting with responsibility for treatment planning and intervention
- 4+ years of experience working with children and families involved with foster care, adoption or juvenile justice.

LICENSES AND CERTIFICATIONS:

- LBSW

FAMILY PEER SUPPORT SPECIALIST / YOUTH PEER SUPPORT SPECIALIST

Work in conjunction with clinical staff to provide support and education for SKY enrollees. Uses personal experiences to develop meaningful and trusting relationships, acting as a mentor.

PRIMARY RESPONSIBILITIES:

- Interviews clients and their families and assist with the coordination activities to meet their social and emotional needs.
- Provides support to care and case managers regarding the coordination of care plans for Enrollees by utilizing social service expertise to evaluate the Enrollees need for alternative services and third party intervention.
- Outreaches to Enrollees telephonically and/or in-person to provide support.
- Provides telephone follow-up to ensure Enrollees have seen their PCP and are completing their treatment plan or preventive care services a defined by the PCP or guidelines.
- Coordinates community resources with emphasis on the development of natural support system. Coordinates benefits, regulations, laws, and public entitlement programs.
- Acts as a liaison and Enrollee advocate between the Enrollee/family, physician, and facilities/agencies.
- Performs other duties as assigned.

EDUCATION:

- High School Diploma or GED

WORK EXPERIENCE:

- Must have experience as a foster and/or adopted parent in the Kentucky Child Welfare system.
- At least 18 years of age youth with lived experience as a foster child or DJJ child in Kentucky

LICENSES AND CERTIFICATIONS:

- Kentucky Certified Peer Support Specialist

CARE COORDINATOR

Coordinates health needs and services for SKY Enrollees across the continuum of care. Assist with the SKY enrollment process when needed. Coordinates and plans activities and routines to meet the medical, social, and emotional needs of Enrollees and their families. Provides support and/or intervention and assists Enrollees in understanding the implications and complexities of their current medical situation and/or overall personal care at the direction of clinical staff. Collaborates with the interdisciplinary team to achieve optimal resource outcomes.

PRIMARY RESPONSIBILITIES:

- Interviews clients and their families and coordinates programs and activities to meet their social and emotional needs. Works within regional DCBS offices to coordinate enrollment, identify and obtain materials related to gaps in care
- Provides support to care and case managers regarding the coordination of care plans for Enrollees by utilizing social service expertise to evaluate the Enrollee's need for alternative services and third party intervention.
- Outreaches to Enrollees telephonically and/or in-person to provide health coaching and consultation and by providing guidance regarding barriers to managing health conditions.
- Assists Enrollees to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health. Reviews benefits options, researches community resources, coordinates services, trains behavioral routines, and enables Enrollees to be active participants in their own healthcare.
- Provides telephone follow-up to ensure Enrollees have seen their PCP and are completing their treatment plan or preventive care services a defined by the PCP or guidelines.
- Coordinates community resources with emphasis on the development of natural support system. Coordinates benefits, regulations, laws, and public entitlement programs.
- Acts as a liaison and Enrollee advocate between the Enrollee/family, DCBS, DJJ, and plan.
- Assists in obtaining benefits for Enrollees through community resources

EDUCATION:

- A Bachelor's Degree in Social Work (BSW), Psychology, Counseling, Rehabilitation, or other relevant field or equivalent work experience in managed care directly related to assisting Enrollees to change behaviors and to locate and access interpersonal, family and community resources that will make it easier to manage their health

WORK EXPERIENCE:

- 5+ years of experience in a health care environment with care coordination responsibilities
- 4+ years of experience working with children and families involved with foster care, adoption, or juvenile justice.
- Experience in a managed care environment

LICENSES AND CERTIFICATIONS:

- LBSW
- Licensed Practical Nurse

v. Overview of the Contractor's proposed training of staff to fulfill all requirements and responsibilities of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," for all operational areas. Provide the Contractor's proposed training program and curriculum for all staff specific to areas of responsibility. Include information about the topics for which staff will receive training, how trainings will differ for new staff members versus ongoing trainings and related training schedules.

PROPOSED TRAINING OF STAFF

WellCare of Kentucky confirms adherence to DMS' expectations and requirements outlined in Section 9.2 Administration/Staffing of the Model Contract. Our approach to meeting DMS' expectations begins with designing training programs aligned with the needs of Kentucky's SKY Enrollees and providers and integrating our resources with DMS' SKY partners. WellCare of Kentucky ensures that all staff, providers, and Subcontractors have appropriate training, education, credentials, experience, liability coverage, and orientation to fulfill the requirements of their positions. All persons assigned to perform work under this Contract shall have the necessary credentials to perform the work herein. We ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice in the Commonwealth of Kentucky. On at least an annual basis, WellCare of Kentucky and our Subcontractors will verify that applicable staff have all necessary current licenses that are in good standing and will provide a list to DMS of licensed staff and current licensure status. Additionally, WellCare of Kentucky will submit to DMS an educational and training plan within one hundred twenty (120) Calendar Days of the Contract Execution Date. We shall update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

COMMONWEALTH SPECIFIC TRAINING FOR STAFF WITH VARYING BACKGROUNDS AND EDUCATIONAL LEVELS

WellCare's Learning and Development department, made up of more than 40 full-time training professionals, develops, facilitates, and evaluates our training curriculum. Led by Anne Read, M.A., Senior Director of Enterprise Learning and Development, we have provided more than 900 hours of market-specific training year-to-date to our associates within the Commonwealth. Since WellCare of Kentucky's focus is to develop a workforce reflective of our diverse Membership, our staff represent different backgrounds and educational levels. Accordingly, we have a depth of experience in designing market-specific training for our diverse staff to successfully acquire the knowledge and skills to be successful in our markets and further their professional careers.

Our training development methodology follows the time-tested **ADDIE** principles, an instructional design development program developed in the 1970s for the U.S. Army. These principles are the gold standard for training course development and have five components:

Analysis – We conduct a thorough market analysis to align training with market needs.

- *Contract Review:* Our learning and development team and regulatory affairs leaders conduct a line-by-line analysis of the SKY Contract identifying training needs based on requirements, policies, and procedures. Content development is parsed out by functional

areas such as Enrollee services, provider relations, care management, and claims/encounters to subject matter experts. For changes to the SKY program, we follow the same process ensuring ongoing compliance with the Contract.

- *Enrollees:* Our analysis identifies the eligibility categories and populations included in Kentucky's SKY Program, demographic attributes, geographic distribution within the Commonwealth, health morbidities, health disparities, as well as any circumstances affecting Enrollees
- *Providers:* We generate training content for our provider-facing staff by assessing the provider environment in terms of the number of SKY providers who are independent practices, large groups, FQHC penetration, health systems, payment models, and familiarity with managed care. Given the wide range of managed care knowledge and experience among the Kentucky SKY providers, our Commonwealth-specific training would prepare our provider-facing staff to assist providers regardless of their size or sophistication whether that means an in-service on the provider portal or a strategic meeting to discuss payment models.

Design and delivery of the curriculum for staff of all educational levels – Our training methodology consists of a blend of instructor-led and web-based learning through WellCare University, which meets the diverse learning styles of our staff. We tailor training to include operational scenarios for roles requiring less formal education yet more operational experience and supplement further with additional modules, reading, practice guidelines, and critical thinking scenarios for roles requiring more formal education. Regardless of our staff's educational levels or role, our market-specific training program design helps them complete the training and be successful in their roles.

Development of training materials for staff of varying backgrounds – Just as we practice cultural competency when interacting with our Enrollees, we abide by the same principles with the staff we train. We honor their individualities, we seek to understand their perspective, respect their religious and cultural beliefs, sexual orientation, and other means of self-identification. We accommodate our staff's language needs and provide American Sign Language (ASL) interpreters if requested, provide materials in large print, include captioning on training videos, and ensure adequate space in our training rooms for wheelchair users to maneuver. Depictions of people in our videos and written materials reflect diversity in race, ethnicity, gender, and disability. Our training model leverages the diversity of our staff to contribute their lived experiences to the success of the market-specific training. We engage our associates to draw from their own culture and heritage and contribute to group discussions about cultural beliefs and healthcare. Some of our staff were former Medicaid beneficiaries who are now transforming their lives through a career. We tap into their experience and have them provide a first-hand perspective to better understand, engage, and serve our Enrollees.

Implementation of the training – Includes tracking associate enrollment through WellCare University, periodic knowledge assessments, completion of the training curriculum, and any additional end-of-training knowledge assessments. The system documents all scored assessments, tabulates, and generates a training report. For required training, our system tracks status and completion sending reminder notices to the associate and successive

escalation notices to their managers if the training is coming due. Through online training, our field employees can access remotely at a time amenable to their work demands allowing them to continue learning while they integrate into communities in Kentucky.

Evaluation of the training in meeting its objectives. Staff are provided with course evaluations to rate the content, the delivery, materials, assessments, and other components of the training program. Our Learning and Development team reviews the results and recommend changes to the training program as needed. For example, as part of that review, we have begun to add additional formats and features to our training with positive feedback such as video, avatars, animation, and gamification. The end result of this evaluation loop is that market specific training tailored to Kentucky evolves based on feedback from local associates who best know the Commonwealth, Enrollees, and providers.

PROVIDING KENTUCKY SKY TRAINING TO OUR STAFF FOR ALL OPERATIONAL AREAS

WellCare's Enterprise Learning and Development department offers a comprehensive onboarding and ongoing training program for Commonwealth associates and contractors. Tonya Farris, our Commonwealth-based Learning and Development Specialist, is responsible for executing our Commonwealth training program. Initial training is delivered in a three phase approach including:

- WellCare New Hire
- Market Specific Training
- Role Specific Training

Our WellCare new hire curriculum orients associates to the company and programs; the market-specific curriculum enables staff and contractors to become subject matter experts regarding Kentucky's SKY program; and the role-specific training focuses on the job-specific skillsets needed to be successful. Following the **ADDIE** process described above, we develop the curriculum to the market's specifications. Training delivery is a combination of instructor-led training, both in the classroom and by WebEx, and computer-based training through WellCare University. WellCare of Kentucky's local Training Specialist is responsible for providing education and training of DMS, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel. Our Training Specialist is also responsible for providing quarterly training for law enforcement officials, judges, district, and county attorneys, including the Kentucky Administrative Office of the Courts and the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy. Training materials consists of written materials, such as PowerPoint slides, multi-media, such as videos, and written or online assessments. Associates enroll in WellCare University which tracks completion of the training and successful performance on the assessments. We will submit to DMS the training program and evaluation within 15 days of Contract award and begin training within five days of approval. We will train our staff within seven days of their start date and can provide completion reports for DMS if requested.

The training outlined in **Table G.2-14** below provides a breakdown of the training phases, course topics, and training frequency. The top sections list the New Hire and Market-Specific courses required for all staff followed by the role-specific courses for each individual training

group. Our role-specific training takes four to eight weeks to complete. Instructor-led training is made available through location of training staff within the Commonwealth as needed.

Table G.2-14 Training Phases, Learning Topics, and Frequency

Training Phase	Learning Topics	Frequency
New Hire All Associates	• Overview of WellCare Health Plans • WellCare's purpose, vision, mission and core values; • WellCare Policies/Procedures • WellCare systems • Mandatory Compliance Training • Sexual Harassment Awareness Training • Emergency Preparedness • Code of Conduct and Business Ethics • Cultural Competency and Cultural Sensitivity • Economic Disadvantage • HIPAA Privacy and Information Security Awareness • Insider Trading • Fraud, Waste, and Abuse • First Aid (all non-clinical Enrollee-facing associates)	Within seven days of hire Annual mandatory compliance training Updated policies and procedures as needed
Kentucky Specific-Contract Requirements All WellCare of Kentucky Associates	• Overview of Kentucky SKY Program (partial list) • Contract requirements • Program eligibility, benefits, covered services, utilization management, cost sharing, transitioning Enrollees, EPSDT • Commonwealth partners including DMS • Unique populations served under Kentucky SKY • LTSS program, policies, and procedures • Fee for Service programs • Provider Networks • Welcome Rooms • Sensitivity training on age, low income, disability, language, culture, reading comprehension and literacy • Understanding unmet health-related resource needs	Within seven days of hire Updated policies and procedures as needed

Training Phase	Learning Topics	Frequency
	• First Aid (all non-clinical Enrollee-facing associates) • Detailed understanding of the Kentucky SKY Program and the roles and responsibilities of DMS, DCBS, and DJJ • The contractual requirements of the Kentucky SKY program • The organization, staffing, infrastructure the Kentucky SKY Contractor must provide to support the Kentucky SKY program • The Kentucky SKY business processes and workflows. • The unique physical health and behavioral needs of the Kentucky SKY populations • The Family First Prevention Services Act and any other federally mandated services or programs impacting Kentucky SKY Enrollees • Trauma-informed Care, ACEs, NAS, SEI, Crisis Intervention Services, and evidence based practices applicable to the Kentucky SKY populations • The aging out process and support from the Kentucky SKY Contractor	
Role Specific Care Coordination Team and Care Management Associates	• Role of the CM and designee CMs (ADH, LHD, CCNC) • Cultural Competency for the general population • HIPAA Privacy and Security and Information Governance Training • Disease Management • Execution of Comprehensive Assessments of Members • Motivational interviewing, including understanding literacy, and cultural awareness. • Self-management to evidenced based care; medication adherence strategies • Person-centered screening, needs assessments, and all elements of care planning • Understanding and addressing unmet health-related resource needs; using available social supports • Transitional care management including medication reconciliation	Four to eight week curriculum depending on role Updated policies and procedures as needed Upskill training annually

Training Phase	Learning Topics	Frequency
	• Behavioral health crisis response (for CMs with assigned Members with behavioral health needs) • How to identify trauma and ACEs • How it impacts care delivery and the way our Enrollees engage in their own health care • Providing guidance on preventing re-traumatization • Empowering Enrollees to realize their individuality that extends beyond their trauma experiences • Establishing and maintaining relationships with DCBS and DJJ personnel	
Role Specific Pharmacy and Clinical Services Staff Responsible for UM	• Pharmacy protocols • Training on application of varying clinical guidelines, • Benefit coverage • Modules on care management resources and processes, • Grievance and administrative review training • HEDIS care gap education • Management information systems • Authorization process - both expedited and standard. • InterQual Training Modules • Preceptor training for up to 80 days depending on previous work experience, performance in training, and demonstrated proficiency.	Four to eight week curriculum depending on role Updated policies and procedures as needed Upskill training annually
Role Specific Enrollee Services Representatives	• Customer Service principles and Quality Governance • Communication Skills and Call Listening • Enrollee self-service • Overview of WellCare Systems and how to navigate WellCare's public website and intranet for information; • Trauma-informed Care, ACEs, and evidenced based practices applicable to individuals in the Foster Care and juvenile justice systems or receiving Adoption Assistance • WellCare SKY program operations • Engaging with DCBS and DJJ staff/guardians • Engaging with adopted parents and foster parents	Four to eight week curriculum depending on role Updated policies and procedures as needed Upskill training annually

Training Phase	Learning Topics	Frequency
	• Enrollee Experience • Enrollee rights and responsibilities • Enrollee Advanced Directives • Overcoming barriers to accessing care • Healthy Rewards program • Appeals and Grievances • Enrollee grievance and appeals process • Documenting grievances and grievance quality • Appeals and Commonwealth fair hearing process • Top call drivers • Provider directory and changing PCPs • Pharmacy basics, PDL, and internal systems • Activating language line and ASL calls, engaging nurse line and behavioral health crisis lines • De-escalation Skills; Safety and Violence Protection for Field Associates • Behavioral Health Overview • Claims Essentials • Eligibility Requirements • Step Actions • covered and carved-out services • VABs • Kentucky place names and surnames (cultural competency)	
Role Specific Provider Relations Representatives	• Overview of WellCare Systems and how to navigate WellCare's public website and intranet for information • WellCare SKY program operations • High Performance Network Strategy • Value-Based Care • Educating providers on WellCare Policies and Procedures including Plan Benefits and Services, Claims, Authorizations, Reporting and on Balance Billing	Four to eight week curriculum depending on role Updated policies and procedures as needed Upskill training annually

Training Phase	Learning Topics	Frequency
	• Quality/HEDIS Overview • Activating language line and ASL calls • AMH Tiering • provider groups - including private child care and DJJ providers • provider Experience • provider rights and responsibilities • Quality and efficiency drivers	
Role Specific Quality Improvement Associates	• Health Literacy • HEDIS Boot Camp • External Quality Review (EQR) Protocol • Medical Record Review • NCQA Accreditation and Guidelines Summit • Cultural Competency and Awareness • PIP Validation • Ongoing Quality Status Updates to Kentucky Associates • Quality Line • Behavioral Health • Medically Frail • Health Literacy • WellCare SKY health outcomes	Four to eight week curriculum depending on role Updated policies and procedures as needed Upskill training annually
Role Specific Associates working with DMS	• Overview of WellCare Systems and how to navigate WellCare's public website and intranet for information • Eligibility process including rules and regulations; • Eligibility categories • WellCare of Kentucky Enrollee journey • 834 files and enrollment flags • Community Connections, (SDOH program), the Community Connections Help Line	Four to eight curriculum depending on role Updated policies and procedures as needed Upskill training annually
Role Specific	• Initial and ongoing education of Commonwealth personnel.	Timeframes and Location to be

Training Phase	Learning Topics	Frequency
DMS, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel	• An understanding of the Kentucky SKY program and the roles and responsibilities of DMS, DCBS, and DJJ. • The contractual requirements of the Kentucky SKY program. • The organization, staffing, infrastructure the MCO must provide to support the Kentucky SKY program. • The Kentucky SKY business processes and workflows. • The aging out process and support from the Kentucky SKY Contractor.	Designated by DMS Updated policies and procedures as needed
Role Specific Law Enforcement Officials and Judges (Enforcement officials, judges, district and county attorneys, including the Kentucky Administrative Office of the Courts and the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy)	• An understanding of the Kentucky SKY Program and the roles and responsibilities of DMS, DCBS, DJJ, and DBHDID, and how these agencies will coordinate and collaborate with the Kentucky SKY Contractor; • Role and responsibilities of the Kentucky SKY Contractor; • Needs of the Kentucky SKY populations; • High Fidelity Wraparound approach; • Family First Prevention Services Act; • Trauma-informed Care; • Impact of ACEs; and • Aging out process and support from the Kentucky SKY Contractor.	Quarterly Updated policies and procedures as needed

vi. Overview of Contractor's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

SUBCONTRACTOR STAFF RECRUITING

Prior to delegating any functions to a third party, we perform due diligence including a comprehensive assessment to prospectively evaluate the Subcontractor's ability to perform the activities to be delegated. The comprehensive vetting and due diligence process is a requirement in our delegated subcontracts, and compliance must be demonstrated prior to a delegated Subcontractor becoming active with WellCare of Kentucky. We perform oversight and monitoring of the delegation activities through scorecards, data analysis, focused reviews, and annual audits. We develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and the Contract. All pre-

delegation audits for new Subcontractors are based on the National Committee for Quality Assurance (NCQA), and state and federal requirements.

We will not delegate to an entity unless it achieves a successful passing score on its pre-delegation audit. Our pre-delegation audit process confirms the Subcontractor has the structural elements, i.e. policies, procedures, staff, licensure, etc., in place to comply with all of the contractual requirements for the functions assigned to them. The pre-delegation audit includes a review of the Subcontractor's recruitment policies so that standard adherence to WellCare policies and procedures are applied during the recruitment of staff. Additionally, for all new requests for delegation, one of the first steps we take is to screen them against the state and federal exclusion lists. On a monthly basis, Delegation Oversight confirms the screening of our subcontractors against the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities and the General Service Administration's System for Award Management exclusion lists and similar state exclusion lists. WellCare will not knowingly hire, retain, or otherwise conduct business with subcontractors that:

- Have been excluded, debarred or suspended from participating in state and federal programs; or
- Have been convicted of a criminal offense within the scope of exclusion laws, but has not yet been excluded, debarred, suspended, or otherwise declared ineligible by a governmental authority.

Subcontractors have to comply with the expectations of the company on an ongoing basis. After delegation, the team continues to monitor performance. In addition to the confirmation, we require the submission of supporting documentation to demonstrate compliance. Examples of documentation may include codes of conduct, compliance policies, copies of training materials, training rosters, etc. WellCare's extensive oversight of Subcontractor performance reflects our commitment to deliver high quality services and our understanding that Subcontractors' performance is a reflection of WellCare's focus on quality.

SUBCONTRACTOR STAFF TRAINING

WellCare places the highest value on the importance of effective associate and Subcontractor onboarding and training. While associate and subcontractor satisfaction and retention are important byproducts, the most important results of our training investment are reflected in the service received by our Members and Providers.

All WellCare associates and Subcontractors who will bear responsibility in the execution of commitments made in this Contract will be required to complete a detailed training program specific to Kentucky Medicaid and WellCare SKY. Content for the training modules will be developed in accordance with the regulations, eligible populations, and characteristics of Kentucky Medicaid and WellCare SKY. All training content is stored, deployed, assessed, and tracked through our Learning Management Platform. This includes aligning all market specific training to the appropriate associate by role or function. WellCare expects delegate entities to provide training reports that demonstrate their staff have been trained to meet the standards of WellCare and our state partners.

WellCare's corporate training team is skilled at building and delivering specialized training content. For Kentucky, WellCare will develop training modules, which provide staff an in-depth understanding of the populations, service coordination needs, and regulatory requirements specific to our membership in Kentucky.

vii. Retention approach for Full-time Kentucky SKY Key Personnel.

WellCare is the employer of choice within the health care industry and we spend considerable effort recruiting and retaining best-in-class employees. With our extensive experience, we have built an organization that has become an attractive place to work for experienced health care executives, people leaders, and individual contributors. Since our inception in 2011, WellCare of Kentucky has established the most experienced and stable leadership team out of any MCO operating Kentucky's Medicaid program. **For the last two years, WellCare of Kentucky has made the list of Best Places to Work in Kentucky. We placed 10th in the Large Company category in 2018 and 8th in the Large Company category in 2019.** The Society of Human Resource Management and the Kentucky Chamber of Commerce sponsor best Places to Work in Kentucky and the rankings are based on an Employer Benefits and Policies Questionnaire (25% weighting) and an Employee Engagement and Satisfaction Survey (75% weighting).

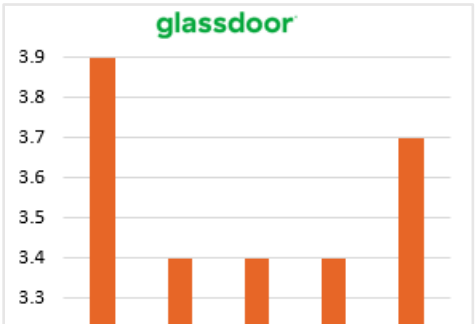


Figure G.2-10 2019 Glassdoor Rating

In 2019, WellCare had a significantly better reviews than our competitors do (see **Figure G.2-10**) as an employer of choice within the managed care industry based on reviews from Glassdoor, which is one of the fastest growing jobs and recruiting sites, and holds a growing database of millions of company reviews. We attract and retain top level talent through our comprehensive benefits package, promoting work life balance with flexible schedules, opportunities for working remotely (15% of our workforce work from home full time and a large percentage telecommute anywhere between one to four days per week), and tuition reimbursement. Additional benefits include:

- Competitive compensation
- Paid time off
- Health/dental/vision insurance
- Telemedicine
- Employee assistance plans
- 401(k) retirement plan
- Company-paid life and disability insurance
- Flexible spending accounts
- Casual Dress Code
- Tuition Reimbursement
- Volunteer Time Off Program

In addition, we are committed to diversity and inclusion, and create an environment in which associates bring their authentic selves to the work place. In addition to the benefits listed above, we use a variety of strategies for retaining key personnel and associates to ensure we always have talented team Enrollees in place to perform the functions of the Contract.

Strategies include leadership goals and training, measures and action plans, career development to engage and empower associates, and targeted retention programs. **In 2018, WellCare of Kentucky's overall undesirable turnover was 10%, well below the healthcare industry average.**

ENSURING RETENTION THROUGH MEASURES AND ACTION PLANS

The WellCare of Kentucky leadership team is committed to ensuring that we have a highly motivated and engaged team of associates in our regional offices, on-site at hospitals, and remotely to provide exceptional support to our Enrollees and providers. We measure the satisfaction and engagement of our associates by soliciting feedback from all employees through a confidential annual Associate Opinion Survey (AOS) and a New Hire Experience Survey (NHES). **In 2018, WellCare of Kentucky's average score for 14 of the 15 AOS categories in the survey was 11% to 31% higher than the U.S. high performing norm comparator, which includes Fortune 100 companies.** WellCare of Kentucky has led the organization in AOS engagement scores for the last two years. In addition, Kentucky had a 100% employee participation rate on the 2018 survey. WellCare's NHES goes out 90 days after a new associate starts. In 2018, WellCare surveyed 2,160 associates with an 87% favorable result. WellCare of Kentucky surveyed 31 associates in 2018 with a 93% favorable result. We review AOS and NHES results with each functional area and partner, creating action plans to address areas of opportunity identified by the surveys and capitalize on successes, leveraging best practices and ensuring strong future results. We hold executives accountable for achieving successful outcomes and addressing opportunities these surveys identify.

ENGAGING AND EMPOWERING OUR ASSOCIATES THROUGH CAREER DEVELOPMENT

One of our most important strategies for enhancing retention and minimizing staff turnover is to create an environment that supports professional achievement by providing associates with the tools and resources they need to succeed. WellCare of Kentucky is committed to providing all associates with effective learning in the necessary business and professional development skills to ensure their success. **In 2016, 82% of WellCare of Kentucky's associates said that they receive the training they need to perform their current job effectively and that they are given a real opportunity to improve their skills (based on WellCare of Kentucky's 2018 AOS Survey Results).** We support all of our employees in their development and individual growth at the company and are proud of our ability to recruit and promote employees from within the organization. In 2018, 15 of WellCare of Kentucky's associates received promotions and WellCare filled more than 33% of open positions with internal associates.

LinkedIn Learning

As our industry and our business grow more complex, our associates must adapt and innovate, faster and better than ever before. WellCare is excited to provide all associates with access to LinkedIn Learning – an award-winning, industry leader in online training – with a digital library of over 11,000+ micro-learning courses covering a wide range of technical, business, software and creative topics. Launching LinkedIn Learning is a strong commitment to providing professional development opportunities for our associates, allowing them to take charge of their learning and planning for their career growth.

TARGETED RETENTION PROGRAMS

Each functional area leader partners with their respective human resources business partner to create retention programs that address retention risks. This ensures we retain our top talent and that our associates are engaged and developed to serve our Enrollees and providers. For example, if we identify an attrition opportunity among a particular functional role, we implement a series of proactive measures to address it. Examples of retention plan action items include 'stay' and 'skip' level interviews with high performing associates, stretch assignments, mentoring, and engagement programs and activities. **These targeted retention programs have proved to be very successful. In 2018, WellCare of Kentucky's overall undesirable turnover was 10%, well below the healthcare industry average.**

viii. Provide a detailed description of the Contractor's organizational structure for the Kentucky SKY program under this Contract, including an organizational chart that displays the following:

WellCare of Kentucky will submit a current organizational chart depicting all functions including mandatory functions, number of employees in each functional department and key managers responsible for the functions to DMS for approval within 30 days of signing the Contract, annually, prior to material revisions and upon request by DMS.

a. Management structure, lines of responsibility, and authority for all operational areas of this Contract.

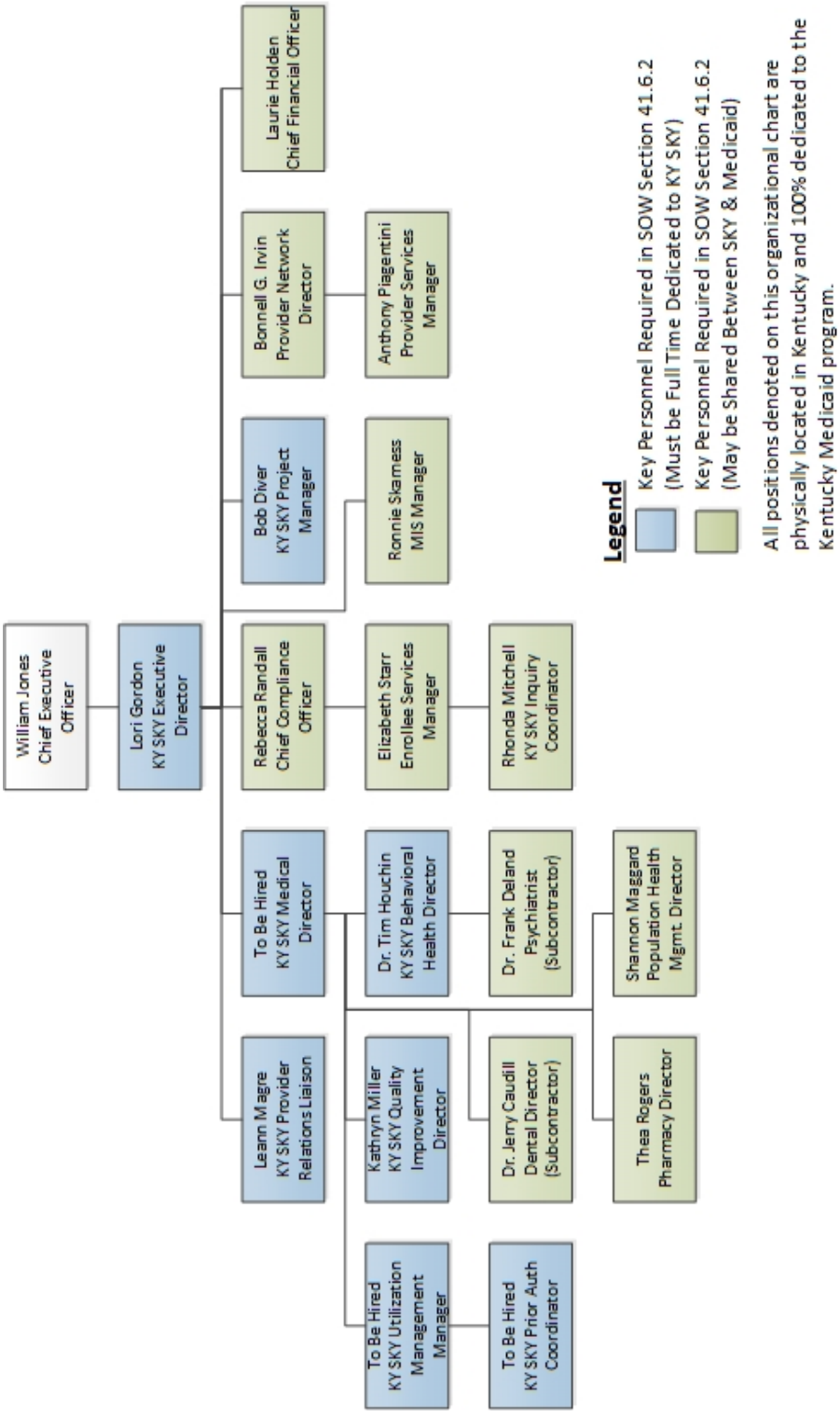
WellCare of Kentucky's Executive Administrator, Lori Gordon, has full accountability for overseeing all operations, strategic direction and administration of our Kentucky SKY Program plan. Working closely with our Executive Administrator is our Kentucky-based leadership team, comprised of key leaders, each of whom are responsible for overseeing specific functional areas within WellCare of Kentucky's organization. Together, our Commonwealth-level leadership team and support staff will anchor each regional staff team. Our dynamic team of local leaders have are responsible for making decisions for WellCare of Kentucky. This decision-making responsibility extends downward to the teams deployed throughout the Commonwealth to ensure that associates closest to our Enrollees, providers, and stakeholders are empowered to make decisions with support and feedback from our Commonwealth leadership team. For example, the scope of decision-making authority of our local team in Kentucky includes, but is not limited to, how staff and resources are deployed throughout the local market to support our Enrollees and providers, the authority to administer the execution and management of our provider network, the ability to make decisions about Value-Based Purchasing with our providers, and the capability to make local decisions regarding claims adjudication and prior authorization issues.

WellCare of Kentucky's infrastructure provides integrated accountability with behavioral, social, pharmacy and physical health staff aligned through our clinical, administrative, and operational structure. This ensures that integration of services begins at the top of our management structure and flows down into our regional and local service delivery at the Enrollee level. Our governance and decision making model ensures that these local leaders engage in daily, weekly, and monthly interactions with our local staff to address Kentucky specific issues, to

ensure challenges are being addressed, to ensure adherence to escalation protocols, and to guarantee our associates are making timely, accurate, and proactive decisions.

The organizational chart below, **Chart G.2-1**, shows the management structure, lines of responsibility, and authority for all operational areas of WellCare of Kentucky for this Contract.

CHART G.2-1: WELLCARE OF KENTUCKY ORGANIZATIONAL STRUCTURE



b. How the Kentucky SKY fits into the overall organizational structure of the Parent Company.

WellCare of Kentucky is an indirect wholly owned subsidiary of Centene Corporation, Inc. (Centene). The ownership path is as follows:

CENTENE

Centene Corporation (Centene), which includes WellCare Health Plan, provides managed care services to more than 12.9 million Medicaid Enrollees across 30 states. Centene's focus and expertise is in serving beneficiaries through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), Modified Adjusted Gross Income (MAGI), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Foster Care, Medicaid Expansion Populations, LTSS, and Medicare-Medicaid Plans (MMPs). Centene serves 1 million Medicare members across 28 states.

WELLCARE HEALTH PLANS

WellCare Health Plans, Inc. ("WellCare") provides managed care to over 4.1 million Medicaid Enrollees in 12 states including serving Aged, Blind and Disabled (ABD), Children's Health Insurance Plan (CHIP), Dual-Eligible Populations (Medicare & Medicaid), Intellectual Developmental Disabilities (IDD), Managed Long-Term Services and Supports (MLTSS), Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF) populations. WellCare also offers Medicare Advantage plans in 21 states serving 506,000 Enrollees including approximately 125,000 dual-eligibles. WellCare also offers Medicare Part D prescription drug plans in all 50 states with approximately 1.05 million Enrollees. WellCare does not split time or our infrastructure in commercial insurance or other types of health coverage, which allows us to ensure that we tailor everything we do for Medicaid and Medicare Enrollees.

WELLCARE OF KENTUCKY, INC.

WellCare of Kentucky, Inc. ("WellCare of Kentucky") is a wholly owned subsidiary of WellCare Health Plans, Inc. WellCare of Kentucky currently serves more than 430,000 Medicaid Enrollees across the Commonwealth, which includes approximately 215,000 Temporary Assistance for Needy Families (TANF)/Kentucky Children's Health Insurance Program (KCHIP), 137,000 Medicaid Expansion, 43,000 Supplemental Security Income (SSI), 24,000 Dual Eligible, and 9,000 foster care, juvenile justice system, adoption assistance, and former foster care Enrollees. Additionally, WellCare of Kentucky services approximately 47,000 Medicare Enrollees across Kentucky, including 14,000 Medicare Advantage Enrollees and 33,000 Medicare PDP Enrollees. We currently employ over 300 people throughout the Commonwealth serving our Medicaid and Medicare Enrollees. Our experience teaches us that a local presence is the key to both successful implementation and ongoing operations. More importantly, local service to our Enrollees and providers has a positive impact on quality and availability of Enrollee care.

The organizational charts that follow (**Chart G.2-2)**, shows greater detail on how Kentucky SKY fits into the overall organizational structure of the WellCare of Kentucky's Parent Company and ultimate parent company (Centene). Parts 12 through 17 provide the specific details of WellCare of Kentucky and our affiliates and direct parent (WellCare).

c. Where Subcontractors will be incorporated.

INCORPORATION OF SUBCONTRACTORS

We choose highly-qualified subcontractors to complement and enhance the services we provide to our Enrollees and providers. We thoughtfully integrated these subcontractors into WellCare of Kentucky's SKY organizational structure to ensure a streamlined experience for our Enrollees, providers and DMS. Reporting to our Executive Administrator, our Chief Operating Officer, Ben Orris, will be responsible for overseeing the day-to-day functions and services supplied by operational subcontractors. The Kentucky SKY Medical Director, once hired, along with Dr. Howard Shaps, Medical Director, will have direct oversight to all clinical subcontractors. Several additional key personnel are responsible for overseeing services performed by our subcontractors.

- Ben Orris, Chief Operating Officer – Responsible for overseeing subcontractors providing Operations Support services
- Dr. Howard Shaps, Medical Director – Responsible for overseeing subcontractors providing Clinical services
- Utilization Management Director (TBD) – Responsible for overseeing subcontractors providing Utilization Management services
- Thea Rogers, Pharm.D., Pharmacy Director – Responsible for overseeing subcontractors providing Pharmacy Benefits Management services
- Bonnell Irvin, MPA, Provider Network Director – Responsible for overseeing subcontractors providing Provider Network services
- Julie Crousore, Claims Processing Manager – Responsible for overseeing subcontractors providing Claims Processing services
- Elizabeth Starr, Enrollee Services Manager – Responsible for overseeing subcontractors providing Enrollee services

Table G.2-15 below shows the Subcontractors WellCare of Kentucky utilizes to support our Kentucky SKY Program plan.

Table G.2-15 Subcontractors, Functions, and Reporting Structure

Subcontractor	Role
Enrollee Services – Elizabeth Starr	
All Asian Group	Translation services
C3/CustomercontactChannels Inc.	Call Center
CareerArc	Career service & employment and training support for our members

Subcontractor	Role
Cobalt Therapeutics, LLC	Behavioral health website training for members
Concentrix Corp. (f/k/a IBM Daksh Business Process Services PVT Ltd)	Enrollment services
CSI Southeast, Inc., d/b/a Interpretek	Sign language interpretation
Eliza Corporation	Interactive voice recognition – member risk assessments
Elahi Enterprises dba Akorbi	Visually and hearing impaired translation services
Healthy Profits, LLC dba HealPros, LLC	Diabetic retinopathy examination screenings
Human Arc Corporation	Outreach enrollment services
Multilingual Group	Written translation services
Novu, LLC	Member wellness reward program
Revel Health, LLC fka Healthtel	Member communications
RJ Health International Systems, LLC	Web based portal for RX claims
SPH Analytics (f/k/a Patient Satisfaction Plus, LLC, d/b/a The Myers Group)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
The Results Companies, LLC	Customer service
TPUSA, Inc. d/b/a Teleperformance	Customer service
Translation Station	Interpreter services – physicians' offices
Voiance Language Services	Grievance letter translation services
WellSource, Inc.	Web access program for telephonic access to health appraisal questions.
Network and Provider Contracting – Bonnell Irvin	
Aarete, LLC	Assist markets with DME provider contracting efforts
Common Health Corporation, Inc. dba Center Care Health Benefit Programs	Credentialing

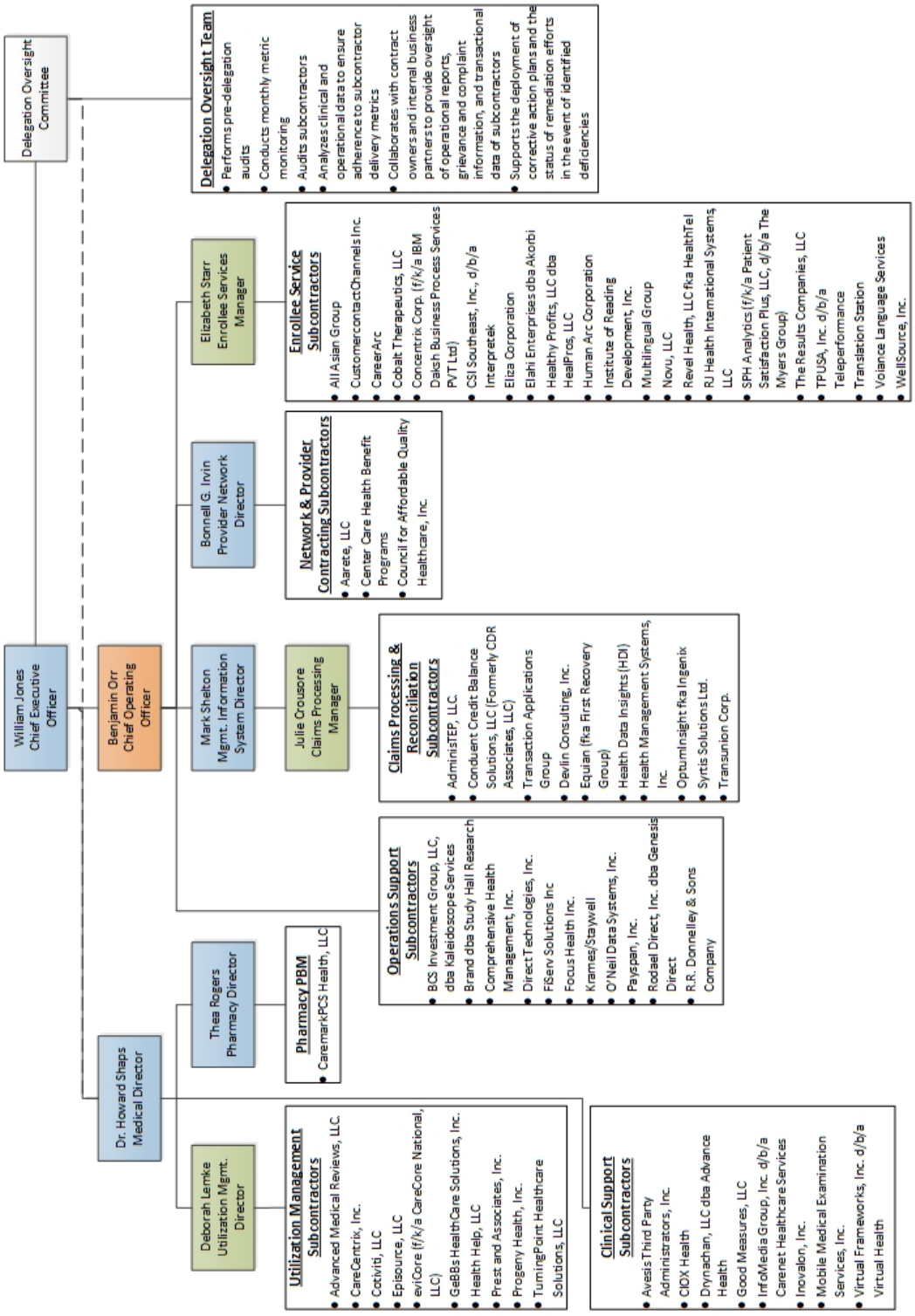
Subcontractor	Role
Council for Affordable Quality Healthcare, Inc.	Source for Provider self-reported data
Claims Processing and Reconciliation – Julie Crousore	
AdminisTEP, LLC	Clearinghouse services for claims and real-time transactions
Conduent Credit Balance Solutions, LLC (Formerly CDR Associates, LLC)	Claims overpayment recovery
Transaction Applications Group	Claims processing and adjudication
Devlin Consulting, Inc.	Overpayment recovery of claims through data mining
Equian (fka First Recovery Group)	Third party liability - subrogation
Health Management Systems, Inc.	Third party liability – coordination of benefits, credit balance and data mining
OptumInsight fka Ingenix	Payment Integrity, Claims editing, Credit Balance Audit
Syrtis Solutions Ltd.	Third party liability – verification of benefit eligibility
Transunion Corp.	Third party liability – claims
Advanced Medical Reviews, LLC.	Physician level independent peer review
CareCentrix, Inc.	Post-acute care services/ Readmissions Management Services
Cotiviti, LLC	Data mining and medical chart review recovery
Episource, LLC	Medical Records Reviews
GeBBs HealthCare Solutions, Inc.	Medical Records
Prest and Associates, Inc.	Physician utilization review and independent review
Progeny Health, Inc.	Utilization Management/ Neonatal Medical Management Services
TurningPoint Healthcare Solutions, LLC	Orthopedic Utilization Management

Subcontractor	Role
Clinical Support – Dr. Howard Shaps	
Avesis Third Party Administrators, Inc.	Vision management services and dental management services
CIOX Health	Chart retrieval/HEDIS chart copy services
Drynachan, LLC dba Advance Health	In-home assessments
eviCore (f/k/a CareCore National, LLC)	Utilization management
Good Measures, LLC	Value Added Benefits Program Administrator
InfoMedia Group, Inc. d/b/a Carenet Healthcare Services	24/7 nurse line
Inovalon, Inc.	HEDIS AdvantageTM services
Mobile Medical Examination Services, Inc.	Home Bone Mineral Density Screening Program
Virtual Frameworks, Inc. d/b/a Virtual Health	IT platform for care management
Health Help, LLC	Utilization Management
Operations Support – Ben Orris	
BCS Investment Group, LLC, dba Kaleidoscope Services	Print and fulfillment
Brand dba Study Hall Research	Focus group research
Comprehensive Health Management, Inc.	Management services
Direct Technologies, Inc.	Print and fulfillment
FiServ Solutions Inc.	Print Fulfillment
Focus Health Inc.	Behavioral health utilization management
Krames/Staywell	Print fulfillment
O'Neil Data Systems, Inc.	Print services
Payspan, Inc.	File Processing, Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA), Online Archive, Print Services

Subcontractor	Role
Rodael Direct, Inc. dba Genesis Direct	Creative services, print and production, fulfillment and shipping services
R.R. Donnelley & Sons Company	Print services
Pharmacy PBM – Thea Rogers	
CaremarkPCS Health, LLC (CVS)	Pharmacy benefit manager (PBM)

The organizational chart below, **Chart G.2-3**, shows where subcontractors will be incorporated into WellCare of Kentucky's organizational structure.

CHART G.2-3: SUBCONTRACTOR MANAGEMENT STRUCTURE



ix. A summary of how each Subcontractor will be integrated into the Contractor's proposal performance of their obligations under the Contract to ensure a streamlined experience for the Kentucky SKY Enrollees, Providers and the Department.

INTEGRATING SUBCONTRACTORS AT THE LOCAL LEVEL

All of WellCare of Kentucky's subcontractors are expected to meet the specific obligations and performance standards under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices in order to ensure a streamlined experience for Enrollees, providers, and DMS. Chief Operating Officer, Ben Orris, is responsible for overseeing the day-to-day functions and services supplied by operational subcontractors. Supporting Ben in these efforts is our Commonwealth-based Regulatory Affairs and Compliance teams, which includes our Chief Compliance Officer, Rebecca Randall. In conjunction with our local Regulatory Affairs and Compliance teams, our team of local leaders responsible for quickly and directly addressing any issues that arise with our Enrollee and provider facing subcontractors. These local leaders include Dr. Howard Shaps, Medical Director, Thea Rogers, Pharmacy Director, Bonnell Irvin, Provider Network Director, Anthony Piagentini, Provider Services Manager, Julie Crousore, Claims Processing Manager, and Elizabeth Starr, Enrollee Services Manager. Along with Dr. Howard Shaps, Medical Director, the Kentucky SKY Medical Director has clinical oversight for all clinical subcontractors.

WellCare of Kentucky has multiple mechanisms for becoming aware of emerging subcontractor performance issues, including metric / scorecard monitoring, complaints and grievances (including those from DMS), regularly scheduled subcontractor audits, Enrollee feedback from our Consumer Advisory Boards, Joint Operating Committee (JOC) meetings with our subcontractors, and our WellCare of Kentucky Quality and Compliance governance meetings. To ensure we are constantly engaging with our subcontractors, our Regulatory Affairs and Compliance Teams, including the Kentucky SKY Medical Director, hold regular JOC meetings with our subcontractors to monitor performance level reports and scorecards, identify and address service and quality issues, and design and execute quality improvement initiatives. These meetings include discussions of any performance issues, including outstanding corrective action plans and the status of remediation efforts. We typically hold these meetings monthly, but for subcontractors with broader member impact, such as Dental and Transportation, we hold them bi-weekly (and even more frequently if needed, such as during Contract implementation).

Delegation Oversight Team

Supporting WellCare of Kentucky in our monitoring and oversight efforts is our Delegation Oversight Team, led by WellCare's Chief Compliance Officer, Lori-Don Gregory, Deputy Compliance Officer, and Chris Price, Vice President Compliance Oversight, our Delegation Oversight Team. This team oversees compliance of services provided by subcontractors to ensure they comply with federal and state regulations, contractual obligations, accreditation standards and company policies and procedures. This team is comprised of subject matter experts for each of the delegated functions and leverages audit tools and expertise, our C360 compliance management system, and national best practices to execute a comprehensive subcontractor oversight process. To further illustrate the breadth of experience of our

Delegation Oversight Team, it includes clinical and non-clinical auditors with industry expertise spanning utilization review, complex case management, claims, customer service, and pharmacy, as well as an in-depth understanding of the requirements for a WellCare of Kentucky subcontractor.

Our Delegation Oversight Team works in conjunction with the governance framework of our Delegation Oversight Committee (DOC). Our DOC provides oversight for all delegated subcontractors and continuous guidance and advisory services to our Delegation Oversight program. The Kentucky SKY Medical Director will work directly with the Delegation Oversight Committee to review all clinical subcontractor reports and will meet with clinical subcontractor directors no less than monthly through the Utilization Management Quality Improvement Subcommittee. Our DOC is governed by our Compliance Program and reports to our Corporate Compliance Committee (CCC), and ultimately to the Audit, Finance, and Regulatory Compliance Committee of WellCare's Board of Directors.

MONITORING SERVICE LEVEL AGREEMENTS

We ensure subcontractor compliance through the rigorous monitoring of service level agreements to ensure a streamlined experience for Enrollees, providers, and DMS. Our approach to establishing and monitoring service level agreements is based on our thorough contracting process, rigorous upfront screening process, and comprehensive ongoing review process. Service level agreements are established to ensure compliance with DMS' contractual requirements for covered services, as well as alignment with DMS key goals for the Kentucky SKY Program.

Monitoring Kentucky SKY service level agreements begins with ensuring they are clearly documented in our contract with our subcontractor. As part of their negotiating and contracting processes, our National Network Performance Team ensures all required state contract standards are included in our subcontracts, and also align these standards with monetary performance incentives and penalties. Our Senior Manager of Vendor Management and Senior Manager of Regulatory Affairs, who are subject matter experts on the SKY Contract and who provide guidance on any interpretation questions, support them in this effort.

Our pre-delegation audit process validates that the subcontractor has the required elements in place to comply with all of the contractual requirements for the functions delegated to them. Items evaluated as part of the pre-delegation audit include eligibility for government healthcare programs, policies, procedures, licensures, and staffing levels. The results of the pre-delegation audit are summarized and presented to our Delegation Oversight Committee. If during the initial delegation audit, an item or process is deficient or not compliant with WellCare of Kentucky's expectations, the subcontractor is placed on a corrective action plan (CAP) which must be remediated. Any exceptions must be presented to and approved by our Delegation Oversight Committee.

Once delegated services have commenced, WellCare of Kentucky continues to monitor service level agreements. The primary forum to discuss these metrics is our reoccurring Joint Operating Committee (JOC) meetings with our subcontractors. Key areas of focus for our JOCs are monitoring performance level reports and Delegation Oversight scorecards, identifying and

addressing service and quality issues, complaints, and grievances, and designing and executing quality improvement initiatives. All subcontractors delegated for network management have service level agreements to meet or exceed DMS' network adequacy requirements.

Our ongoing service level monitoring through our JOC structure is supplemented by the compliance monitoring of our Delegation Oversight Team. As part of our governance process, our Delegation Oversight Team reports directly through our Compliance Organization and Chief Compliance Officer, making their review and assessment independent from WellCare of Kentucky's day-to-day operational team. Delegation Oversight uses a risk-based approach to determine the level and frequency of review, and every subcontractor has an annual review. Our reviews include metric-based scorecards (of service levels that are aligned with Kentucky SKY standards), targeted / focused audits, and annual functional audits. Delegation Oversight imposes corrective action plans for subcontractor service level misses as necessary and monitors their completion. In the case of an explicit failure to meet Department standards, the "Improvement Plan" due to WellCare of Kentucky and DMS will mirror the corrective action plan. If a subcontractor fails to remediate the deficiency underlying the corrective action plan, WellCare of Kentucky imposes disciplinary action and fines up to and including de-delegation. Delegation Oversight's activities are managed through our compliance management system, Compliance 360 (C360), which enables accurate tracking and reporting.

A summary of how each Subcontractor will be integrated into the WellCare of Kentucky's proposal performance of their obligations under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices is shown above in **Chart G.02.c-3**.

x. Identification of staff positions that will be based (1) in the Contractor's Kentucky office(s), (2) in the field, and (3) at a corporate office of the Contractor or Subcontractors. Information should include physical locations for all Contractor operational areas to support this Contract.

LOCATION OF WELLCARE OF KENTUCKY STAFF

Local staffing and leadership have been foundational to our successful implementation and ongoing operations in Kentucky, and our structure for Kentucky SKY will follow this model. Our SKY Executive Team lives and work in Kentucky today, and we are the only MCO with Enrollee- and Provider-facing staff located throughout the Commonwealth.

Staff Positions Based in WellCare of Kentucky's Offices

139 staff positions are located in one of our six offices within the Commonwealth of Kentucky. These individuals are fully dedicated to serving the people of Kentucky and are comprised of leadership staff, operational staff, non-field based provider, and non-field based clinical staff.

Staff Positions Based in the Field

WellCare of Kentucky has 81 field-based staff positions located throughout the Commonwealth to support our Enrollees and Providers, including dedicated Care Coordination staff who have been providing high-touch services working in the field with DCBS, DJJ, Enrollees, and caregivers for eight years. An example of our proposed regional staffing structure is outlined below:

- Region 1: Care Manager (BH), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager
- Region 2: Care Manager (BH), Care Manager (RN), Care Coordinator, Case Management Manager
- Region 3: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager
- Region 4: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager
- Region 5: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager, Coordinator Supervisor
- Region 6: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager, Coordinator Supervisor
- Region 7: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager, Coordinator Supervisor, Transition Coordinator
- Region 8: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager
- Region 9: Care Manager (BH), Care Manager (RN), Health Coach, Care Coordinator, CM Supervisor, Case Management Manager, Coordinator Supervisor

In addition to the staff positions listed above, WellCare of Kentucky a proven, field-based, provider-facing outreach and education program with Provider Relations representatives and managers established regionally across the state. WellCare's Provider Relations (PR) representatives live in the region where they support providers, giving them both proximity to the providers they support and familiarity with their communities. Additionally, we will have Enrollee Services call center includes our Work-At-Home- Agent (WAHA) service model staffed by associates who are located in Kentucky.

Staff Based in WellCare's Corporate Offices

All staff that is dedicated to the meeting the Kentucky SKY program requirements will be located within the Commonwealth of Kentucky.

xi. Number of proposed FTEs dedicated to the Kentucky SKY program, by position type and operational area and how the Contractor determined the appropriateness of these ratios.

DETERMINING THE APPROPRIATENESS OF FTE RATIOS

Over the years, WellCare has had significant experience launching new programs, integrating acquired programs and expanding with new populations, geographies, and services with positive results, allowing us to become one of the largest Medicaid managed care providers in the country. As a company with over 30 years of experience developing staffing plans for our Medicaid programs and over eight years of experience providing Medicaid services within the

Commonwealth, we have a tested process in place for developing the appropriate level of FTEs to ensure successful operations of the SKY program. In order to develop a staffing plan to fulfill the requirements of the Kentucky SKY program, WellCare conducts a detailed and thorough information gathering process to ensure that the necessitated staffing levels for the Kentucky SKY program are accurately captured and planned for over time. We achieve this through a series of structured review sessions with functional area leaders that span all functions of the organization to ensure a clear understanding of the contract requirements, deliverables, and the strategy in place to effectively achieve and execute those deliverables. Following these review sessions, each functional area is responsible for providing a detailed staffing plan that includes the number and type of FTEs as well as the anticipated dates of hire, over time, including the time leading up to contract implementation. Senior level leadership reviews, revises (if needed), and approves the plan to ensure strategic direction is achieved and the inputs are appropriate to meet the established requirements.

Number of Proposed FTEs Dedicated to the Kentucky SKY Program by Position, Type, and Operational Area

Table G.2-16 below describes the projected WellCare of Kentucky staff dedicated to the Kentucky SKY program broken down by functional area, position, and FTE count. This table does not include WellCare of Kentucky shared staff.

Table G.2-16 Proposed Full-Time Equivalent Positions

Functional Area and Position	# of FTEs
Key Leadership	
Executive Director	1.0
Project Manager	1.0
Provider Relations Liaison	1.0
Medical Director	1.0
Utilization Management Manager	1.0
Quality Improvement Director	1.0
Behavioral Health Director	1.0
Prior Authorization Coordinator	1.0
Child Psychiatrist	1.0
Pharmacy Director	1.0
Dental Director	0.25

Functional Area and Position	# of FTEs
Hospital Based Care Managers	2.0
Provider Network Director	1.0
Provider Services Manager	1.0
Population Health Management Director	1.0
Enrollee Services Manager	1.0
Inquiry Coordinator (Ombudsman Coordinator)	3.0
Chief Financial Officer	1.0
Chief Compliance Officer	1.0
Management Information Systems Director	1.0
Clinical Services	
Manager, Utilization Management - Outpatient Services	1.0
Quality Practice Advisor	2.0
Quality Improvement Project Manager	1.0
DJJ Liaison	1.0
Community Relations Specialist	1.0
Peer Support Specialists	2.0
Masters level licensed Behavioral Health clinician	20.0
Care Coordinator	64.0
Behavioral Health Specialist	37.0
Nurse Care Manager: Medically Complex Children	8.0
Nurse Care Manager	14.0
Care Management Supervisor	8.0
Coordinator Supervisor	5.0

Functional Area and Position	# of FTEs
Appeals Coordinator	1.0
Behavioral Health UM Care Manager	3.0
Manager, Case Management	9.0
Behavioral Health UM Coordinator	1.0
Director, Clinical Management	1.0
PM Specialist, Clinical	2.0
PM Specialist, Non Clinical	1.0
Business Technical Analyst	2.0
Operational Services	
Network Development Specialist	2.0
Provider Operations Coordinator	2.0
Provider Relations Representative	3.0
Field Regulatory and Compliance Specialist	1.0
Administrative Support Staff	3.0
Manager, Field Regulatory Affairs	1.0
Instructional Designer	2.0
Business Technical Analyst	1.0
Information Technology Support Specialist	1.0
Grievance Coordinator	1.0
Member Resolution Specialist	1.0
Customer Service Representative	1.0
Escalation Coordinator	1.0
Correspondence Analyst	1.0

xii. Describe the roles and responsibilities of Care Coordinators and Care Coordination Team. How will the Contractor maintain adequate Kentucky SKY to Kentucky SKY Enrollee ratios and number of Care Coordination personnel and management staff having expertise in Physical Health, Behavioral Health, and the Kentucky SKY Enrollee to build Care Coordination Teams? Provide the Contractor's approach to locating the Care Coordinators areas in which they serve.

ROLES AND RESPONSIBILITIES

WellCare will assign each Enrollee a Care Coordinator and interdisciplinary Care Coordination Team (CCT) based on their specific needs within one business day of enrollment in Kentucky SKY. To meet individual Enrollee needs, we will assign Care Coordinators as follows:

- An RN Care Manager will be assigned as the Care Coordinator for Enrollees with complex medical needs, including but not limited to those with a Medically Complex designation from the Office of the Commission on Children with Special Health Care Needs.
- A Behavioral Health Care Manager will be assigned as the Care Coordinator for Enrollees with complex behavioral health needs.
- A Health Coach will be assigned as the Care Coordinator for Enrollees with low and moderate needs.

The CCT will include clinical and non-clinical representatives to meet the individual needs of Enrollees. For example, the CCT for a moderate risk Enrollee with well-controlled depression will include a Behavioral Health Care Manager or Behavioral Health Specialist who can provide appropriate support to the assigned Care Coordinator in assessing and monitoring the depression and integrating any treatment within the Enrollee's overall care plan. Other CCT support will include our Field Outreach Coordinators working onsite at DCBS regional offices (and at DJJ facilities when needed) to conduct initial outreach and engagement with new Enrollees, and Transition Coordinators and Youth Peer Support Specialists to assist with transition age youth and former foster care Enrollees. Additionally, our Family Peer Support Specialists will assist the CCT to provide support for foster and adoptive families.

The roles and responsibilities of WellCare's Care Coordinators and CCTs for Kentucky SKY align with the standards of health case management for children and adolescents in foster care outlined in the American Academy of Pediatrics' Healthy Foster Care America. Established by a multidisciplinary task force of experts, these guidelines are intended to result in the integration of the health care plan with the foster care permanency plan and ensure delivery of "high-quality, comprehensive, and coordinated health care". We have built our Kentucky SKY Care Coordination Program to incorporate these guidelines, which mirror and complement Department requirements for the Care Coordination function.

The most important role of our Kentucky SKY Care Coordinators and CCTs is serving as the advocate for the Enrollee and family. As such, our Care Coordination staff are responsible to encourage and support Enrollee and family voice and choice throughout the Care Coordination process and across the system of care. They are also responsible for ensuring all needs are identified and met through timely access to an integrated continuum of services and supports

to improve health outcomes and achieve stability and permanency. Advocacy also includes promoting trauma-informed care and approaches among all Department, DCBS, and DJJ staff, providers and stakeholders involved with the Enrollee's care and services.

Below we summarize roles and responsibilities, which are described in detail in our responses throughout this proposal.

Care Coordinators

Care Coordinators serve as the lead member of the CCT and the key point of contact with DMS, DCBS, and DJJ, the Kentucky SKY Enrollees, Adoptive Parent(s), Caregivers, Fictive Kin, and providers. The Care Coordinator is responsible for:

- Initial outreach to new Enrollees and their caregivers, in coordination with DCBS/DJJ, to screen for immediate and urgent needs.
- Convening Assessment Team meetings, as needed, to support Enrollee needs and facilitating completion of comprehensive needs assessments, to include all required assessments and screenings and mandated timeframes (including EPDST periodicity) as specified in the Contract and in the SOP Manual.
- Leading development of a care plan which identifies the Enrollee's Care Coordination needs within 30 calendar days of enrollment (or sooner as needed). This includes involving, educating, and coordinating with the multidisciplinary team (MDT) which includes Enrollees, caregivers, PCP, dental provider, behavioral health (BH) provider, other specialist, and ancillary providers, other stakeholders as approved by DCBS, and DCBS/DJJ.
- Ensure the Care Coordination Team has the information it needs to make timely and appropriate authorizations and referrals to meet Enrollee needs. This includes, but is not limited to, contacting prior MCOs and providers for information the Care Coordination Team may need to work with current providers to develop treatment plans.
- Ensure that approved Care Plans and authorizations are communicated timely to providers, DMS, DCBS, and DJJ as required.
- Ensure that Enrollees, providers, Foster Parents, Adoptive Parents, Fictive Kin, Caregivers, DCBS and DJJ have the most current information regarding community resources available to assist Enrollees with meeting their needs and assist Enrollees with connecting with these resources.
- Conduct ongoing monitoring and follow-up to evaluate Enrollee progress and identify new or changed needs.
- Oversee regular review of the care plan with updates as needed, in conjunction with the MDT.

Care Coordination Team

The CCT is comprised of a group of professional WellCare staff with targeted qualifications and backgrounds that align with the individual Enrollee's needs, including:

- Master's level Behavioral Health Clinician

- RN Case Manager
- Behavioral Health Specialist
- Family Peer Support
- Youth Peer Support
- Health Coach

CCTs are supported by additional clinical and non-clinical WellCare resources such as our Medical and Behavioral Health Medical Directors, Pharmacy director and staff, Utilization Management nurses, and administrative support staff.

The CCT will coordinate care and services for the Enrollee in collaboration with DMS, DCBS, and DJJ. This will include meeting quarterly with DCBS to identify, discuss and resolve any health care issues and needs of our Kentucky SKY membership, and consulting with DCBS before the development of a new case management plan (on a newly identified health care issue) or modification of an existing case management plan. The CCT will also assist our leadership team in development of business processes and workflows in collaboration with DMS, DCBS, and DJJ, including those related to the transmission of Kentucky SKY Enrollee information. The CCT works under the direction of the Care Coordinator to:

- Assist Enrollees and families to navigate the health care system, coordinating all necessary health assessments within specified timeframes and ensuring required access to provider appointments.
- Involve and include the preferences of the Enrollee, Adoptive Parent(s), Foster Care Parent(s), Caregivers, and Fictive Kin in Care Coordination processes, care planning, and Care Plan implementation.
- Provide information to and assist providers, Enrollees, Foster Parents, Adoptive Parents, Fictive Kin, Caregivers, and DCBS and DJJ staff with Care Coordination services.
- Ensure access to primary, dental and specialty care and support services, including assisting Enrollees, Foster Parents, Adoptive Parents, Fictive Kin, Caregivers, and DFCS and DJJ staff with locating providers, and scheduling and obtaining appointments as necessary.
- Expedite scheduling of appointments for assessments and facilitating providers' timely submittal of assessment results used to determine Residential Placements as requested by DCBS and DJJ.
- Compile assessment results used to determine Residential Placements as requested by DCBS and DJJ and submitting those results to the appropriate DCBS or DJJ staff within the timeframes identified by DCBS or DJJ or otherwise specified in the Contract.
- Assist with coordinating NEMT services for Enrollees as needed for provider appointments and other services.
- Arrange community supports for Enrollees and arrange for referrals to community based resources as necessary.

- Document efforts and barriers to obtain provider appointments, arrange transportation, establish meaningful contact with the PCP, Dental provider, specialists and other providers, and arrange for referrals to community based resources.
- Collaborate with PCPs and specialists of prior MCOs to ensure continuity of care for Enrollees with Special Health Care Needs receiving services authorized in a treatment plan by their prior MCO.
- Provide Care Coordination services at a level of intensity to meet Enrollee needs as indicated by stratification and according to the requirements for each case management tier.
- Proactively provide discharge planning, including a comprehensive evaluation of the Kentucky SKY Enrollee's health needs and identification of the services and supplies required to facilitate appropriate care following Discharge from an institutional clinical setting or when transitioning between levels of care.

Maintaining Adequate Ratios, Number of Staff, and Expertise

WellCare has extensive experience maintaining ratios and number of Care Coordination personnel and management staff with the expertise necessary to provide effective services and support to Enrollees that are similar to the KY SKY population in the intensity of their needs and level of multi-system involvement. This includes but is not limited to medically complex children and youth in child welfare systems in seven other states in addition to Kentucky.

Based on this experience, we have developed a staffing plan with ratios and number of staff based on factors such as:

- The need to initiate Care Coordination as soon as possible and ideally within 24 hours of the court order.
- Our plan to conduct a face-to-face visit with all children and youth coming into the foster care system within five to seven days for those with immediate needs and within 30 days for all others, based on the need to assume that all new Enrollees are high risk and have complex needs
- The need for a higher intensity of Care Coordination services than for other populations, such as more face-to-face interaction with Enrollees, DCBS, and DJJ; more frequent monitoring than traditional child population; and more frequent participation in rounds and staffing to develop discharge plans and support placement stability and permanency.
- More and changing stakeholders with whom to coordinate to ensure Enrollee needs are identified and met.

Our staffing plan establishes an overall Enrollee to Care Coordinator ratio based on stratification of the enrolled population. We will use ratios of 12:1 for our Complex and Medically Complex care coordination tiers; 35:1 for our Intensive tier; 200:1 for our Standard tier; and 500:1 for Health Coaching.

Our Human Resources team will be responsible for implementation of our recruitment and hiring plan. In addition to education, experience, licensure, and qualifications for Care

Coordination and Case Manager positions to ensure applicable physical health, behavioral health, and other necessary expertise, we will seek to hire individuals who demonstrate a true personal commitment to serving these children/youth and their families. We will require experience or detailed knowledge of the Foster Care and juvenile justice systems, Adoption Assistance, the delivery of Behavior Health Services, Trauma-informed Care, ACEs, Crisis Intervention Services, and evidence-based practices applicable to the Kentucky SKY populations. Our intensive Kentucky SKY staff training program, with initial and ongoing components as described in detail in our response to Question 4, will enhance and supplement the knowledge of our Care Coordination management and staff.

To ensure we have adequate ratios and number of staff with necessary expertise, we will use ongoing audits to evaluate staff performance against contract requirements. Monthly, our Audit staff will review records for three Enrollees (selected randomly) to assess staff ability to complete Care Coordination functions in a timely manner and in compliance with all requirements. The audit also will look for evidence of integration across the CCT as well as Field Outreach Coordinator coordination with the DCBS/DJJ caseworker as documented in the Enrollee record. If the audit finds the Care Coordinator or member of the CCT has not met requirements and expectations, the Auditor reviews three additional Enrollee records for that staff member and uses the combined score to determine compliance. Results are reviewed by the Care Coordination Manager to identify staff that need improvement and implementation of corrective action. For staff that need improvement, a Care Coordination Supervisor provides coaching and retraining and as needed review of and mentoring for daily work. That staff member is audited monthly until performance meets requirements. If the staff fails subsequent audits, corrective action is escalated up to and including termination. Additionally, audit results are part of individual staff goals that are taken into account for Mid-year Review and Annual Review and can play a role in merit increases.

The Care Coordination Manager also reviews combined audit results to identify departmental trends that indicate the need for retraining or changes to ratio/numbers of staff. Trends are discussed on our monthly Care Coordination department call, with retraining provided when indicated. If trends indicate the need to consider changes to staffing ratio or numbers, the Care Coordination Director develops a plan to make the change including any immediate hiring needs. In 2018, our monthly Care Coordination audits averaged over 98% compliance.

In addition to staff oversight, we will regularly evaluate overall performance of our Care Coordination Program based on operational, quality, and Enrollee outcome metrics to identify additional hiring needs. This will occur through our Quality Assurance and Performance Improvement program ongoing monitoring and Annual Evaluation.

Our Care Coordinators and CCTs will receive support from other clinical and non-clinical staff. For example, we will assign administrative support staff to CCTs to allow Team clinicians to operate at the top of their license rather than spend time on tasks that can appropriately be performed by unlicensed individuals. In addition, we will provide support through WellCare Kentucky SKY personnel including the SKY Medical and Behavioral Health Medical Directors, our Pharmacy Director, and utilization management staff. These individuals will provide additional

support to enhance the clinical expertise and coordination assistance available to DCBS, DJJ, Enrollees, caregivers, families, and providers.

Workforce Development to Maintain Staffing Adequacy

WellCare is heavily involved in workforce development in Kentucky, partnering with the Kentucky Community Technical College (CTC) system, University of Louisville, and others to develop and invest in programs that benefit the Commonwealth while also supporting our own staffing needs. We will enhance our current efforts to ensure a strong pipeline of qualified candidates for our Kentucky SKY Care Coordination positions. Examples include the following.

- WellCare partners with the University of Louisville's Kent School of Social Work to fund scholarships for ten students each year. We work with the Kent School to offer training to their students on trauma informed care, and routinely post open positions to their graduates. We are expanding this partnership to further support development of a future Care Coordination workforce, such as creating certificate programs in relevant topics such as trauma-informed care and recover and resiliency support.
- WellCare has collaborated with DCBS and DJJ to develop and implement an education-to-work program focused on educating the WellCare workforce on the state system of care, collaboration, and required operating procedures for DCBS and DJJ staff.
- WellCare currently provide scholarships to students at Hazard CTC and Kentucky 1 East working toward relevant degrees or certifications in areas such as nursing.
- We will work with the CTC system and other post-secondary programs to host job fairs and information sessions throughout the Commonwealth to support our hiring of staff with appropriate expertise who live in the regions we serve.

Ongoing Criminal Background Checks

Our Human Resources Department will complete criminal background checks for all required and shared Well-Care Kentucky SKY personnel. This will occur upon hire and every two years thereafter and include verification with sexual offender registries. WellCare also requires drug testing for all staff with any Enrollee contact. This occurs upon hire, annually, and as needed when there are indications of drug use.

WellCare will not place any staff in contact with Kentucky SKY Enrollees, permit staff to access Kentucky SKY Enrollee information, or co-locate staff in DCBS Service Region offices until Human Resources verifies with the appropriate Department Directors that the initial background check and drug test are complete and the staff has passed both. Additionally, no staff will be permitted contact with a Kentucky SKY Enrollee or have access to their information if they have not passed a background check or are alleged to have committed a criminal offense that would prohibit him or her from having contact with Kentucky SKY Enrollees or accessing their information.

Approach to Locating CC Teams in Areas They Serve

WellCare already locates Care Coordinators and CCT in the areas they serve. Because our CC staff for this population is field based, it offers the increased flexibility to work in any environment including DCBS offices, PCP offices, provider offices, foster homes, and family homes. Our staff are assigned to one of our six offices across the Commonwealth, but work from the field. We will expand on our successful field-based approach to locate Field Outreach Coordinators, Care Coordinators, and CCT staff statewide in the Service Regions and Community Districts in which they serve.

We will collaborate with DCBS and DJJ to develop a plan for our staff to locate in their regional offices, including scheduling times staff will be onsite. We propose to have a Field Outreach Coordinator and Care Coordination staff onsite at all nine DCBS regional offices and availability to be onsite at all DJJ Community District offices. See our responses to Questions 3 and 10 for additional detail.

G.2 Company Background

- Attachment G.2.c.iv Key Personnel Resumes

WELLCARE OF KENTUCKY SKY KEY PERSONNEL RESUMES

Below, we provide resumes for our SKY key personnel including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Per the Addendum, we have provided job descriptions (in Section G.02.C.iv.a) in lieu of resumes for those Full Time Kentucky SKY Key Personnel positions for which we are currently recruiting and will be hired post-award.

Title	Name	Office Location	Employee or Subcontractor
Project Manager	Bob Diver	Louisville	Employee
Executive Administrator	Lori Gordon, LCSW, MBA	Bowling Green	Employee
Medical Director	To be hired upon contract award	TBD	Employee
Quality Improvement (QI) Director	Kathryn Miller, LCSW, CCM	Louisville	Employee
Behavioral Health Director	Timothy Houchin, MD, MHCDS	Louisville	Employee
Utilization Management Manager	To be hired upon contract award	TBD	Employee
Nurse Case Managers	To be hired upon contract award	TBD	Employee
Masters level licensed Behavioral Health clinician	To be hired upon contract award	Field Based	Employee
Nurse Care Manager to assist Kentucky SKY Enrollees designated as Medically Complex Children	To be hired upon contract award	Field Based	Employee
Behavioral Health Specialist with at least five (5) years of Behavioral Health experience	To be hired upon contract award	Field Based	Employee
Family Peer Support Specialist and/or Youth Peer Support Specialist	To be hired upon contract award	Field Based	Employee
Care Coordinator	To be hired upon contract award	Field Based	Employee
Prior Authorization/Pre-Certification Coordinator	To be hired upon contract award	TBD	Employee
Provider Relations Liaison	Leann Magre, MSSW, MBA, LCSW, CCM	Louisville	Employee

BOB DIVER – PROJECT MANAGER

Bob Diver is an experienced Senior Leader with over 17 years' experience working in strategic planning, IT infrastructure, program management, cyber security, staff leadership and financial management in both private and public sector. Within his current role, Mr. Diver drives both strategic and tactical initiatives through pre-close due diligence, assessment and execution of business integrations and new market programs across the enterprise to opportunize on synergies across the business, increasing revenue to meet company objectives. Provides leadership and direction to matrixed teams to ensure the successful completion of strategy, work streams and execution of integrations.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE HEALTH PLANS, INC. – TAMPA, FL

Senior Director of Integrations (2016 – Present)

- Directing multiple large integrations and successful execution of identified strategies through close collaboration with all impacted internal departments and external companies to ensure all supporting processes, programs, and structures are optimized and implemented in accordance with agreed upon commitments across multiple locations
  - Serves as a trusted resource in business planning, organizational planning, financial performance and initiatives related to integration activities. Provides interim leadership for acquired businesses or new growth until permanent leadership is established and serves as a trusted adviser with business leaders and IT.
  - Responsible for actively planning, overseeing and delivering the strategic integrations of acquisitions and new market start-up programs across the enterprise from due diligence or RFP through the final stage of the integration or launch of the new market.
  - Drives both strategic and tactical initiatives through advanced skills in strategic planning, change management, issue resolution, and program management.

OPTUM TECHNOLOGY, INC. – PLYMOUTH, MN

Director of Mergers & Acquisitions, Mergers & Acquisitions Division (2015 – 2016)

- Led integrations of eight separate Acquisitions to Optum's managed technology network, systems, applications and processes cultivating collaboration and partnerships across multiple business units, business partners, clients and vendors.
  - Successfully re-aligned a 12-month behind and over-budget large scale acquisition with $305 million in revenue and 11,000 users.
  - Regained confidence with business stakeholders, with business partners to identify business processes, re-energized the scope across 9 workstreams, identified show-stopper dependencies, provided solutions, and developed deployment plans to meet business roadmap
  - Created a transformative organization with a focus on quality delivery, developing people and processes to deliver results, drive growth and reduce expenses.

OPTUM TECHNOLOGY, INC. – PLYMOUTH, MN

Director of IT Infrastructure Project Management, Project Management Office (2011 – Jan. 2015)

- Brought in to drive all efforts to migrate disparate legacy systems and environments into a shared managed services business model and enhance the delivery of information systems

services to all divisions. Based upon success, recruited by leadership to turnaround the Advanced Persistent Threats (APT) Program for the Information Risk Management Division. Hold direct management responsibility for 6 senior project / program managers and up to 100+ resources through 15 dotted line reports.

- Successfully turned around 6-month behind and over-budget Advanced Persistent Threats (APT) Program. Led the deployment of new secure workstation endpoints for engineering team accountable for rewriting the Healthcare.gov federal health insurance marketplace site.
  - Within a week, conducted a complete assessment of issues and capabilities, redefined the business goals, established new project plan, and restructured and led team in achieving aggressive deadlines.
  - Regained confidence with business stakeholders, led joint-workshops with business partners to identify business processes, re-energized the scope across 30 workstreams, identified show-stopper dependencies and provided solutions, and developed deployment plans to meet business roadmap.
  - Managed efforts of over 50 subject matter experts, a program budget of $5M, and technology implementation through the design, build, test, deployment, and compliance phases.
  - Conducted program reviews with impacted business and senior leadership. Developed executive scorecards
- Recipient of the United Health Care Shadow Caster Award (2013 & 2014)based upon annual feedback from direct employees on management effectiveness and employee engagement for achieving a leadership rating of 100%, exceeding the company average by 17%. Earned personal recognition by the CEO.
  - Built a high-performance team of 15 project and program managers recognized for guiding the achievement of availability, integrity, security, performance, and recoverability goals.
  - Improved portfolio planning by implementing capacity / capital estimating strategies and creating business partnerships.
  - Established an effective framework for capturing business requirements and service level requirements for the procurement and deployment of infrastructure to global Data Centers and business partners.

STATE OF MINNESOTA, OFFICE OF ENTERPRISE TECHNOLOGIES – ST. PAUL, MN
IT Product Manager (2009 – 2011)

- Core member of leadership team that established the IT infrastructure / business information capability strategies and new scalable shared services model that greatly reduced costs and improved revenue generation.
  - Defined new portfolio of IT services leveraging centralized, shared, and decentralized operations that encompassed co-location, Mainframe / Distributed / Virtual platforms rationalization and centralization, storage, and databases.
  - Led the creation of new action / orderable service catalog for all platforms, storage, and data centers co-provisioned within the organization.
  - Drove the negotiation of favorable contracts with hardware and software vendors that resulted in $20M in savings within 2 years. Deployed the on-demand provisioning framework and transformed the finance structure from a capital expenditure model to an operational expenditure model.

- Provided the leadership to identify and resolve strategic, technology, and finance issues that had prohibited the Data Center consolidation efforts.
  - Defined the strategy and execution roadmap to replace 38 Tier 1 through Tier 4 Data Centers with 2 Data Centers.
  - Established the strategic direction to reduce server footprint from 5,000 physical servers to 400 virtual servers.

THOMAS REUTERS, INC. – EAGAN, MN

Manager of Technology, IT Portfolio and Inventory Management – Professional Division (2006 – 2009)

- Defined, deployed, and aligned IT Portfolio and Inventory Management framework with complex business needs.
  - Spearheaded the development of new IT Portfolio Management group to manage the provisioning, configuration, delivery and tracking of more than 3,000 yearly assets across 3 Data Centers.
  - Built IT Portfolio Management reporting framework to provide scorecards to business, increasing overall customer satisfaction from 10% to 93.8% within 6 months.
  - Established an Inventory Management Model to forecast future technology needs and enhance the on-time acquisition of assets for business.
  - Facilitated the capture of funding, and establishment of dedicated staff providing optimal support to new organization.
  - Led the creation of new demand management tool to automatically track all server, storage and networking assets provisioned within the organization, and developed a forecasting delivery data model based on current available resources and technical complexity, increasing on-time delivery from 10% to 94%.
  - Negotiated contracts with Sun, HP, IBM< and Insight partners that reduced costs and increased on-time delivery.
  - Developed and deployed a decision-support framework, providing executive leadership with an 18-month high-level integrated view of all programs and project across 3 PMO organizations.
- Defined strategy, assembled team of 35, and led the configuration and deployment of 1,200 servers within 5 weeks.
  - Developed lessons learned and implemented new processes to maximize the on-time delivery of servers for new projects.
  - Standardized server build provisioning processes, reducing build times from 90 days to 5-10 days.
  - Established standard base configurations based on key systems and standardized new hardware selection with existing divisional standards,.

THOMAS REUTERS, INC. – EAGAN, MN

Thomson Reuters, Inc.: Manager of Project Management Office – Professional Division (2005 – 2006)

- Built a formalized Project Management Office (PMO) structure. Defined the mission, developed the strategy, and built the framework to ensure the delivery of value-driven solutions.

- Restructured and expanded project management team to effectively support business needs. Spearheaded comprehensive training and mentoring programs for project managers based on Project Management Institute's principles and best practices. Directed team in achieving PMP credentials.
- Developed, implemented and facilitated the adoption of an internal Project Management Life Cycle (PMLC) methodology within Data Center operations, providing an effective means to define, track and rollout key initiatives.
- Aligned PMLC methodology with ITIL and CMMI processes to enhance integration across business development life cycle. Instituted a project dashboard for the individual business units that enhanced visibility and decision-making.
- Developed and managed Service Level Agreements (SLAs) within the Data Center, enabling business to monitor and control capacity of applications and hardware availability.

DONALDSON COMPANY – BLOOMINGTON, MN

Thomson Reuters, Inc.: Manager of Project Management Office – Professional Division (1995 - 2005)

- Brought on to oversee the design, deployment and management of emerging technologies into engineering organization to centralize key processes and reduce costs. Collaborated with business leaders and technical teams to develop, test and implement CAD/CAM/CAE systems and interfaces to enhance collaboration between engineering, manufacturing and customers throughout China, India, Japan, Mexico, and North America. Managed team of 8.
- Built the team, defined the standards, and drove the evaluation, selection, implementation, customization, integration, and management of software applications and associated infrastructure that enhanced collaboration and innovation.
  - Directed the rollout of software to engineering organizations globally that improved teams' agility to quickly respond to customers' needs, increasing overall productivity while reducing cycle time to completion.
  - Built the Services and Support Organization and established and managed Global Service Level Agreements (SLA), increasing on-time delivery of IT services from 65% to 99%.
  - Implemented a centralized license management framework and tool supporting 4 sites to track and trend usage, resulting in the reduction of license purchases and $60-75K in yearly savings.
  - Owner of one US and one global patent, "Restriction Indicator for an Air Cleaner of an Internal Combustion Engine", a new product for the organization.

PRATT & WHITNEY GOVERNMENT ENGINE AND SPACE PROPULSION – WEST PALM BEACH, FL

Human Factor Simulation Engineer / Design Systems Support Specialist / Design Systems Integrator / Designer (1988 – 1999)

- Designed and implemented systems, environments, and solutions to strengthen data exchange with customers and enable the delivery of critical solutions to clients.
  - Built the virtual lab for the Virtual Reality F22 Program to design of electronic tools for virtual human simulation.
  - Spearheaded the design of a data communication process improvement strategy for the Joint Strike Fighter Program, reducing notification timeframe from 28 days to 30 minutes that was adopted as the standard.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Bachelor of Science in Management Information Technology – Cardinal Stritch University
- Certified Project Manager — Capability Maturity Model Integration (CMMI) Certification
- ITIL Foundation and Service Level Management Practitioner Certificates — HIPAA Certification Training
- Project Management: The Complete Curriculum and Conquering Chaos — Clear Writing that Drives Successful Projects

LORI GORDON, LCSW, MBA – EXECUTIVE ADMINISTRATOR

Lori Gordon has over ten years of public sector managed care experience. She holds a Six Sigma Green Belt certification and is an excellent communicator with the ability to bring diverse ideas together. Ms. Gordon is a precise planner who translates ideas into action and an energetic manager who fosters motivation, loyalty and effective action. She is a collaborative colleague with vision, flexibility and reliability and bring with her a strong analytical and problem solving skills. Exceptional trainer with National, State and Local Experience

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Director – Behavioral Health (Jan. 2014 – Present)

Director of Behavioral Health (May 2012 – Jan. 2014)

- Responsible for the overall implementation of behavioral health services in a previously unmanaged state, including provider service development, collaboration with system configuration, and the development of both short term and complex case management structures.
- Developed integrated (physical health/behavioral health) teams including a pilot project that reduced inpatient utilization
- Excelled with key partner relationships including state government, providers and community advocates.

WESTERN KENTUCKY UNIVERSITY SCHOOL OF SOCIAL WORK

Adjunct Faculty (Aug. – Present)

HOTEL, INC (LOCAL NON-PROFIT WORKING TO END HOMELESSNESS)

Board of Directors (Jan. 2016 – Present)

MAGELLAN HEALTH SERVICES – MARICOPA, AZ

Director of Utilization Management (May 2008 – May 2012)

- Responsible for utilization management of large public sector behavioral health contract. Developed process to reduce readmission of the individuals with the highest utilization by developing community based services to meet needs.
- Achieved URAC accreditation during the second year of the contract with acknowledgement for utilization practices and clinical documentation.
- Served on national quality committee responsible for development of medical necessity criteria, inter-rater reliability studies and QI oversight.
- Instrumental in the development of integrated physical and behavioral healthcare model including the integration of electronic medical records and the development of risk stratification for physical and behavioral health conditions. Served as the conduit between clinical services and IT in the development of program software.

MAGELLAN HEALTH SERVICES

Clinical Manager (July 2006 – June 2008)

Training Lead (November 2006 – May 2008)

- Assisted in the development and implementation of the organizational and operational plans for the effective delivery of clinical services.

- Lead the clinical team in the monitoring and managing inpatient, outpatient and intermediate levels of care including ambulatory follow up and intensive recovery care management related to mental health and substance abuse treatment.
- Developed peer led recovery care management program for individuals with multiple hospitalizations and limited community support.
- Managed clinical team member performance through the review of qualitative and quantitative performance results on an ongoing basis.
- Developed and implemented overall training plan for Care Management Center including all clinical training initiatives.
- Coordinated Quality Improvement activities.
- Served as a member of the Senior Management Team.

FOUNDATION ASSOCIATES – NASHVILLE, TN
Clinical Operations Director (Aug. 2003 – July 2006)

- Directed daily operations of a treatment organization with 100+ employees and a full continuum of treatment services for the lifespan.
- Lead organization in becoming CARF accredited.
- Worked with information systems department to develop and implement electronic medical records system.
- Developed and implemented successful online training program.
- Facilitated National, Statewide and local training sessions on co-occurring disorders.

FOUNDATION ASSOCIATES – NASHVILLE, TN
Clinical Operations Director (Aug. 2003 – July 2006)

- Directed daily operations of a treatment organization with 100+ employees and a full continuum of treatment services for the lifespan.
- Lead organization in becoming CARF accredited.
- Worked with information systems department to develop and implement electronic medical records system.
- Developed and implemented successful online training program.
- Facilitated National, Statewide and local training sessions on co-occurring disorders.

NASHVILLE STATE COMMUNITY COLLEGE
Adjunct Faculty (Sept. 2005 – Dec. 2007)

- Taught the following courses:
  - Family Systems
  - Intro to Social Work

TEMPLE UNIVERSITY-SCHOOL OF SOCIAL ADMINISTRATION
Adjunct Faculty (June 2000 – May 2003)

- Taught or co-taught the following MSW courses:
  - Financial Management 1 & 2
  - Staff supervision and training

PHILADELPHIA HEALTH MANAGEMENT CORPORATION
Director CHANCES program (May 1998 – June 2003)

- Directed all operations of a women and children's outpatient substance abuse treatment program through a period of transition and expansion.
- More than doubled annual program budget.
- Developed all public and community relations materials.
- Worked with management team, managed care plans and state officials to develop and implement billing process that maintained collection ratio of more than 97%.
- Developed, implemented and evaluated staff training curriculum that was adopted organization wide.
- Developed program polices to meet all local, state and federal guidelines (Managed Care policy manual was given perfect score 4/02).
- Designed and implemented a collaborative job-training program (SUCCESS) for women in recovery.
- Assisted with the development of a client-tracking database utilized for outcome evaluation, long range planning and billing.
- Collaborated with the Treatment Research Institute to implement and evaluate CSAT and NIDA funded projects.

PHILADELPHIA HEALTH MANAGEMENT CORPORATION
Admissions Coordinator (Nov. 1997 – May 1998)

- Co-authored biopsychosocial evaluation instrument.
- Worked with project staff to test instrument reliability and validity.
- Presented instrument finding to state and local officials.
- Performed admissions assessment for all clients referred to program.

PHILADELPHIA HEALTH MANAGEMENT CORPORATION
Therapist (Oct. 1994 – May 1996)

- Provided individual and group therapy for post-partum women who were substance dependent and HIV positive.
- With collaboration of hospital committee, designed and implemented evaluation plan that led to the development of universal assessment and referral protocols for home visitation services.

RESOURCES FOR HUMAN DEVELOPMENT
Children's Outreach Services-Behavioral Services Clinician (Aug. 1996 – Nov. 1997)

- Recruited, hired and supervised 15 therapeutic support staff.
- Developed behavioral plans for children with DSM diagnosis.
- Provided Utilization Review to ensure continued care.
- Developed and implemented cost/benefit analysis that was utilized to develop program structure and long range plans.

PENNSYLVANIA EVALUATION AND RESEARCH INSTITUTE
Evaluator (Oct. 1995 – Aug. 1996)

- Evaluator for outcome study for two drug treatment facilities. ARTREACH

ARTREACH (May 1996 – Feb. 1997)

- Authored more than 30 foundation and corporate grants.
- Developed grant funding database for program use.

- Assisted in recruiting and hiring permanent development assistant.

MSW INTERN
(Sept. 1995 – May 1996)
- Worked with Associate Director of large non-profit organization.
- Provided technical assistance to start up programs that included: program development, marketing, funding and licensure.
- Worked with Veteran's Administration to develop substance abuse treatment program for long-term VA hospital residents.

FAMILY SERVICES OF DELAWARE
Health Educator (Sept. 1993 – Aug. 1994)
- Provided individual options counseling for sexually active teens.
- Classroom instruction on sexual health in public schools.

NATIONAL ADOPTION CENTER
Adoption Specialist (Sept. 1992 – Sept 1993)
- Assisted families to connect with children awaiting adoption.
- Worked with various news media to promote adoption.

BARREN RIVER DISTRICT HEALTH DEPARTMENT
Social Worker (May 1991 – July 1993)
BSW Intern (Oct. 2010 – May 1991)
- Developed teen parenting program based on needs assessment (including funding, implementation and evaluation).
- Developed all marketing and recruitment materials for teen program.
- Provided individual and group counseling for prenatal clients.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS
- MBA-2018, University of Phoenix
- Green Belt Certification, 2011: Acuity Institute
- LCSW, 2006, State of Tennessee
- LCSW, 2015, State of Kentucky
- MSW, 1996, Temple University, School of Social Administration, PA
- BSW, 1991, Western Kentucky University, KY

KATHRYN MILLER, LCSW, CCM – QUALITY IMPROVEMENT DIRECTOR

Kathryn Miller has over 25 years of experience working in the healthcare field. She has experience partnering with the DCBS, DJJ and other systems to ensure positive client experience and outcomes. Ms. Miller is also trained in Trauma Informed Care.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Manager, Quality Improvement – Behavioral Health (Oct. 2018 – Present)

- Develop and implement a pilot QI plan related to behavioral health measures including pay for performance programs and initiatives.
- Assist with identification, collection and analysis of performance measurement data including needs assessment, evaluations, root cause analysis and interventions.
- Oversees the day-to-day operations for the PCA Health Coach program entailing member outreach services to achieve quality and service driven objectives.
- Serves as an instrumental partner in monitoring and tracking key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results for assigned market(s) or state.
- Implement behavioral health operational priorities and manages resources to operational goals and budgets.
- Establish, maintain and foster professional working relationships with all behavioral health providers including community mental health centers, treatment facilities and other significant behavioral health providers in the market.
- Partner and collaborates with other departments and the corporate office regarding behavioral health matters and initiatives.
- Monitors processes and procedures to ensure compliance with contractual, regulatory (Federal/state) and accreditation entities.
- Coordinate and completes all QI activities required to meet national accreditation and regulatory performance improvement initiatives.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Senior Manager, Behavioral Health (May 2014 – Oct. 2018)

- Oversees the day-to-day operations for the Behavioral Health including activities designed to achieve quality and service driven objectives.
- Serves as an instrumental partner in monitoring and tracking key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results.
- Implement behavioral health operational priorities and manages resources to operational goals and budgets.
- Develop regular and ongoing working relationship with the community mental health system.
- Partners and collaborates with other departments and the corporate office regarding behavioral health matters and initiatives.
- Provides recommendations and support to behavioral health leadership for future expansion and growth efforts.
- Manages and optimizes workflows to achieve successful quality outcomes and benefit maximization within the scope of responsibilities.

- Monitors processes and procedures to ensure compliance with contractual, regulatory (Federal/state) and accreditation entities.
- Monitors and ensures medical expense ratios and approved staff ratios are in line with budget.
- Monitors and tracks production and quality driven work products and outcomes to individual performers.
- Manages work assignments, measures results and initiates personnel actions as required.
- Leads talent management activities to develop and cultivate future leaders.

NECCO THERAEPUTIC FOSTER CARE – LOUISVILLE, KY
Treatment Director (July 2013 – April 2014)

- Clinically and administratively supervise therapists, and masters level interns.
- Responsible for oversight of comprehensive treatment plans to ensure goals are measurable and individualized for each youth.
- Provide therapeutic supervised visits with youth in care and their biological parents to assist in meeting permanency goals along with family, individual and group therapy.
- Oversee mental health files to ensure all components meet the Office of the Inspector General expectation and ensure compliance. Assist therapists in maintaining charts that score at least 90% or higher on all internal audits for compliance. Ensure corrective action occurs when needed.
- Participate in treatment team meetings with internal and external providers, family and foster parents.

SEVEN COUNTIES SERVICES, INC. – LOUISVILLE, KY
Social Worker – Crisis Stabilization Unit (Oct. 2011 – April 2014)

- Every other weekend, provide individual, family or group therapy to promote positive replacement behaviors and stabilization of mood.
- Complete required documentation for services provided in accordance with Seven Counties Services, Inc and Impact Plus requirements.
- Communicate with other service providers to enhance team cohesion in providing treatment
- Recommend resources and other services to family and/or treatment team.

SEVEN COUNTIES SERVICES, INC. – LOUISVILLE, KY
Project Coordinator – KY Impact Therapeutic Support Program (Sept. 2001 – July 2013)

- Administrative and clinical supervisor of up to 40 part time and 4 full time therapeutic aides who provide intensive in-home services. Coordinate schedules that are self-implemented to ensure program budgetary expectations are met.
- Liaison to coordinate and ensure continuity of care across multiple programs within Seven Counties Services.
- Oversee treatment plans, client charts and other relevant documentation. Complete bio-psychosocial assessments, including mental health diagnosis.
- Recruit, hire and train new employees.
- Provide in-home clinical services, including family and individual therapy, to clients served in the therapeutic support program.
- Coordinate with utilization management to ensure that all required documentation was compliant with payer sources.

- Educate and support employees in understanding the requirements of insurance plans and managed care companies.

SEVEN COUNTIES SERVICES, INC. – LOUISVILLE, KY

Program Director (June 2001 – Aug. 2001)

- Served as liaison between clients, families, and service coordinators to maintain a successful camp experience .
- Supervised camp counselors, including scheduling, monitoring classroom activities, and training.
- Responsible for maintaining budgets for camp expenditures.

MARYHURST – LOUISVILLE, KY

Youth Counselor (April 1993 – May 2001)

- Responsible for providing structure, supervision and direction to residents of a youth treatment center for girls in the custody of DCBS, DJJ or other agencies.
- Assisted in designing treatment plans and goals for residents, as well as composing and presenting status reports to treatment team members.
- Co-leader of therapeutic groups.

UNIVERSITY OF LOUISVILLE/APPALACHIA HIDTA – LOUISVILLE, KY

Research Assistant – Department of Justice Administration (Jan. 1998 – March 2001)

- Assisted in managing a 6M budget for law enforcement agencies in Kentucky, Tennessee and West Virginia.
- Responsible for assistance in research, data collection and analysis in program evaluation, including composing evaluation reports and graphs.
- Created data collection forms and instruction sheets for all agencies involved with the HIDTA grant.
- Completed all required duties to ensure grant compliance for both the University of Louisville and funding source.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Science in Social Work – University of Louisville, Louisville KY
- Bachelor of Arts in Psychology – Bellarmine College, Louisville KY
- Licensed Clinical Social Worker-license number KY2024
- Certified Case Manager
- Trained in Trauma Focused CBT
- Trained in Process Improvement (Plan-Do-Study-Act)
- Two terms on Citizens Review Panel to assist in making policy recommendations to DCBS

TIMOTHY HOUCHIN, MD, MHCDS – BEHAVIORAL HEALTH DIRECTOR

Dr. Timothy Houchin was born and raised in Louisville, Kentucky. Upon completing his undergraduate degree outside the Commonwealth, he returned to Kentucky to complete his MD at the University of Kentucky. After practicing full-time for nearly a decade, he furthered his education by completing a Master's degree in health care policy and economics at Dartmouth. His wife is a University of Kentucky physician and they have three children.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY
Behavioral Health Medical Director (July 2018 – Present)

COMMONWEALTH FORENSIC PSYCHIATRY, PLLC DBA 360 MENTAL HEALTH SERVICES
President (March 2012 – Present)

RUTLAND MENTAL HEALTH SERVICES
Medical Director (Oct. 2014 – Nov. 2015)

PSYCHIATRIST, BLUEGRASS.ORG
Adult, Child and Adolescent & Forensic (July 2008 – Sept. 2014)

UNIVERSITY OF KENTUCKY
Assistant Professor of Psychiatry (March 2009 – Aug. 2012)

ACADEMIC APPOINTMENTS

GEISEL SCHOOL OF MEDICINE AT DARTMOUTH
Clinical Assistant Professor of Psychiatry (Nov. 2014 – Present)

UNIVERSITY OF KENTUCKY
Adjunct Assistant Professor of Psychiatry (Aug. 2012 – Sept. 2014)

RESIDENCY AND FELLOWSHIP TRAINING

UNIVERSITY OF ROCHESTER (NEW YORK), DEPARTMENT OF PSYCHIATRY, DIVISION OF FORENSIC PSYCHIATRY
Forensic Psychiatry Fellowship (July 2007 – June 2008)

UNIVERSITY OF KENTUCKY, DEPARTMENT OF PSYCHIATRY
General Psychiatry Residency (July 2005 – June 2007)

UNIVERSITY OF KENTUCKY, DEPARTMENT OF PSYCHIATRY, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
Child and Adolescent Psychiatry Fellowship (July 2003 – June 2005)

UNIVERSITY OF KENTUCKY, DEPARTMENT OF PSYCHIATRY
General Psychiatry Internship (July 2002 – June 2003)

NATIONAL COMMITTEES

- American Academy of Child and Adolescent Psychiatry – Member – Committee for Children and the Law (2015 – Present)
- American Academy of Child and Adolescent Psychiatry – Member - Committee for Juvenile Justice Reform (2014 – Present)

PROFESSIONAL MEMBERSHIPS

- American Psychiatric Association (APA)
- Kentucky Psychiatric Medical Association (KPMA)
- American Academy of Psychiatry and the Law (AAPL)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- Kentucky Academy of Child and Adolescent Psychiatry (KACAP)

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Master of Health Care Delivery Science (MHCDS) – Tuck School of Business at Dartmouth
- Doctor of Medicine (MD) – University of Kentucky College of Medicine
- AB in Chemistry, Graduated summa cum laude – Wabash College
- American Board of Psychiatry and Neurology
- Diplomate in Forensic Psychiatry
- Diplomate in Child and Adolescent Psychiatry
- Diplomate in General Psychiatry
- Diplomate National Board of Medical Examiners

LEANNE MAGRE, MSSW, MBA, LCSW, CCM – PROVIDER RELATIONS MANAGER

Leann Magre is an accomplished program developer and administrator with extensive experience in creating, implementing, managing, and monitoring programs. Results-oriented, decisive leader with proven success within child welfare, nonprofit, behavioral health, and managed care environments. Accomplished track record of collaboration with all involved systemic players in the strategy, development, implementation, and compliance of programmatic requirements, goals, and required outcomes. Skilled clinician with extensive experience in trauma informed interventions.

RELEVANT EXPERIENCE AND QUALIFICATIONS

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Sr. Manager, Foster Care, Adoption and Adult Guardianship Services (2012 – Present)

- Management and oversight of case management activities for members enrolled who are committed to the Commonwealth of Kentucky. Activities include establishing strong community partnerships with the Department of Community Based Services, the Department of Aging and Independent Living, and medical/behavioral health providers; forging collaborative relationships; establishing and monitoring programmatic standards; ensure compliance to regulatory and contractual requirements; and advocate for systemic change. Recognized subject matter expert in behavioral health, child welfare, long term support services and individuals with special health care needs.

WELLCARE OF KENTUCKY – LOUISVILLE, KY

Quality Improvement Project Manager, Behavioral Health

- Oversight of Quality Improvement activities and interventions directed to improve the behavioral health services provided to WellCare members within the Commonwealth of Kentucky. Project manager for EQRO audit and corrective action process. Additional tasks include leading specific projects and interventions, HEDIS process, and Kentucky Health initiatives as required for Kentucky contract.

FAMILY & CHILDREN'S PLACE

Child Welfare Team Leader (2006 – 2012)

- Supervising assessment and community-based, in-home services under multiple grants facilitated by the Department for Community Based Services. Skilled clinician in trauma therapy, adoption family preservation, family assessments and treatment. Grant, regulation, and accreditation oversight and compliance.

DR. JEFFREY L. HICKS, PH.D. PSYCHOLOGICAL SERVICES, MATTINGLY CENTER

Behavioral Support Specialist (2011 – 2012)

- Providing behavioral support services to individuals with intellectual disabilities and developmental disabilities. Completion of functional analysis, development and implementation of behavioral support plans.

CENTRAL STATE HOSPITAL

Principal Social Worker (2005 – 2006)

- Member of multidisciplinary team, responsible for providing social services to assigned patients.
- IMPACT Plus Program

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE
Behavioral Health Professional (2002 – 2005)

- Responsible for clinical and regulatory oversight of state-wide, community-based, Medicaid funded program. Lead in Wraparound curriculum development and training. Collaborated with Professional Review Organization to conduct utilization management determination for initial eligibility and continuing service eligibility.

MARYHURST, INC.
Admissions Manager (1998 – 2002)

MARYHURST, INC.
Family Treatment Home Program Manager (1997 – 1998)

- Team lead for the Maryhurst foster care program. Lead in foster parent recruitment, foster parent training, and clinical services for children in care.

MARYHURST, INC.
Family Treatment Home Therapist (1995 – 1998)

- Clinical therapist providing trauma informed services to foster children in care and support for their foster families.

ADANTA, LINCOLN TRAIL HOSPITAL AND SPECTRUM CARE ACADEMY
(1990 – 1995)

- Provided various trauma informed therapy services to children and their families at all locations.

RELEVANT EDUCATION AND PROFESSIONAL CERTIFICATIONS

- Masters of Business Administration, Public Administration, August 2017 – Keller Graduate School of Management
- Masters of Science in Social Work, December 1992 – University of Louisville
- Bachelors of Arts, Human Services, May 1990 – Lindsey Wilson College
- Licensed Clinical Social Worker
- Certified Case Manager

3. Kentucky SKY Implementation

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G.3. KENTUCKY SKY IMPLEMENTATION

a. Describe the Contractor's approach to project management, including a summary of responsibilities for project governance and how the Contractor will track action items, risks and issues, as well as contingency and mitigation plans. At a minimum, the implementation plan must include elements outlined in the RFP, for example:

i. Establishing an office location and call centers;

ii. Provider recruitment activities;

iii. Staff hiring and a training plan;

iv. Establishing interfaces to information systems operated by the Department and DCBS; and

v. Communicating with and educating Network Providers and Kentucky SKY Enrollees through a web site and required materials, and how that interaction will support program participation and program goals.

b. Describe the Contractor's approach for building relationships with DCBS staff at the Service Region and county level, and with Department for Juvenile Justice (DJJ) staff at the Community District level to support enhanced coordination of care, reduced duplication of services, and improved access to the most appropriate services to meet the needs of Kentucky SKY Enrollees. Please address education, training, communications, and process development.

G.3. KENTUCKY SKY IMPLEMENTATION

WellCare of Kentucky will comply with the Department of Medicaid Services' expectations and requirements as specified in Section 41.6.4 Kentucky SKY Implementation Plan in Draft Medicaid Managed Care Contract in and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**.

WellCare of Kentucky is an experienced managed care partner that has successfully completed all required readiness reviews for the Kentucky Medicaid Managed Care Contract as well the successful implementation of new populations and program changes, quickly and efficiently with minimal Enrollee and provider issues and impacts. On a corporate level, WellCare Health Plans, Inc. (WellCare) implementations encompassed more than 1,880,000 Enrollees over the last eight years, as illustrated in **Figure G.3-1.**

WELLCARE IMPLEMENTATION EXPERIENCE

The total is more than **1,880,000** members over 10 years.

Implementation Description	2019	2018	2017	2016	2015	2014	2013	2012	Pre 2012	Number of members Transitioned
WellCare Transition of Florida children with special healthcare needs, including foster care, to our statewide Children's Medical Services (CMS) Health Plan	✓									68,000 members
Staywell Transition of Florida Medicaid members, including the SMI and LTSS populations	✓									78,000 members
Harmony Health Plan Statewide Medicaid expansion into all Illinois counties		✓								190,000 members
Care 1st Health Plan Arizona Transition of Arizona members		✓								100,000 members
Missouri Care Statewide expansion of Medicaid managed care into all 115 counties			✓							179,000 members
WellCare of Nebraska Statewide implementation of Medicaid managed care for Heritage Health			✓							70,000 members
WellCare of South Carolina Transition of Medicaid members from Advicare Corp.				✓						30,000 members
WellCare of New York Statewide carve-in of behavioral health services for adult Medicaid members				✓	✓					71,000 members
WellCare of New Jersey Transition of 46k Healthfirst members & implementation of LTSS program						✓				46,000 members
Staywell Transition of Florida Medicaid members from FFS due to mandated managed care						✓				394,000 members
WellCare of Kentucky Transition of 43k members due to realignment of MCOs (open enrollment): enrollment of 28k members (Reg 3 expansion)							✓	✓		71,000 members
WellCare of Kentucky Transition of members due to realignment of MCOs							✓			63,000 members
`Ohana Health Plan Statewide implementation of the Hawaii QExA, QUEST and CCS programs								✓	✓	30,000 members
WellCare of Georgia Transition of Medicaid members									✓	490,000 members

Figure G.3-1 WellCare Implementation Experience (prior to 2020)

Our accomplishments serving the Commonwealth of Kentucky during other Contract implementations include:

2011 Kentucky Medicaid Managed Care Contract: This new Contract was awarded July 2011 for the entire state except Region 3. Project go-live was November 1, 2011 with all requirements being met to pass readiness review and begin operations. This was a four-month implementation for WellCare of Kentucky, a full market standup, and the first time there was a statewide Managed Care Program in the Commonwealth.

2013 Kentucky Medicaid Managed Statewide Contract and Medicaid Expansion: In 2013, we moved to a statewide Contract that included Region 3 and added Medicaid Expansion Enrollees. The Commonwealth awarded the Contract in October 2013, bringing Region 3 and Medicaid Expansion Enrollees onboard for a January 1, 2014 go-live. A separate readiness review occurred for the Medicaid Expansion population. WellCare of Kentucky accepted 45,000 Medicaid Expansion Enrollees at go live. In addition, we transitioned 71,000 Enrollees to WellCare of Kentucky from another managed care organization (MCO) in an expedited timeframe, along with all required transition of care elements.

2015 Kentucky Medicaid Managed Care Contract Rebid: A renewal Contract was awarded July 2015 with a go-live of November 2015. WellCare of Kentucky continued serving Medicaid

Enrollees and our on-going operations continued seamlessly with uninterrupted care for our Enrollees

2018 Kentucky HEALTH Readiness: WellCare of Kentucky was fully prepared for the Kentucky HEALTH implementation July 1, 2018 when a federal judge delayed program implementation on June 30--the day before go-live. Consequently, WellCare of Kentucky staff spent the weekend reverting the system to the pre-waiver implementation state with minimal disruption to Enrollees. As part of this anticipated implementation, we conducted prospective education in communities throughout the Commonwealth, including four provider forums and nine stakeholder engagement meetings. We also conducted weekly webinars during the monthly of June. These webinars covered all Kentucky HEALTH topics and had an average weekly attendance of 325. We received feedback that providers and the stakeholder community received these educational efforts favorably around this major program change.

2019 Kentucky SKY Bid: We anticipate a go-live of January 1, 2021. We will conduct the Kentucky SKY Implementation in the same professional and thorough manner as our previous Kentucky implementations, applying all of our experiences, lessons learned, and best practices, which we have acquired and adopted. WellCare of Kentucky plans to use the same implementation approach we took in the past under the Kentucky Medicaid Managed Care contracts, which we completed on time.

a. Describe the Contractor's approach to project management, including a summary of responsibilities for project governance and how the Contractor will track action items, risks and issues, as well as contingency and mitigation plans. At a minimum, the implementation plan must include elements outlined in the RFP, for example:

i. Establishing an office location and call centers;
ii. Provider recruitment activities;
iii. Staff hiring and a training plan;
iv. Establishing interfaces to information systems operated by the Department and DCBS; and
v. Communicating with and educating Network Providers and Kentucky SKY Enrollees through a web site and required materials, and how that interaction will support program participation and program goals.

WELLCARE OF KENTUCKY'S APPROACH TO PROJECT MANAGEMENT

Our Kentucky SKY Implementation Plan supports the successful implementation of all the requirements outlined in the Kentucky Medicaid Managed Care Request for Proposal (RFP) and Medicaid Managed Care Draft Contract requirements for Section 41, "Kentucky SKY Program."

Our approach to project management calls for an alignment of dedicated resources across the WellCare organization and our WellCare of Kentucky SKY leadership team, our Project Management Office (PMO), and Business Area Teams. They serve as the subject matter experts and stewards for the new Medicaid Managed Care Kentucky SKY Contract implementation and requirements.

Upon Contract award, our primary focus to align expectations around project meetings, 30, 60, 90, and 120-day deliverables, key milestone dates, and requirements. As documented in the Project Initiation section of the Implementation Plan, we assign a dedicated Project Management Team, including a dedicated Readiness Manager responsible for all readiness review activities. The Readiness Manager works hand-in-hand with the Kentucky PMO, in close collaboration with the Department's Readiness Team, and in unison with our Compliance and Regulatory Affairs Team to usher policies and procedures and other deliverables through the Department's review and approval process. Our Readiness Manager provides oversight for the overall readiness review process and is in direct contact with our Business Owners and Business Leads for required updates and revisions to policies and procedures and other deliverables, as well as requirements and evidence for Desk Readiness and the Onsite Readiness Review.

Other Project Initiation activities include engaging with business leads and subject matter experts from each of our business areas to conduct a GAP requirements assessment of the Medicaid Managed Care Kentucky SKY Contract and Appendices, and document any important information about each of the requirements and assign business owners for accountability. All GAP Assessment findings serve as input to the final and baselined Implementation Plan.

Our draft Implementation Plan is based on the Procurement Milestone dates in **Table G.3-1.**

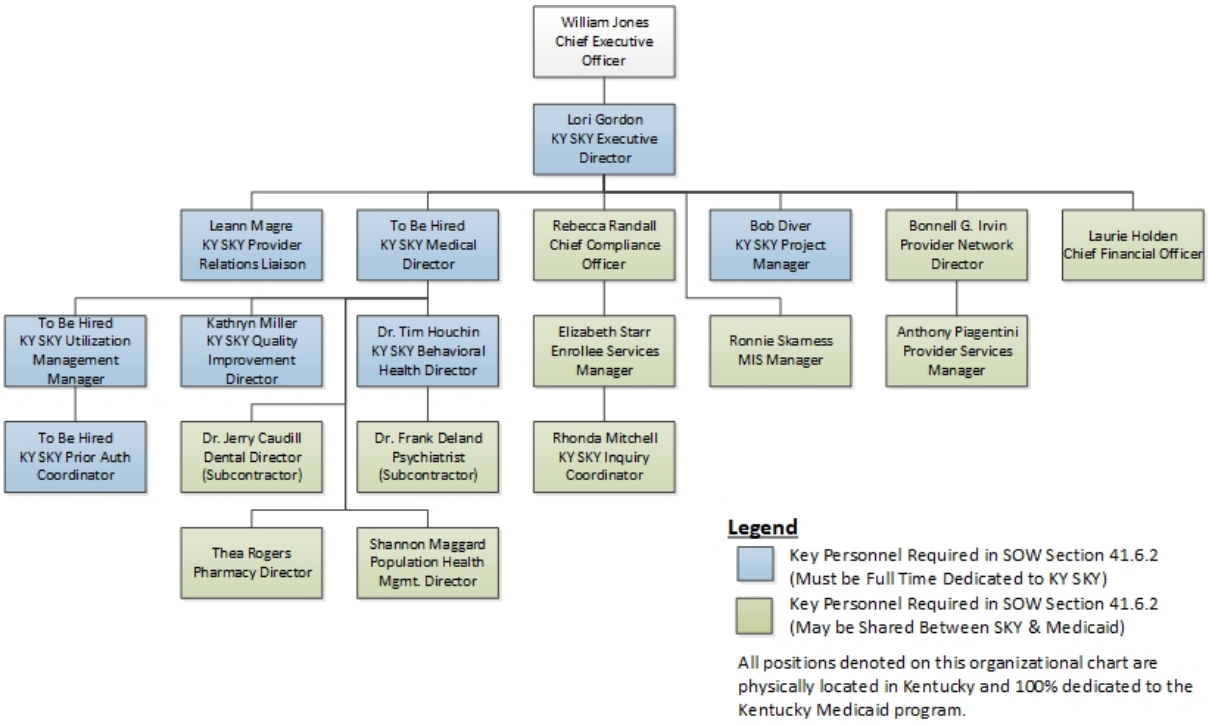
Table G.3-1 Implementation Plan Procurement Milestones

Procurement Milestones	Start Date	Finish Date
Kentucky Request for Proposal Posted	1/10/2020	1/10/2020
Kentucky Proposal Response Submission	2/7/2020	2/7/2020
Kentucky Contract Award Date	Spring 2020	Spring 2020
Kentucky Readiness Review - Anticipated	Summer 2020	Spring 2020
Kentucky Project Go-Live Date	1/1/2021	1/1/2021
Kentucky Post Go-Live + 90-Days	1/1/2021	3/31/2021

Our PMO meets at least weekly with our business area teams to collaborate on project activities, risks, issues, action items, and updates to the Implementation Plan. The PMO provides this information to our Kentucky SKY Program Leadership Team, which meets weekly to review the overarching project status, review weekly synopsis for project status updates, and serve as the key liaison(s) with the Department. Our Program Steering Committee meet weekly to provide executive program oversight, make needed decisions, remove roadblocks, and resolve escalations.

Project Governance

As illustrated below, WellCare of Kentucky's locally based leadership team, led by Chief Executive Officer William (Bill) Jones and Lori Gordon, our Kentucky SKY's Executive Director, take ownership of our governance framework and implementation responsibilities:



The Kentucky leadership team institutes our governance framework, including the Kentucky Program Steering Committee, Program Leadership, Program Management, along with other dedicated resources across the organization and assigned to the Kentucky Implementation.

The Kentucky governance framework includes the following forums, responsibilities and purpose, meeting frequency, and participants:

Forum	Responsibilities	Meeting Frequency	Kentucky SKY Participants
Program Steering Committee	Final point of escalation Organization level conflict resolution Senior Executive program oversight	Weekly	SKY Executive Leadership in Collaboration with our Core Medicaid Team
Program Leadership	Key Executive liaison with Commonwealth Executive program oversight Accountable for overarching process/project success	Weekly	SKY Team Program Leaders in Collaboration with our Core Medicaid Team

Forum	Responsibilities	Meeting Frequency	Kentucky SKY Participants
	Review Weekly Synopsis for project status updates		
Program Management	Project oversight, leadership and strategy Strategic/Tactical direction Point of escalation/conflict resolution Cross-pillar coordination and project reporting	Weekly	Dedicated SKY Project Manager in Collaboration with our Medicaid Project Manager and Readiness Review Manager
SKY Project Ownership, Management, & Project Execution	Hands on project management organized by Business Area Maintenance of project schedule and work plans Commonwealth Project status reporting	Weekly, as needed	SKY Project Leads and Business Leads/SMEs

WellCare of Kentucky SKY Implementation Plan

We organized the Kentucky SKY Implementation Plan by business area, as shown in the bulleted list below. For each of these functional areas, we create and maintain detailed project plans, which roll-up into one cohesive master Kentucky SKY Implementation Plan.

- Project Initiation
- Readiness Review
- Office Locations and Call Centers
  - Evaluate existing office locations and call centers, space needed, location, training, and oversight
  - Evaluate Enrollee call center/customer service facilities
  - Evaluate provider call center/customer Service facilities
- Human Resources
  - Staff recruiting, hiring, onboarding, and training
  - Training development plan and delivery for external partners and key stakeholders
- Finance & Actuary
- Information Technology and Reporting
  - Establish interfaces to Department, DCBS, and DJJ information systems
- Product
- Provider Operations
- Channel Communications
  - Communication and education of Enrollees and providers through web, digital, and other channels
- Quality and Analytics
- Population Health

- Community Engagement and Unmet Social Needs
- Provider Network
    - Engage in provider recruitment activities and contracting activities
- Pharmacy
- Compliance and Regulatory
- Legal
- Project Go-Live

The Kentucky SKY Implementation Plan is validated by readiness review, where all the activities and teams come together to demonstrate our services and solutions to the Commonwealth. We will submit the final Kentucky SKY Implementation Plan at Contract award or as otherwise specified by the Commonwealth.

Track Action Items, Risks and Issues, and Contingency and Mitigation Plans

In collaboration with our Kentucky SKY leadership team, our WellCare Project Management Office continually works to identify and discuss risks, issues, and action items. We hold weekly meetings to discuss risks and document any identified risks into our Kentucky Project Risk, Action, Issue, and Dependencies (RAID) log. We keep the RAID log up-to-date during weekly meetings and produce standard weekly project dashboards and status reports.

We follow a standard five-step approach to risk management, shown in **Figure G.3-2** below.

Figure G.3-2 Risk Management Steps

Risk Identification: Risks are identified and documented in our Kentucky Project RAID log.

Risk Evaluation: The project team works together to evaluate risks for probability and potential impact to the overall implementation.

Risk Mitigation: The project team works together to determine the mitigation strategy.

Risk Contingency: The project team determines contingency plans where needed.

Risk Communication: Risks are an integral part of our weekly Executive Leadership Team meeting and status report, our Steering Committee Meeting and status report, and our Work Stream Team meetings and status reporting to ensure effective communication, timely project delivery, issue resolution, scope control, and escalation to appropriate parties when necessary.

b. Describe the Contractor's approach for building relationships with DCBS staff at the Service Region and county level, and with Department for Juvenile Justice (DJJ) staff at the Community District level to support enhanced coordination of care, reduced duplication of services, and improved access to the most appropriate services to meet the needs of Kentucky SKY Enrollees. Please address education, training, communications, and process development.

OUR APPROACH FOR BUILDING RELATIONSHIPS WITH DCBS AND DEPARTMENT OF JUVENILE JUSTICE STAFF AT THE LOCAL LEVEL FOSTERS COLLABORATION

WellCare of Kentucky's Foster Care and Adoption Program has met both regionally and locally with DCBS staff and Department of Juvenile Justice (DJJ) staff since the award of the Kentucky Managed Care Contract in 2011. During the initial 2011 implementation, WellCare of Kentucky established regional teams of associates who live and work in the regions and districts where DCBS and DJJ offices are located. We assign a WellCare of Kentucky local care coordinator to each DCBS Service Region. This care coordinator meets with his or her assigned Service Region and county level offices to establish internal relationships. These regional staff meetings occurred monthly at program go-live and now are held quarterly. Similar meetings have occurred with DJJ East and West Service Districts since the beginning of the program.

Engaging with our Partners to Enhance Coordination
In 2018, our care coordinators held almost 1,000 care planning meetings with DCBS and DJJ staff for our Enrollees in foster care.

In addition to regional staff meetings, we maintain consistent contact with DCBS leadership both monthly and quarterly to share information, ensure we are operating the Kentucky SKY program in accordance with DCBS needs and identify any emerging issues. Today, Provider Relations Liaison Leann Magre attends meetings with DJJ leadership on a quarterly basis. As we implement Kentucky SKY, we will expand on our current DJJ engagement process to include each of the Community Districts.

Beyond program level meetings, our local care coordinators have frequent Enrollee-level treatment planning meetings with Service Region, county level, and Community District staff to ensure each Enrollee is receiving the care and services he or she needs. We leverage established relationships during these meetings as we gain an understanding of our new Kentucky SKY Enrollees' existing care coordination and access needs and work together to connect the Kentucky SKY Enrollee with services without duplicating them.

Expanding These Existing Relationships As We Implement Kentucky SKY

As part of the Kentucky SKY program implementation, we will expand these existing relationships with regional staff in the Service Regions and Community Districts to address concerns, problem resolution, educational needs, and risk management for the Kentucky SKY program. Our objectives in this regional staff engagement are to:

Working Together to Solve Kentucky SKY Enrollee Needs
Our aim is to build processes so Kentucky SKY Enrollees have access to what they need in the shortest amount of time.

- Establish a collaborative partnership so that when a Kentucky SKY Enrollee is newly committed, we have the relationships and procedures established for the Kentucky SKY Enrollee/foster family/guardian to access services as quickly as possible
- Expand existing processes to further enhance communication, coordination of care and problem resolution so that Kentucky SKY Enrollees have access to the most appropriate services while minimizing duplication
- Improve access to the most appropriate services to meet the needs of Kentucky SKY Enrollees
- Identify educational needs and coordinate training with DCBS and DJJ regional leaders to enhance regional staff knowledge of the Kentucky SKY program without duplicating existing training
- Build communication and process streams between WellCare of Kentucky and local DCBS and DJJ staff as we work together to secure the best care for WellCare of Kentucky Enrollees while mitigating risks to Kentucky SKY Enrollees
- Communicate jointly established processes and workflows to regional DCBS and DJJ staff

First Step: Meeting, Educating and Building a Plan

As a first step in our DCBS and DJJ engagement plan, we will meet with DCBS Service Region and DJJ Community District leadership to educate them on what the new SKY Program means to them and the collaborative requirements that affect each individual DCBS and DJJ worker. During these meetings, we will identify the processes and procedures DCBS and DJJ regional leadership need to engage with their staff on, down to the individual worker, so there is an understanding of the Kentucky SKY MCO services that WellCare of Kentucky will offer. At this time, we confirm our understanding and then identify and address the unique and specific needs for each office. Discussion topics include:

- How we can best coordinate care under Kentucky SKY
- Where we are currently duplicating services
- Current access to care issues and methods to improve access
- Education, training, and communication between WellCare of Kentucky and the local offices
- How to leverage technology to facilitate information sharing
- Joint processes between WellCare of Kentucky and regional DCBS or DJJ staff
- Joint implementation planning
- Program risks and methods to mitigate those risks

Our Kentucky SKY project manager coordinates initial meetings, which the WellCare of Kentucky SKY Executive Director, Medical Director, Behavioral Health Director, Regulatory Affairs Manager, Provider Relations Liaison, Peer Support Youth, Peer Support Parent, DCBS Liaison, and DJJ Liaison attend.

Acting On What We Have Learned

From these meetings we develop tailored and region-specific Kentucky SKY Implementation Plans based on the needs and unique qualities of each region, with DCBS and DJJ providing direction as to how we interface with them to as we administer the MCO services required by the Contract. These region-specific implementation plans will include timelines and responsibilities to build out the necessary education, training, communications, and processes so we successfully support DCBS and DJJ regional staff, the Kentucky SKY Enrollee and foster family.

Critical components of implementation plans include**:**

Education and Training: Our aim is to supplement, not duplicate, the ongoing DCBS and DJJ training that already occur. Our primary focus here is to educate regional staff on the components of the Kentucky SKY program and how it affects their day-to-day activities. We will ask for DCBS and DJJ input and expertise as we create our Kentucky SKY training program for associates and providers.

Communication: Our DCBS/DJJ Communication Plan includes regular meeting schedules and methods of ongoing communication so it best meets the needs of regional and local staff.

Process Development: We establish and document processes that define the interactions between WellCare of Kentucky and DCBS/DJJ regional and local staff. These processes include the complete flow of information from the caseworker connected to the SKY Enrollee to DCBS and DJJ leadership.

Specific tasks we have already identified as part of our implementation planning include:

- Processes to engage with local DCBS and DJJ staff on PCP assignment so the SKY Enrollee is assigned to the PCP currently managing his or her care
- Processes for DCBS and DJJ to participate in ongoing care planning activities and interdisciplinary care coordination team meetings
- Processes to allow DCBS and DJJ regional and local staff to access SKY Enrollee records
- Requests for records, forms, and processes
- Communication plan for when an individual is committed but has not yet been enrolled in the Kentucky SKY Program, including bi-directional recommended data exchanges
- Completion of specific training with Service Region and Community District staff as required under Section 41.6.3 of the Draft Contract

Regional Meetings to Implement the Plan

Once we build a Kentucky SKY Implementation Plan (in conjunction with the regional leads), we will engage in the plans and timelines we co-developed. This will include monthly meetings with regional leaders to adjust the work plan, add to it, and be flexible as to the agency's every

changing needs. We hold meetings locally, which our regional team attends, with dial in and WebEx capabilities, adjusting meeting timeframes as needed.

These region specific implementation meetings with DCBS and DJJ staff will help us identify how we can best support enhanced coordination of care, reduced duplication of services and improved access to the most appropriate services so the needs of each Kentucky SKY Enrollee, in the shortest amount of time.

Post Implementation

Our engagement with DCBS and DJJ regional staff continues post implementation in the form of monthly meetings regarding the overall program. Enrollee-specific meetings assure services are meeting each SKY Enrollee's needs or modified to meet current needs.

Program Specific Meetings: Monthly Service Region and Community District meetings focus on concerns, problem resolution, educational needs, and risk management. These meetings occur in the regions at convenient locations for DCBS and DJJ. They are attended in-person by our regionally based teams, with WebEx and dial in capabilities offered for those who cannot attend in person. Our Kentucky SKY Implementation Plan includes discussions with DCBS and DJJ as to how we can join already scheduled meetings and training to facilitate productive engagement without adding to the already heavy workload of regional staff.

Enrollee Specific Meetings: Quarterly, or more frequently as needed, we hold meetings with DCBS staff to identify, discuss, and resolve any health care issues and needs of our Kentucky SKY Enrollees. This might include specialized Medicaid Covered Services, community services, and whether the child's current primary and specialty care providers are part of our Network. These meetings focus on identifying barriers to accessing care, specific treatment needs, or specific Kentucky SKY Enrollee populations that need stronger service options.

In accordance with Section 41.6.6, our Kentucky SKY Implementation Plan includes separate or joint monthly meetings with the Department, DCBS, and DJJ to collaborate on issues, ideas, and innovations for the efficient and economical delivery of quality services to the Kentucky SKY Enrollees. Our collaboration with DCBS and DJJ is not just around the Enrollees, it includes their families and current caregivers. Our objective is to identify systemic needs and issues, region by region, for targeted community interventions and leverage our Community Connection program for assistance with social resources.

Our collaboration efforts will assist in building out prevention services for non-committed children and their families, in conjunction with the Family First Preservation Services Act. While Kentucky SKY is not the primary care coordination entity for non-committed children, the collaborative efforts can inform the systemic needs. Kentucky SKY personnel engage key WellCare of Kentucky partners to assist with meeting the needs we identify.

4. Kentucky SKY Contractor Educational and Training Requirements

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G. 4. KENTUCKY SKY CONTRACTOR EDUCATIONAL AND TRAINING REQUIREMENTS

a. **Describe the Contractor's proposed approach for collaborating with experts including the Department, DCBS, and DJJ) to identify Provider training needs. Please include examples from other Contractor programs exhibiting collaboration with state agencies to identify training needs.**

b. **How will the Contractor ensure that the Contractor's staff and Network Providers (including but not limited to hospitals, pharmacies, and specialty Providers) receive in depth training on the Kentucky SKY program, including what is and is not allowable exchange of information in a HIPAA compliant organization, to preserve and support continuity of care. Describe how the Contractor will ensure Network Providers are aware of the requirements of the Kentucky SKY program, and how the needs of this population may differ from those of the Medicaid managed care population?**

c. **Describe how the Contractor will educate Law Enforcement Officials, the courts, judges, attorneys, and judges about the Kentucky SKY program.**

G. 4. KENTUCKY SKY CONTRACTOR EDUCATIONAL AND TRAINING REQUIREMENTS

WellCare of Kentucky will comply with the Department for Medicaid Services' (DMS) expectations and requirements as specified in Section 41.1. Scope of Services, Section 41.6.2.B.3 Kentucky SKY Contractor Staff Training, Section 41.6.3 Kentucky SKY Contractor Educational and Training Requirements and Section 41.14 Provider Services of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

WellCare of Kentucky will ensure that our staff and providers (including but not limited to hospitals, pharmacies and specialty providers) receive in-depth training on the Kentucky SKY program, its requirements and the ways in which the needs of the population served by the SKY program may differ from those of the Medicaid managed care (MMC) population. Led by our Provider Relations Liaison LeAnn Magre, who has worked with Kentucky's child welfare systems for 30 years, we will work with Kentucky and national experts to build on our current training program for staff and providers, including current foster-care specific training, to develop and deliver customized training modules. These new modules will ensure that WellCare of Kentucky staff and providers are fully prepared to work in partnership with youth and their families to transform the current system of care.

Our first step in implementing training efforts will be to develop a join plan with DMS, DCBS and DJJ to identify opportunities for content sharing, cross training, co-presenting and creating a unified approach so that the SKY stakeholders will appreciate that there are changes and new opportunities for improved health care for Enrollee in foster care or adoption assistance.

WellCare will work with the University of Louisville Kent School of Social Work to develop and implement a statewide Trauma Informed Care (TIC) training, including identifying secondary trauma, targeted to providers, community-based organizations, and law enforcement. The TIC training will be provided in communities across the commonwealth. WellCare will work with Kentucky Partnership for Families and Children to develop and implement training focused on

the youth guided, family driven engagement model, as well as the Youth and Family Leadership Academy. In addition, as the only managed care organization to meet with the National Wraparound Implementation Center through the University of Maryland, we are collaborating with them to develop a training plan for implementing the high fidelity wraparound model for care management. This process includes training for DCBS, DJJ, caregivers, providers, AA parents, judges, law enforcement, and DMS sister agencies on the implementation of this model.

a. Describe the Contractor's proposed approach for collaborating with experts including the Department, DCBS, and DJJ) to identify Provider training needs. Please include examples from other Contractor programs exhibiting collaboration with state agencies to identify training needs.

COLLABORATING WITH EXPERTS TO IDENTIFY PROVIDER TRAINING NEEDS

WellCare has a long history of collaborating with the local state agencies to identify training needs and will leverage those relationships with DMS, DCBS, and the DJJ, as well as other stakeholders, to identify provider training needs specific to the Kentucky SKY program. We will begin this process with a series of regional forums attended by local providers and stakeholders from across the state prior to implementation. This will enable us to receive provider input, questions, and feedback on how we can best assist them with training. We will take this information and work closely with our counterparts at DMS, DCBS, and DJJ to identify topics where providers require more information and training opportunities.

The following examples highlight our past collaborations with the local state agencies on identifying provider training needs:

- *Kentucky Health Summits:* Prior to implementation of the Kentucky HEALTH waiver, DMS requested that WellCare conduct provider education on aspects of the waiver implementation, including the community engagement requirements. WellCare conducted four provider summits and nine community summits throughout the state which included a detailed presentation on the Kentucky HEALTH waiver and extensive question and answer sessions. In addition to these summits, we conducted multiple webinars leading to the scheduled launch data which averaged over 400 attendees per webinar.
- *Copay Education:* Prior to implementation of copays for certain Enrollees and certain services in early 2019, DMS requested that WellCare conduct provider education on provider responsibilities around the collection of copays. WellCare conducted about 2 months of targeted provider outreach related to the copay implementation, including written material and dedicated Webinars, prior to implementation. As a result, implementation of the new process went far more smoothly than anticipated.
- *IMPACT Education:* At DMS' request, during implementation of the IMPACT and IMPACT+

We have worked with Kentucky providers and state agencies to identify and conduct impactful professional coursework for implementation of the Kentucky HEALTH waiver, IMPACT+, care coordination criteria and the concurrent review process.

programs in 2013, WellCare conducted provider education for providers new to Medicaid managed care on how to work with WellCare, including claims payment and other business processes.

- *Managed Care Launch:* In 2011, at the launch of the Medicaid Managed Care program, WellCare conducted 16 provider summits including some which were in coordination with DMS. Today, our Provider Relations team continues to host a weekly webinar focusing on new programs, relevant issues, provider concerns, changes, and new regulations or rules pertaining to provider groups. We will continue this weekly webinar for our SKY providers.
- *Medically Complex Foster Care:* Over the past three years, we have participated in a specialized training curriculum that assists medically complex foster care parent providers with better understanding and navigating the services offered for our most vulnerable Enrollees. Training topics include accessing durable medical equipment, accessing specialized services through EPSDT, requesting medical records, and connecting with specialized support from a WellCare care coordinator/care manager assigned specifically to assist Enrollees with highly specialized needs and their care providers. To date, we have participated in five different foster care parent training events focused on providing direct support.

b. How will the Contractor ensure that the Contractor's staff and Network Providers (including but not limited to hospitals, pharmacies, and specialty Providers) receive in depth training on the Kentucky SKY program, including what is and is not allowable exchange of information in a HIPAA compliant organization, to preserve and support continuity of care. Describe how the Contractor will ensure Network Providers are aware of the requirements of the Kentucky SKY program, and how the needs of this population may differ from those of the Medicaid managed care population?

WellCare of Kentucky's staff training program is designed to ensure our staff provide unparalleled support and service to Enrollees, caregivers, and providers. Our training program includes mandatory training on topics such as HIPAA, cultural competency, and fraud, waste and abuse. In addition, WellCare's care coordination team currently is trained in motivational interviewing, suicide prevention, mental health first aid and trauma-informed care.

IN-DEPTH TRAINING OF STAFF - INITIAL CARE COORDINATION STAFF TRAINING

Care Coordination personnel responsible for children involved in Kentucky's SKY program will complete an intensive new hire training program that complements various adult learning styles: instructor-led in-person training, instructor-led, web-based training, and self-paced training. Using the curriculum provided to every WellCare Care Coordinator as the foundation, we will design Kentucky SKY-specific modules to address the special behavioral and physical needs of children and youth in foster care. Because of our substantial investment in training programs, our Care Coordinators have access to more than 1,000 self-paced courses through CE Direct.

Through our continuous training program, we ensure that Care Coordinators have the requisite knowledge, competencies and skills to understand and navigate our operations, information systems and tools, and engagement programs and services, and clinical standards, all with the purpose of better serving our Enrollees. Within 120 calendar days of the contract

execution date, WellCare of Kentucky will submit our educational and training plan demonstrating orientation and ongoing training on subjects relevant to children and youth in foster care to the DCBS for review and approval. Included in the plan will be formal training classes as well as practicum observation and instruction for newly hired staff and ongoing in-service training on topics relevant to Kentucky SKY Enrollees and their families/guardians. We welcome the participation of DMS, DCBS and DJJ in our training plan. All training dates and staff attendance are documented and maintained along with copies of training materials.

Initial Kentucky SKY Training

Following completion of core training, SKY care coordinators and other SKY Enrollee-facing staff will complete focused training, explained in **Table G.4-1** designed to ensure our staff is universally equipped to manage care for children who are child welfare-involved. Staff of the Kentucky SKY Call Center, administrative staff and leadership, Enrollee Services and Enrollment staff, Provider Relations and Network staff all are Enrollee-facing positions who will receive training on the Kentucky SKY program.

Table G.4-1: Kentucky SKY Staff Training Topics

Topic	Learning Objectives	Staff	Frequency
Kentucky SKY Overview	• Program overview: • Purpose • Roles and responsibilities of DMS/ DCBS/ DJJ • Contractual requirements of the program • WellCare's organization, staffing and infrastructure to support Kentucky SKY • Kentucky SKY business processes and workflows • Providers: Types and Roles	All SKY staff	New Hire and Annually
Enrollee Needs	• System of Care Approach • Unique physical health and behavioral health needs of Kentucky SKY populations • Comparison to general MMC population	SKY Enrollee-facing staff	New hire and Annually
Coordinating Services	• Overview of Wraparound Process and Care Planning • Assessment/Identification of needs • Youth-guided, family-led care planning • Care coordination teams	SKY Enrollee-facing staff	New hire
Covered Services	• Appropriate use of psychotropic drugs	SKY Leadership	New hire
Family First Prevention Act	• Impact on Kentucky SKY Enrollees • Other federally mandated services or programs impacting Enrollees	SKY Enrollee-facing staff	New hire
Trauma-Informed Care	• Trauma-informed care training provided with University of Louisville Kent School of Social Work	SKY Enrollee-	New hire and annually

Topic	Learning Objectives	Staff	Frequency
	• WellCare policies and procedures for referral and escalation • Community referrals	facing staff	
ACES	• ACES and their impact on Enrollees • Defining ACES • What is the ACE Study? • Prevalence; Effects	CC, FOC staff and leadership	New hire
Neonatal Abstinence Syndrome (NAS)	• Evidence-based practices to prevent, identify and treat neonatal abstinence syndrome	CC Staff	New hire
Six-Seconds Emotional Intelligence (SEI)	• Unlocking EQ • Developing a clear case for emotional intelligence • Exploring the Six Seconds Model for making emotional intelligence practical • Reviewing the latest research on the brain, emotions and performance • Clarifying your vision and defining key goals for EQ development • Learning to use the TFA (Think, Feel, Act) cards to introduce EQ	CC Staff	New hire
Crisis Intervention Services	• Outline of crisis services covered and overview of providers	Enrollee-facing staff	New hire
Evidence-Based Practices Applicable to the Kentucky SKY Enrollees	• High Fidelity Wraparound Services (provided through National Wraparound Implementation Center) • AAP Bright Futures periodicity	CC staff and SKY leadership	New hire and annually
CANS	• Transformational Collaborative Outcomes Management (TCOM) • CANS: What is it, why are we using it? • Six Key Characteristics • CANS Assessment report • KIDnet Outcome Monitoring System Overview	CC staff	New hire and annually
Aging Out Process	• Support from WellCare • Youth-Led Transition Planning Model • Role of Independent Living Specialist	CC staff and FOC	New hire
HIPAA	• Defining Protected Health Information (PHI) • Your role in protecting PHI and procedures for reporting compliance or privacy concerns • Allowable vs. non-allowable exchange of information • Your role in preserving and supporting continuity of care	Enrollee-facing staff	New hire and annually

Upon successful completion of care coordination new hire training, our learning and development and clinical leadership staff use role playing, case presentations, and final course assessments to gauge learner comprehensive and aptitude. In addition, all new hires must complete one to two weeks of preceptor shadowing, depending on their previous work history

and performance throughout new hire training. During preceptor shadowing, care coordinators are assigned a task log for shadow experience, complete one-on-one coaching and ride-alongs, if applicable, and complete hands-on application of care management process and documentation, all while under the supervision of their manager or preceptor.

Understanding the Needs of Kentucky Sky Enrollees

Led by LeAnn Magre, who has a deep understanding of how the needs of this population differ from those of the general Medicaid managed care population, WellCare of Kentucky will ensure that Enrollee-facing staff training addresses those different needs. It will include an overview of the System of Care approach, trauma-informed care, and the high-fidelity wrap-around approach to care management. Specifically, we acknowledge the critical importance of implementing the high-fidelity approach as an intervention that can truly transform the way we support SKY Enrollees. Through this nationally recognized model, our Enrollee-facing staff will work with families and children to meet their needs by identifying and focusing on their strengths to help develop family-driven care plans.

HIPAA and Continuity of Care

WellCare currently provides training to staff on what is and is not an allowable exchange of information in a HIPAA compliant organization, to preserve and support continuity of care. Initial and annual ongoing training on HIPAA compliance is provided to all WellCare staff, including defining Protected Health Information (PHI), their role in protecting PHI and procedures for reporting compliance or privacy concerns at WellCare. WellCare recognizes that the protections for children and, particularly, DJJ Enrollees have more stringent requirements and our training programs will be modified to address these elements.

ONGOING CARE COORDINATION STAFF TRAINING

Staff learning and development is a dynamic process so we make training available to our staff year-round. Using a variety of innovative learning modalities, including instructor-led classroom and virtual, self-paced, eLearning, web updates, staff town halls and in-services, and information dissemination (i.e., meetings), we keep our staff up-to-date on program changes, support clinical and professional growth, provide refresher and “skills boost” training, and more. Staff meetings and announcements are used to communicate critical program updates. In-services with our clinical leaders or contracted providers allow staff to better understand clinical conditions, benefits and services while our online courses allow staff to stay abreast of current clinical trends and practices at their own pace.

We will continue to develop and provide staff training on key topics as they arise. For example, our affiliate in Florida addressed the rising topic of human trafficking by completing nearly 40 hours of human trafficking awareness training provided by the National Human Trafficking Resource Center (NHTRC). All staff continues to receive education and training on an annual basis. Through ongoing supervision, case reviews, identifying potential secondary trauma, and professional development opportunities, we help our staff members achieve their goals, stay healthy, and remain passionate about helping those most in need.

In-depth Education for Providers

WellCare of Kentucky's provider education program uses a combination of in-person provider meetings, town halls, webinars, web-based materials and traditional printed collateral to provide training and education opportunities. In addition, through CE Direct, providers in our network including PCPs, hospitals, pharmacies and specialty providers have access to thousands of on-line courses. Our provider relations staff conducts in-person provider visits, covering topics such as new provider orientations, quality performance, new program education, and any other topic that is relevant to the provider. Each visit's agenda is collaboratively developed by WellCare and our providers to include topics relevant to both parties. We use each encounter as an opportunity to educate contracted providers and their office staff about the program and the benefits of managed care and promote available education including that offered through our annual Provider Summits and biweekly webinars. In addition to our entire Provider Relations team which will be available to educate and support these providers, we will add a dedicated Manager and provider relations representatives wholly focused on the Kentucky SKY program and provider support. We will build on this core program as well as the expertise of LeAnn Magre and others who have been working with other experts in Kentucky's foster care system to develop a robust education program for providers to address the specific requirements of the Kentucky SKY program, depicted in **Table G.4-2**.

Table G.4-2: Kentucky SKY Provider Education Topics

Topic	Learning Objectives	Provider Audience	Initial/Ongoing
Kentucky SKY Overview	• Program overview: • Purpose • Requirements of the program • Roles/responsibilities of DCBS, DJJ and DBHDID • Working with WellCare	All	Initial and ongoing
Enrollee Needs	• System of Care Approach • Unique physical health and behavioral health needs of Kentucky SKY populations • Comparison to general MMC population	All	Initial
Care Coordination for SKY Enrollees	• Overview of Wraparound Process and Care Planning • Assessment/Identification of needs • Youth-guided, family-led care planning • Accessing the care coordinator	All	Initial
Covered Services	• Provider's responsibility for providing and/or coordinating such services • Differences from Medicaid coverage and processes • Coordination with foster parents/caregivers/fictive kin/adoptive parents, DCBS/DJJ/other Cabinet professionals, CASAs, Judges, law enforcement officials	All	Initial

Topic	Learning Objectives	Provider Audience	Initial/Ongoing
Other requirements	• Medical consent requirements • Required timelines for services and assessments • Specific medical information required for court request and judicial review of medical care • Appropriate utilization of psychotropic medications	All	Initial
Trauma-Informed Care	• About Trauma-Informed Care: • Overview: Trauma-informed care • WellCare policies and procedures for referral and escalation • Community referrals • Trauma Informed Care training (University of Louisville Kent School of Social Work) Please see Question G.7 for curricula	All	Initial and ongoing
ACES	• ACES and their impact on Enrollees • Defining ACES • What is the ACE Study? • Prevalence; Effects • Performing ACES screening Please see Question G.7 for curricula	All PCPs	Initial and ongoing
CANS	• Transformational Collaborative Outcomes Management (TCOM) • CANS: What is it, why are we using it? • Six Key Characteristics • CANS Assessment report • KIDnet Outcome Monitoring System Overview Please see Question G.7 for curricula	All	Initial and ongoing
Crisis Intervention Services	• Outline of crisis services covered and overview of providers Please see Question G.7 for curricula	All	Initial
Evidence-Based Practices Applicable to the Kentucky SKY Enrollee	• High Fidelity Wraparound Services • What is Wraparound? • Why Wraparound? • Wraparound Outcomes • What takes place during the Wraparound process? (engagement and team preparation; initial plan development; implementation; transition) • Implementation requirements for Wraparound • AAP Bright Futures Periodicity Please see 60.7 G.7 for curricula	All	Initial
Neonatal Abstinence Syndrome	• Evidence-based practices to prevent, identify and treat neonatal abstinence syndrome Please see Question G.7 for curricula	All	Initial

Topic	Learning Objectives	Provider Audience	Initial/Ongoing
Substance Exposed Infants	• Create familiarity with the DCBS Substance-Exposed Infants In-Depth Technical Assistance site: • Hospital assessments and discharge planning for infants with NAS • Incorporating assessment finding into DCBS prevention plans, case plans and aftercare plans	All	Initial
Behavioral Health	• Screening for BH disorders • Identification and referrals for BH disorders • Toolkit for Improving BH Quality Performance in Children Please see Question G.7 for curricula	All	Initial
Six Seconds Emotional Intelligence	• Unlocking EQ • Developing a clear case for emotional intelligence • Exploring the Six Seconds Model for making emotional intelligence practical • Reviewing the latest research on the brain, emotions and performance • Clarifying your vision and defining key goals for EQ development • Learning to use the TFA (Think, Feel, Act) cards to introduce EQ Please see Question G.7 for curricula	All	Initial
Performance measures and health outcomes	• Performance measures including: • HEDIS measures • Operational measures • Utilization measures • Evidence-based practices • Placement and permanency measures • WellCare Performance Improvement Project	All	Initial and ongoing
Family First Prevention Services Act	• Impact on Kentucky SKY Enrollees • Other federally mandated services or programs impacting Enrollees	Private Child Care Agencies	Initial
HIPAA	• Defining Protected Health Information (PHI) • Your role in protecting PHI and procedures for reporting compliance or privacy concerns • Allowable vs. non-allowable exchange of information • Your role in preserving and supporting continuity of care	All	Initial
Aging Out Process	• Support from WellCare • Youth-Led Transition Planning Model • Role of Independent Living Specialist	Private Child Care Agencies	Initial and on-going

WellCare of Kentucky has provided technical assistance to private child care providers around services, prior authorization processes, concurrent review processes, and appeals, among

other topics. We meet with providers, including the Children's Alliance, Bart Baldwin Agency and their providers, outpatient and community-based service providers, private child residential and foster care providers, on a consistent basis. WellCare of Kentucky's utilization management staff recently held a training for all targeted case management providers regarding utilization management criteria and the concurrent review process.

HIPAA TRAINING

WellCare currently provides training to providers on what is and is not an allowable exchange of information in a HIPAA compliant organization, to preserve and support continuity of care. Initial and annual ongoing education on HIPAA compliance is provided to all WellCare providers, including defining Protected Health Information (PHI), their role in protecting PHI and procedures for reporting compliance or privacy concerns at WellCare. Because we are aware that providers may be concerned about sharing information and unintentionally violating HIPAA provisions, WellCare use a high-touch approach to education on HIPAA, including practice vignettes.

c. Describe how the Contractor will educate Law Enforcement Officials, the courts, judges, attorneys, and judges about the Kentucky SKY program.

WellCare of Kentucky understands the key role that the courts and law enforcement play in ensuring the safety and well-being of children and youth in foster care and has planned a comprehensive program of education. We will provide at least one training per quarter for law enforcement officials, the courts, judges, and district and county attorneys, including the Kentucky Administrative Office of the Courts, the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy, as in **Table G.4-3**. In addition, we would like to extend the training to Court Appointed Special Advocates (CASA) and guardians ad litem.

Topics will include:

Table G.4-3: Kentucky SKY Law Enforcement and Judges Education Topics

Topic	Learning Objectives
Kentucky SKY Overview	• Program overview: • Purpose • Roles/responsibilities of DCBS, DJJ and DBHDID and how they will work with WellCare • Roles/responsibilities of WellCare
Enrollee Needs	• System of Care Approach • Unique physical health and behavioral health needs of Kentucky SKY populations
High Fidelity Wraparound	• Overview of Wraparound Process and Care Planning • Assessment/Identification of needs • Youth-guided, family-led care planning • Accessing the care coordinator
Trauma-Informed Care	• Trauma-informed care training with University of Louisville Kent School of Public Health • WellCare policies and procedures for referral and escalation • Community referrals

Topic	Learning Objectives
ACES	• ACES and their impact on Enrollees • Defining ACES • What is the ACE Study? • Prevalence; Effects
Crisis Intervention Services	• Outline of crisis services covered and overview of providers • Crisis intervention • For communities that already have a Crisis Intervention Team (CIT) in place, WellCare commits to have a staff member attend a committee meeting during the first year of implementation to brief them on the Kentucky SKY program
Neonatal Abstinence Syndrome	• What is NAS? • Preventing NAS • Signs and symptoms of NAS • Complications of NAS • Testing and treatment of NAS
Family First Prevention Services Act	• Impact on Kentucky SKY Enrollees • Other federally mandated services or programs impacting Enrollees
Aging Out Process	• Support from WellCare • Youth-Led Transition Planning Model • Role of Independent Living Specialist
Other topics	• Psychotropic medication oversight • Human trafficking • Emotional de-regulation

To provide the training for the courts, judges and attorneys, we will work through the Administrative Office of the Courts (AOC), which has an extensive program of training and education and offers participants Continuing Education Units (CEUs). We will also work in collaboration with the Eastern Kentucky University Training Resource Center, which provides training opportunities for the high-fidelity wraparound model, training for DCBS staff and foster parents, and training for the Department of Behavioral Health, Development and Intellectual Disabilities (DBHDID). This training will also be provided to the Family Resource Center.

For local police officers, we have received feedback that the best way to provide education opportunities is to collaborate with the Department of Criminal Justice Training (DCJT), which offers a catalog of training options for police officers to obtain their 40 hours of annual required training. We will partner with DCJT to develop training offerings for law enforcement personnel. In addition, we propose to partner with police departments to offer 25-minute trainings during their daily briefings. Because law enforcement is unique to each county, city and within the state, WellCare SKY will partner with state police, county sheriff offices and school police to develop training program specific to their needs.

5. Kentucky SKY Enrollee Services

G.5. SKY ENROLLEE SERVICES

a. **Describe the Contractor's proposed approach for coordinating with the Department, DCBS, and DJJ to ensure Kentucky SKY Enrollees begin receiving services immediately upon entering Foster Care. Please include the Contractor's experience expediting enrollment in other markets.**

b. **The eligibility of Kentucky SKY Enrollees often changes due to their status in Foster Care or the juvenile justice system. Describe the Contractor's proposed process for resolving Enrollment and eligibility discrepancies. Include the Contractor's approach for collaborating with the Department, DCBS and DJJ in resolving eligibility issues.**

c. **Describe the Contractor's proposed process to assign Kentucky SKY Enrollees to a PCP within two (2) Business Days of Enrollment. Include a discussion of the Contractor's approach to:**

   i. Assist Kentucky SKY Enrollees to select a PCP and auto-assign Kentucky SKY Enrollees who do not make a selection within the required timeframes

   ii. Work with the Department, DCBS, DJJ, Foster Parents, and Adoptive Parents to assign PCPs

   iii. Track data to confirm that every Kentucky SKY Enrollee is assigned to a PCP.

   iv. Inform PCPs of new Kentucky SKY Enrollees within the required timeframes.

   v. Confirm that PCPs received the list of assigned Kentucky SKY Enrollees

   vi. Provide a sample of the report the Contractor will use to notify PCPs of their assigned Kentucky SKY Enrollees.

d. **Describe the Contractor's proposed process for communicating with Kentucky SKY Enrollees about their PCP assignments and encouraging Kentucky Care Enrollees to schedule regular appointments with their assigned PCPs and keep scheduled appointments. Include how the Contractor will identify and work with Kentucky SKY Enrollees to resolve barriers to keeping appointments and how the Contractor will work with resources available at the Department, DCBS and DJJ to communicate with Kentucky SKY Enrollees. Include a discussion of how this process would differ when communicating about their Dental Provider assignment and encouraging Kentucky SKY Enrollees to schedule and keep regular appointments with Dental Providers.**

e. **Foster Care (FC) Enrollees and Juvenile Justice (JJ) Enrollees often experience changes in placement. These placement changes may require assignment of new PCPs and Dental Providers. Describe the Contractor's proposed process to assess a FC or JJ Enrollee's access to a PCP and Dental Provider timely after a change in FC Enrollee or JJ Enrollee placement and assigning a new PCP or Dental Provider if the prior Provider no longer meets access standards.**

f. **Describe the Contractor's process for engaging Adoptive Parents who request to opt out of the Kentucky SKY program to stay enrolled, including:**

   i. Process for outreach and engagement of Adoption Assistance (AA) Enrollees.

ii. Conducting surveys with AA Enrollees to determine the reason for opting out of the Kentucky SKY program.

iii. Attempts for periodic re-engagement after Disenrollment.

iv. Include how the Contractor will use results from the survey to improve the program.

g. Provide the Contractor's proposed plan for providing Kentucky SKY Enrollees with ID cards in the required timeframes (be issued initially within five (5) Calendar Days of receipt of the eligibility file from the Department and reissued within five (5) Calendar Days of a request for reissue) in the following instances:

i. Report of a lost ID card.

ii. A Kentucky SKY Enrollee name change.

iii. A new PCP assignment.

iv. FC or DJJ Enrollee moves to a new placement or for any other reason that results in a change to the information disclosed on the Kentucky SKY Enrollee's ID card.

h. Describe how the Contractor will address and manage crisis calls during business hours as well as after hours.

i. Describe the processes, protocols and guidelines the Contractor will use to achieve maximum stability and the best outcomes for Kentucky SKY Enrollees in crisis as well as avoid inappropriate and unnecessary Emergency Care and hospital admissions. Describe how the Contractor will prioritize emergency and crisis calls over routine calls, protocols that will be in place to support warm transfers, and what technology the Contractor will have to enable direct telephonic/computer connectivity to emergent and crisis intervention resources.

j. Describe trainings and resources the Contractor will provide to call center staff related to recognition and management of crisis calls to ensure the most expedient and risk-reducing outcomes, including a description of the level and type of training.

G.5. SKY ENROLLEE SERVICES

a. Describe the Contractor's proposed approach for coordinating with the Department, DCBS, and DJJ to ensure Kentucky SKY Enrollees begin receiving services immediately upon entering Foster Care. Please include the Contractor's experience expediting enrollment in other markets.

WellCare of Kentucky will comply with the Department for Medicaid Services' (DMS) expectations and requirements as specified in Section 22 Enrollee Services and Section 41 Kentucky SKY PROGRAM of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix,** provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

EXPEDITING ENROLLMENT

We are prepared and equipped to deliver services to Kentucky SKY Enrollees immediately upon entering Foster Care. We understand that service delivery requires coordination with a variety of stakeholders who have information vital to successful care coordination, beginning with the Department for Medicaid Services (DMS), Department for Community Based Services (DCBS), and Department of Juvenile Justice (DJJ).

Our preparation for this task is based on our history as an MCO dedicated exclusively to government health programs. We answer calls promptly with trained, efficient, culturally competent staff. We quickly activate to link Enrollees to seamless service delivery. We streamline their access to resources offered by other stakeholders where we have already laid the groundwork prior to the Enrollee ever picking up the phone. We meet the Enrollee where they are, focusing on their strengths and their preferences for obtaining information. For the Kentucky SKY program, our preparation is further tempered by our experience with children and youth in child welfare and our commitment to ensuring that each Enrollee is quickly connected with services that are tailored for them, youth-guided and family driven.

Getting Prepared: Coordination Begins Before Contract Start

WellCare understands the need to begin collaboration well before the first Enrollee comes into managed care. We work closely with DMS, DJJ, DCBS, and other stakeholders such as CASA, the courts, and foster care agencies such as KY FACES, in cross-organizational discussions on roles and responsibilities and current processes. We will build on this culture of shared commitment to openly discuss concerns, streamline current processes and remove barriers.

We have Care Coordinators working with Enrollees involved in Kentucky's Foster Care system. We have relationships with the Commonwealth's key child welfare stakeholders, including Children's Review Program, Children's Alliance, Bart Baldwin's Agency, Orphan Care Alliance and Kentucky Partnerships for Families and Children. This on-the-ground experience is assisting us to develop key program components for Kentucky SKY Enrollees, including enrollment, data transfer, eligibility coordination, and crisis intervention services.

Expediting Enrollment

To ensure that children and youth entering foster care begin receiving services immediately, WellCare proposes to assign a Field Outreach Coordinator (FOC) in each DCBS office. Depending upon the number of Enrollees and the intensity of services required, the FOC may serve daily (five days per week) in the DCBS office or on a routine schedule between multiple offices. The FOC will serve as the first contact for DCBS when a child enters Foster Care.

If the child or youth coming into foster care is already a WellCare Medicaid Enrollee, the FOC will immediately schedule the comprehensive assessment and take all necessary steps to initiate or resume services the Enrollee needs. If the child or youth is not a WellCare Medicaid Enrollee, the FOC will work with the DCBS benefits worker to trigger enrollment of the child or youth into WellCare.

We will accept all official notification of eligibility such as from the DJJ or DCBS and will begin care coordination immediately. While we will rely on the 834 enrollment file for official

eligibility, we understand that in many situations enrollment for Kentucky SKY will occur on an emergency basis due to a child's removal from the home or an enrollment that occurs while a child is inpatient. These enrollments can occur well ahead of the receipt of the enrollment file. We propose that we work with DCBS to develop a file that DCBS staff can use to inform us of a child entering the foster care system immediately, before the enrollment is completed and the child's information is provided on the 834 file. We also will collaborate with DCBS and DJJ to provide our FOCs with access to TWIST, the state automated child welfare information system and JORI, the state automated DJJ JORI information system. This will allow the WellCare FOC to quickly begin the outreach and assessment process and ensure the Enrollee begins receiving services to address any immediate needs.

Our FOC will note any missing demographic information in the Enrollee's file and any enrollment or eligibility concerns and will follow to resolution. The FOC also will inform DMS of any needed edits to the official state eligibility file. Our Care Coordinator will ensure the Enrollee's continuity of care needs are met including, for instance, that all current medications are filled and available, and will provide for any transitional needs, including DME and appointment-scheduling for behavioral health support.

If an Enrollee comes into foster care after-hours and with an immediate need for services such as DME or an inpatient admission, our dedicated SKY Enrollee Call Center or our 24-Hour Nurse Line will step in to assist in addressing those immediate needs without waiting for the 834 file.

Ensuring Service Delivery

Upon notification of enrollment, WellCare's FOC will obtain all available information, including from DJJ and DCBS, and outreach for any missing or incomplete data. The FOC will obtain the DCBS Service Plan, review it with the DCBS worker and work with the DCBS worker to develop a plan for initiating care coordination. Based on this plan, the FOC will assign a Care Coordinator to the Enrollee to begin scheduling required assessments, ensure a smooth transition and begin developing a person-centered care plan. The FOC will serve as "One Call" coordinator for all stakeholders, removing any barriers and eliminating the early confusion that sometimes can accompany emergency placements and initial enrollments.

Our Care Coordinator will ensure that required assessments and services are provided promptly and within required timeframes. The DCBS and DJJ Service Plans will be collected and reviewed. If the member is in DJJ, our Care Coordinator will request the Criminogenic Needs Questionnaire and Risk and Criminogenic Needs Assessment. The Care Coordinator will begin conducting a Comprehensive Needs Assessment (consisting of a trauma screen, a community resource assessment, a health risk assessment, a medication profile review, a past claim history review, a care giver assessment, a cultural assessment, a depression screen and a substance use screen and smoking/vaping screen), assisting in scheduling the CANS (if not already complete) assessment, and scheduling the PCP appointment where the PCP will complete EPSDT required appointments and a screening for Adverse Childhood Events (ACEs) screen.

In 2016, the WellCare Kentucky child welfare case management team recorded 8,000 individual contacts with the Department for Community Based Services (DCBS), parents, Enrollees, and providers for care coordination and collaboration.

The Enrollee's Care Coordinator will schedule an Assessment Team meeting to occur within ten days of notification of enrollment. At this meeting, the Enrollee's assigned Care Coordinator will ensure that assessment and screening results are shared as needed with DCBS, DJJ and the Enrollee's providers and ensure that any previous medical records are transferred to their new PCP. The Care Coordinator provide each foster caregiver with access to WellCare's ClearSKY app loaded on their mobile device and ensure they know how to use the app to access the Enrollee's past history, current Medical Passport and list of current providers, including the PCP, dental provider and any specialty providers. If the enrollee does not own a mobile device, the Care Coordinator can issue a tablet with the ClearSKY app pre-loaded. The Care Coordinator also will report out the Enrollee's progress to involved case workers and maintains contact to expedite any needed reports for the court.

During the Assessment Team meeting, participants will create the initial care plan and assign tasks to the Enrollee's Multidisciplinary team. The Care Coordinator will then work with the care giver, Enrollee, providers and state guardian to ensure the care plan is enacted. The Care Coordinator will schedule a second meeting at the end of 30 days to review the care plan tasks, update new information provided, create an ongoing care plan and assign the Enrollee into ongoing care management.

Within five calendar days of receipt of the 834 Enrollment File, WellCare will send a Enrollee Information Packet containing all requirements in Section 41.11.2 Kentucky SKY Enrollee Information Packet and Enrollee Handbook of this Contract to the state Social Worker or the DJJ Children's Benefit Worker, as appropriate for each new Enrollee, either via mail or a secure portal depending upon the worker's preference. For Adoption Assistance (AA) Enrollees, we will mail the Packet to the AA Enrollee or Adoptive Parent, also within five calendar days of receipt of the 834 eligibility file. Upon request from the state Social Worker or Children's Benefit Worker, we also will mail the Packet to the Enrollee's Foster Parent, Caregiver, or DJJ Residential Treatment Facility. Our welcome letter in each packet will include the name and contact information for the Kentucky SKY Care Coordinator and the 24/7 telephone number of our dedicated Kentucky Sky Enrollment Services Call Center.

ONGOING DIALOGUE

As a managed care plan well-known in Kentucky by both stakeholders and Medicaid beneficiaries, WellCare is dedicated to ongoing dialogue and feedback from the community. We already understand and are involved in solutions to expedite service to our Enrollees, provide them with outstanding service, and ensure them access. We already have a provider network that understands the immediacy and sensitivity needed by the Foster Care Enrollee and we have established relationships with DCBS.

EXPERIENCE IN DELIVERING EXPEDITED AND ANTICIPATORY SERVICE

We are experienced in collaborative planning for the delivery of immediate and needed service to children and youth in foster care and juvenile justice. For example:

- In Nebraska, as a new entrant to the state, we combined our stakeholder outreach with intensive recruitment of new staff with experience in juvenile justice, child welfare, and children with special needs. We hired and trained 175 associates across all positions and levels, in order to quickly serve Enrollees at go-live and ongoing.
- Since Nebraska has the nation's high rate of children in foster care, including children in out-of-home and residential placement, we created "Grand Rounds" with the state's child and family services representative to discuss challenging cases and identify children who are able to move into community-based services from more restrictive forms of care.
- In Arizona, our affiliate has systems in place to identify children at risk of removal by the State's child welfare agency so that enrollment can be expedited. Through care coordinator evaluation and monitoring, specialized programs such as an enhanced opioid management program, provider referral and information, and schools and data reporting from the crisis network, we are able to identify families in crisis and develop a "ready program" so that the child's continued service is seamless.

b. The eligibility of Kentucky SKY Enrollees often changes due to their status in Foster Care or the juvenile justice system. Describe the Contractor's proposed process for resolving Enrollment and eligibility discrepancies. Include the Contractor's approach for collaborating with the Department, DCBS and DJJ in resolving eligibility issues.

As a managed care plan with extensive experience in the Child Welfare population, including in the Commonwealth, we focus on implementing strategies to identify and resolve enrollment and eligibility issues before they impact the Enrollee's access to services. Since 2016, we have securely processed over 400 million Enrollee transactions via the 834 enrollment file. With our volume and performance experience, we ensure all new, existing, or disenrolled Enrollees are accounted for and their correct information routed to our management information systems (MIS) to avoid enrollment and eligibility discrepancies. We collaborate with DMS on eligibility and enrollment and will experience no learning curve to interface with DMS' file transfer protocols or to seamlessly exchange data with the enrollment broker, AHS. Our experienced Kentucky-trained Enrollment and Eligibility System (EES) team facilitate enrollment transactions and remediate file discrepancies usually within 24 hours. Our system is agile, accommodating quick adjustments in response to contract changes or enrollment procedures and our excess system capacity can easily absorb enrollment increases.

We will provide specific, designated staff for DMS, DJJ and DCBS to contact in the event of an enrollment or eligibility issue. Our Enrollee Call Center will maintain a contact list of assigned care coordination staff to assist with after-hours enrollment and eligibility issues, so frequent in this population, and to provide transition and care coordination in the event of an emergent Enrollee situation, such as emergency placement, removal, or relocation.

RESOLVING ROUTINE ENROLLMENT AND ELIGIBILITY ISSUES

WellCare has a robust, tested process in place to resolve enrollment and eligibility discrepancies. In our experience, there are two major areas where discrepancies are noted: at the start of enrollment and at the point of first service when the Enrollee tries to receive provider or pharmacy services.

At the Start of Enrollment

When we receive the 834 file, our system generates a report of SKY Enrollees who are new to the program and a report of those who have disenrolled. Systematically, we audit the new files and submit any variance to DMS. Variances might include an address not within the Commonwealth, an Enrollee at or over age 26, or indication that a child's adoptive parents have elected other health coverage for the Enrollee. In these cases, we review the Kentucky Health Choices database to confirm that the data received on the 834 matches with the data held in the database. Our FOC will contact the Enrollee or caregiver to confirm the coverage or identify if a discrepancy exists. Once the root cause of discrepancy is identified, our FOC will correct the discrepancy with DMS.

Corrections and updates to an Enrollee's record will be electronically routed to the WellCare Enrollment Department, which also can flag our FOC if any issues are detected. Routine file audits conducted by the Enrollment Department also can serve as an early warning for eligibility issues. To assist DMS in validating enrollment and eligibility information and correcting any errors, WellCare will collaborate with DMS to build a routine report to provide DMS with eligibility information, including terminations of eligibility we have encountered.

Resolving Eligibility Discrepancies

While Ethan's adoptive mother was struggling to figure out how to get Ethan the care he needed during a crisis precipitated by his medical and behavioral health needs, she received an erroneous notice that Ethan's Medicaid coverage had lapsed. She had given Ethan into state care as a dependency case because she felt she couldn't meet Ethan's complex needs and now Ethan had been admitted to the Children's Assessment Transitional Service center, a residential treatment center at Home of the Innocents. Ethan's mom contacted Laura N., Ethan's WellCare Care Coordinator, who immediately helped disentangle the problem and walked Ethan's mom through the steps to work with DMS to restore Ethan's Medicaid eligibility.

At the Point of Care

For eligibility and enrollment issues at the point of care, we educate our network providers to contact our toll-free Enrollee Services call center with any concerns and train our provider call center staff to resolve the issue in real-time to minimize any negative impact for the Enrollee.

Our Enrollee Services staff access the KY HealthNet system to check the Enrollee's status. In most instances, our staff determine that one of three things has occurred:

- The Enrollee is listed as eligible and enrolled in WellCare and the provider's information was incorrect. In this case, our staff informs the provider of the correct information.
- The Enrollee, who appears to be eligible, has lost eligibility. In this case, our staff contacts WellCare's Enrollee Services Department which works directly with DMS to reinstate

eligibility. In complex cases, Enrollee Services may also bring the FOC into the situation for additional support and documentation.

- The Enrollee is eligible but enrolled with another MCO. In this case, under the Kentucky SKY program, we will contact our Enrollee Services to have the Enrollee's enrollment changed to WellCare.
- The Enrollee has lost eligibility and does not appear to be eligible.

Our FOC will notify and work with the DCBS to resolve the eligibility or enrollment issue and to ensure that they have the correct information. We also will monitor claims from providers delivering services during this "gap" period to ensure that reimbursement is timely and not impacted by the eligibility issue. Our primary concern is to ensure that the Enrollee receives the provider services to which they are entitled, and that the provider is compensated appropriately for services rendered. In most cases, we can resolve the issue during the provider call, instructing them to provide the service with reassurance that the claim will be paid.

In cases where a state Social Worker or DJJ Children's Benefit Worker calls our Enrollee Services call center to resolve an eligibility or enrollment problem, our call center staff validate the caller is authorized to receive information and/or to speak for the Enrollee under both HIPAA and the confidentiality of information requirements of DMS or DJJ. No confirmation of Kentucky SKY enrollment nor any information to any caller regarding Enrollees in Kentucky SKY will be provided without a verification and authorization check. As part of our "one call" service to DJJ and DCBS, if the worker cannot be verified but insists that they are authorized to obtain information and speak on behalf of the Enrollee, our call center immediately will engage the support of a DCBS-based FOC to help resolve the matter as expeditiously as possible.

Resolving Emergent Enrollment and Eligibility Issues

As already noted, discrepancies can occur when the Enrollee is already in crisis, at the point of an emergency removal, a sudden and unplanned placement change, or during in-facility treatment. To minimize disruption during an already difficult time for the Enrollee, the Social Worker or Benefit Worker, and the Enrollee's caregivers, we will develop a Priority Care Protocol to ensure that Enrollees with emergent or transition needs receive care even while eligibility issues are being resolved. Our FOC will print and provide these Enrollees with a temporary Enrollee ID at their field-assigned DCBS office location, enabling the Enrollees and their caregivers to access needed services, such as prescription refills for medication left behind or urgent/emergent care. As eligibility issues are re-checked and enrollment processes, our Care Coordinators will document details in a temporary electronic record to ensure coordination of care going forward. This also will allow our Care Coordinators to share information with the Enrollee's providers and respond to requests from DJJ or DCBS, as appropriate.

We will assign care coordinators to the dedicated Kentucky SKY Enrollee Call Center to assist with after-hours enrollment and eligibility issues.

Collaboration to Avoid Discrepancies and Delay of Care

We understand that the Kentucky SKY Enrollees will have immediate, unique care coordination and medical management issues that require immediate attention. Many also will have experienced trauma, have existing medication regimens, and have complex medical needs. Because we have served children in foster care since 2011, we know that delays in care due to eligibility or other administrative issues are unacceptable.

WellCare will promote collaboration with DMS, DCBS and DJJ in resolving eligibility issues by having our Regional Managers and DJJ Liaison meet at least quarterly with DMS, DCBS and DJJ representatives in each region. The participants will identify barriers, discuss recent issues and develop workable strategies for real-world situations, such as placement changes, new fictive placements and movements of adoptive Enrollees from Kentucky SKY into other Medicaid categories. Our Quality Department will provide needed resources for systemic plan improvements using the Plan-Do-Study-Act Model in order to develop and road-test solutions quickly. As needed, we can establish ad hoc work groups with governmental stakeholders to remediate any technology interface issues that are impacting eligibility, create routine telephonic touch-points to ensure that emergency placement protocols are working smoothly for our partners, and conduct training sessions with new Social Workers and Benefit Workers to explain processes and introduce local WellCare staff.

c. Describe the Contractor's proposed process to assign Kentucky SKY Enrollees to a PCP within two (2) Business Days of Enrollment. Include a discussion of the Contractor's approach to:

ASSIGNING SKY ENROLLEES TO A PCP WITHIN TWO DAYS OF ENROLLMENT

We understand that immediate access to a PCP for coordination and continuation of care is essential to the Kentucky SKY population. WellCare will comply with DMS requirements for PCP selection and auto-assignment for Kentucky SKY Enrollees within two days as stipulated in Attachment F. 41.14 of this contract and all federal regulations. Our number one priority is to ensure that the Enrollee's caregiver, foster parent, parent, DCBS or DJJ social worker, or the Enrollee (if emancipated), has the ability to select the PCP of their choice. Once chosen, PCPs will be assigned within two business days of receipt of notification via the 834 enrollment file or electronic notification from DMS or DJJ of the enrollment in Kentucky Sky. The Enrollee's caregiver, foster parent, parent, DCBS or DJJ Social Worker, or emancipated Enrollee is provided a temporary ID card provided by the embedded FOC or will have the potential to print Enrollee ID cards from the portal. We will also permit Enrollees to change their PCP at any time.

i. Assist Kentucky SKY Enrollees to select a PCP and auto-assign Kentucky SKY Enrollees who do not make a selection within the required timeframes

There will be times when it is not possible for a PCP to be selected quickly. To that end, our DCBS-embedded FOC will reach out to the involved parties after notification of enrollment to determine if a PCP with whom the Enrollee has a relationship is within access standards based on the official residence of the Enrollee, the location of the DCBS case, the Adoptive Parent's official residence, or the DJJ residential facility. For Former Foster Care Enrollees, assignment will be based on the county of residence.

We will follow this process whether WellCare is notified via the 834 enrollment file or via electronic notification from DMS or DJJ. We understand that a PCP selection must be made within two business days of our notification or WellCare will auto-assign the Enrollee.

While we prefer that the Enrollee select their PCP, if no PCP is selected, we will promptly auto-assign the Enrollee based on this Contract's requirements using our proven process that places a premium on quality. To ensure Enrollees have timely access to their PCPs and that PCPs are aware of their assigned panel, WellCare strives to process all 834 files and assign PCPs within 24 hours of receipt. Our Florida plan, which includes children in foster care, meets this requirement 100% of the time.

Our auto-assignment process adheres to GeoAccess® standards provided by our state partners and recognizes PCPs with high quality performance metrics. Because of the sensitive needs of this population, for Kentucky SKY Enrollees the process also prioritizes PCPs who have traditionally provided services to at-risk and Foster Care children and youth or have professional background in trauma-informed care and ACEs. We have found that PCPs who understand the population's needs, the immediacy often required in their care and the involvement of multiple critical stakeholders in the Enrollee's life provide more responsive, inclusive support and services to the Enrollee. Our auto-assignment algorithm also prioritizes network providers who follow the guidelines of the American Academy of Pediatrics in their *Health Foster Care America* initiative.

ii. Work with the Department, DCBS, DJJ, Foster Parents, and Adoptive Parents to assign PCPs

On initial enrollment, our locally-based FOC will reach out to the Enrollee's assigned state social worker and all related parties, including DMS as needed, to determine if the Enrollee has an established relationship with a PCP in the Enrollee's Medical Region or within the access standards for the Enrollee's location. As stated above, our preference is to maintain the Enrollee's current PCP (assuming the Enrollee's Guardian/Parent wishes to continue the relationship) for continuity of care.

In our Enrollee Handbook, orientation, and website, we will notify Foster Parents and Adoptive Parents of the need to maintain a PCP within access standards. We will instruct them to notify our Care Coordinator or Enrollee Services call center for any change of residence, concern about the current assigned PCP, or other need to change PCP (for instance, if the parent's other child have an in-network PCP and the parents wish to have the Foster Child be seen by that provider). All requests by Foster Parents and Adoptive Parents for PCP re-assignment on behalf of their child will be honored.

We also will discuss the assignment and auto-assignment process and any barriers to prompt initial PCP-of-choice assignment at joint monthly meetings with DMS, DCBS, and DJJ. By monitoring satisfaction with the assignment process as a routine item, we can develop improvements, create better early communications, and plan for any staffing or other changes at the stakeholder level that may impact our ability to meet the required timeframes for initial PCP assignment.

For placement changes post-enrollment for a Foster Care or JJ Enrollee, within one business day of receipt of notification, our FOC will work with the assigned state social worker to assess whether the Enrollee's access to the currently assigned PCP is still viable. If a new PCP is required because of the placement change, our FOC will work with the assigned social worker, Caregiver, or Foster Parent and assist in the selection of a new PCP based on factors such as distance, preferred gender, preferred language, quality, PCMH status, and familiarity with the Foster Care population. While we understand that the process of re-assignment must be complete within three business days of our receipt of notification of the Enrollee's relocation, either through the 834 eligibility file or written or telephonic notification from DMS or DJJ, it is our goal that Enrollees who relocate will select their PCPs in discussion with their care coordinator or FOC rather than be subject to auto-assignment.

If a Caregiver, Foster Parent, or Adoptive Parent (or an emancipated AA Enrollee) wishes to change PCP based on the Enrollee's needs, our Care Manager/Care Coordinator or Enrollee Services call center can assist in new selection and reassignment at any time.

For any PCP change, we will send a new ID card with the selected PCP assignment to the Enrollee within 5 business days of the receipt of the 834 file or 5 business days of the request for reassignment. The ID card will include the PCP's name, address, and telephone number. Our Core Processing System will electronically push the information about the assigned PCP downstream for all subsequent Enrollee contacts, including for care management and Enrollee Services. The Core Processing System will update changes to the PCP's Enrollee panel in our Provider Portal daily which exceeds this contract's requirement of an available PCP roster on the first day of each month.

iii. Track data to confirm that every Kentucky SKY Enrollee is assigned to a PCP.

Once a PCP is selected or auto-assigned, the information is loaded in our Core Processing System and immediately available and integrated into our downstream systems and applications, such as CareCentral for Care Coordination, Care Management and Utilization Management and CAREConnects for integrated Enrollee services, provider portals and websites, Enrollee mobile applications and other internal processes. Kentucky SKY Enrollees will be identified as a priority population and processed daily for Care Management assignment and engagement, helping to ensure that all assessments are monitored and completed in a compliant, timely fashion. This also ensures that all staff who provide direct Enrollee support, such as our Enrollee Services call center, have access to information for authorized caller verification and to support provider relations, claims, quality, and all plan-level functions.

iv. Inform PCPs of new Kentucky SKY Enrollees within the required timeframes.

WellCare's Provider Portal serves as a one-stop shop for providers to access needed information, including PCP assignment, panel additions and deletions, authorization support and training and claims support. The portal also allows provider to access our web-based tracking portal to view an Enrollee's care gaps, upload Enrollee information, and notify us when those care gaps have been closed or when the closure is not picked up by claims or encounters.

When a change is made to a provider's Enrollee panel, the change is submitted electronically to the Provider Portal. Providers can sort the updated list of their panel to quickly identify new Enrollees and Enrollees with outstanding care gaps.

We train providers in portal use upon entry to the network and our field-based Provider Relations staff provide additional assistance as needed. Providers can use our web chat function to interact with the health plan provider services team or to get real-time assistance with registration, login or technical issues with the portal.

v. Confirm that PCPs received the list of assigned Kentucky SKY Enrollees

WellCare is committed to providing immediate access to service to Enrollees in Kentucky SKY, which includes confirming that PCPs know when a Kentucky SKY Enrollee has been assigned to their practice. We will begin by training all our Kentucky SKY providers on the information available to them through the Provider portal, including a Member 360 view of each Enrollee on their panel. Upon assignment of an Enrollee to a PCP, in addition to updating the provider roster, we will automatically generate an email to the PCP notifying them that there is a new Enrollee on their panel and encouraging them to log onto the Provider portal to acknowledge receipt of the updated panel list. In addition, WellCare's Care Coordinator will conduct outreach and confirm that the PCP has received the list and has access to the information, including previous medical records that they need to begin providing care immediately.

vi. Provide a sample of the report the Contractor will use to notify PCPs of their assigned Kentucky SKY Enrollees.

Please see **Attachment G.5.c.vi. Sample Notification to PCP of Assigned Kentucky Enrollees.**

d. Describe the Contractor's proposed process for communicating with Kentucky SKY Enrollees about their PCP assignments and encouraging Kentucky Care Enrollees to schedule regular appointments with their assigned PCPs and keep scheduled appointments. Include how the Contractor will identify and work with Kentucky SKY Enrollees to resolve barriers to keeping appointments and how the Contractor will work with resources available at the Department, DCBS and DJJ to communicate with Kentucky SKY Enrollees. Include a discussion of how this process would differ when communicating about their Dental Provider assignment and encouraging Kentucky SKY Enrollees to schedule and keep regular appointments with Dental Providers.

WellCare's proposed process for communicating with Kentucky Sky Enrollees about PCP assignment and encouraging them to schedule and keep regular PCP appointments is grounded in a singular purpose: to ensure that Kentucky's most vulnerable children and youth receive routine care to avert health problems and early detection to diagnose and treat any condition. We recognize that foster and adoptive parents and caregivers of Enrollees with behavioral issues, unstable living environments, and tremendous daily stress will spend much time on management of existing physical and behavioral health diagnoses and are less likely to be attentive to routine health care. Providers, in

WellCare will issue electronic tablets with embedded applications to foster caregivers to ensure the caregiver has access to the Enrollee's history, Medical Passport, and providers.

turn, are more likely to focus on existing special health needs, such as depression, autism, and severe asthma, over more routine health checks.

Our process will focus on strategies and tactics that have proven successful in delivering EPSDT and other PCP and dental services to children and youth who have multiple health issues, such as the nearly 34,000 children and youth with special health care needs that we serve in Florida, or who are in child welfare or juvenile justice programs. Our tactics include extensive and ongoing outreach and engagement, care coordination, education for caregivers, and Enrollee incentives.

INITIAL COMMUNICATION ON PCP AND DENTAL ASSIGNMENT AND APPOINTMENTS

Immediately after enrollment and PCP assignment, we will notify the Enrollee (and their Caregivers) in writing and provide an ID card as described above. We also will notify the assigned providers of the addition to their enrollment roster.

Along with the ID card, we mail the Enrollee a New Enrollee Packet, compliant with this contract, including an Enrollee Handbook. The Enrollee Handbook includes a complete list of all EPSDT health check services, the age of the child for each service, and a simple explanation as to why these services are so important for a child's wellbeing. We also remind caregivers of Enrollees to contact our call center for help scheduling appointments and provide special information for Enrollees with asthma or diabetes.

As part of our enrollment process, we also will provide a new Enrollee orientation during the comprehensive care management assessment care plan process. During this orientation the Care Coordinator reminds the Enrollee and their caregivers of their PCP's location and hours and attempts to set an initial appointment. The Care Coordinator also explains the WellCare Healthy Rewards Program and the benefits the Enrollee can receive automatically for completing certain routine care visits.

After the comprehensive assessment upon enrollment, the Care Coordinator or FOC will notify the Enrollee's PCP of any care gaps, including any needed EPSDT primary care services that should be completed at the first appointment. To avoid care gaps during the transition, WellCare will allow PCPs to bill for EPSDT services for a new Enrollee even if the EPSDT service has already been billed within the given time frame.

Additionally, the Enrollee's WellCare Care Coordinator will reach out to the Enrollee regarding all care gaps, including the annual dental exam and other dental services. As needed, the Care Coordinator will provide instruction and coaching to the Caregiver about the need for services, growth and developmental milestones, and the role of the PCP as a true partner in their Enrollee's move toward stability and permanency. The Care Coordinator also will

- Assist in appointment scheduling
- Offer transportation assistance and work to remove other social need barriers to maintaining a preventive health schedule
- Coordinate with school-based clinics and nurses to determine what preventive services can be offered at school, a setting that can be more comfortable for some Enrollees than a provider's office

- Collaborate with the Enrollee's circle of support and/or community advocates, such as special education advocates, to reinforce the need for the Enrollee to schedule and maintain preventive PCP appointments and obtain all EPSDT services
- Involve the services of our community-embedded Community Health Workers for a personal home or provider office visit with the Enrollee to remove barriers to care, encourage healthy behaviors, and instruct on self-help, such as diabetes management at school for the Enrollee and how to properly store and dispense medications for the caregiver.

ENCOURAGEMENT AT MULTIPLE TOUCH-POINTS

We will use every opportunity to remind Enrollees of the need for PCP visits and preventive care. Our Enrollee education process recognizes the need for multiple varied and innovative strategies to effectively communicate the benefits of self-care to our Enrollees and their caregivers. We will attempt to engage Enrollees early in their enrollment and then consistently reinforce the messaging. We will address the importance of preventive care, the periodicity schedule and the depth and breadth of EPSDT services, how and where to access services, including transportation and scheduling assistance, and will remind Enrollees that services are provided without cost.

With our dental benefits administration subcontractor, WellCare is launching a multi-modal outreach program in 2019, (including mailings, phone calls and text messaging) to reach the 12% of our foster care Enrollees who have not had a dental visit in the previous two years. Based on our subcontractor's previous success, we anticipate increasing the rate of Enrollees in this group who get their recommended dental visit by as much as 33%.

We also will remind our Enrollees that their PCP is their navigator for many services besides "a check-up." We will instruct PCPs on how to obtain a variety of Enrollee services specifically for the Kentucky SKY population, such as wrap-around services from community agencies, assistance with social determinants of health (such as food scarcity), educational assistance, behavioral health services for the Enrollee and/or the Caregiver, and 24/7 telephonic assistance for all PH and BH questions and crisis through our 24-Hour Nurse Line.

To encourage Enrollees to make and maintain their appointments, WellCare will

- Send out "Happy Birthday" reminders of needed annual services. Based on our research, we mail these cards two months prior to the Enrollee's birthday so Caregivers have time to plan their schedules. We also send out immunization reminders. These reminders have proven very successful in our other state plans. Between HEDIS reporting years 2016 and 2017, our Florida adolescent well-care visits rates improved by over 4%, well-child visits in the first 15 months of life improved by 13.5% and visits in the 3rd, 4th, 5th and 6th years by more than 6%.
- Reach out Enrollees or Caregivers of EPSDT-eligible Enrollees who have not seen their assigned PCP soon after initial enrollment to assist in appointment scheduling, provide education on the need for the visit, and discuss needed dental services. Our EPSDT Coordinator also can assist in re-assigning an Enrollee to a different PCP or dentist if, upon

discussion, it seems that another network provider is a better fit for the Enrollee. In our experience, some Enrollees and Caregivers who are auto-assigned because they did not choose to make a selection discover that they do have a preference in network provider. The EPSDT Coordinator will arrange the new assignment and offers to schedule the appointment. We also will mail a follow-up letter encouraging the appointment if one is not made.

- Capitalize on Enrollee or caregiver-initiated calls to our call center to remind them about recommended screenings, check-ups, and immunizations. Our care gap identification analytics are integrated into our contact management system, CAREConnects, so that they are readily available to our Enrollee Services representatives. This allows our representatives to address the reason for the call and then to remind them of existing and upcoming care gaps. The representative also will offer to schedule appointments and remove barriers and will connect the family to the assigned care coordinator to assist. For adopted Enrollees, a health coach will outreach twice per year and is available to assist between those visits. The health coach will remind the adoptive parents of appropriate EPSDT services.
- Monthly, using our data management solution, WellCare runs a care gap data model identifying Enrollees who may be due or non-compliant for important EPSDT services to target specific outreach and education. We will use this same process to identify and target Enrollees who have not had dental screenings. We also will electronically “push out” this care gap information on the ClearSKY app we provide to each foster parent so that they can see all their child’s needed appointments and screenings in one view. We will use ClearSKY to communicate with foster parents on the importance of maintaining a relationship with the Enrollee’s PCP and dental provider and offer detail on contacting us immediately if they experience a barrier to service.
- Provide a variety of colorful, age-appropriate health information materials that meet or exceed all contractual standards for readability, font size, language, and alternative formats. We distribute materials via the Enrollee portal.

IDENTIFYING AND RESOLVING BARRIERS TO CARE

Every WellCare staff who interacts with our Kentucky SKY Enrollees will be responsible for identifying and resolving any immediate barriers to PCP access. As examples:

- Our Care Coordinator will work directly with the Enrollee and caregiver to remove any individual barriers that prevent scheduling and keeping appointments with PCPs or dentists, such as pre-appointment reminders , assistance with transportation, and re-assignment assistance to a more preferred PCP or dentist, and developing personalized home-reminders of upcoming appointments (e.g. refrigerator calendars, etc.)
- Our dedicated Kentucky SKY call center agents also will provide reminders, set appointments, arrange transportation, and notify the Care Coordinator for barriers related to unmet social needs impacting appointment compliance (e.g. child care arrangements for other children).
- We will permit Enrollees or their caregivers to change PCPs at any time.

We know from our experience with children involved in the foster care or juvenile justice systems in other states that there are sometimes barriers unique to these Enrollees when accessing PCP and dental services. These Enrollees often have experienced serious trauma and have behavioral health and development differences that negatively impact their ability to enter a provider's office or receive routine services and treatments. WellCare is committed to ensuring access for all Enrollees and we work with our providers to ensure that every Enrollee feels safe, comfortable, and valued during provider appointments. For example, we will:

- Provide training in Trauma-Informed Care, including identifying secondary trauma, to all providers, including pediatric dentists. We will track which providers have received the training and our Provider Relations staff will connect a provider to additional training if necessary.
- Provide the American Association of Pediatrics' (AAP) Trauma Toolbox for Primary Care for Children with Adverse Childhood Experiences to prepare practitioners for these visits, as well as AAP policy statements on management of pediatric trauma.
- Provide materials for download to help prepare providers, Enrollees and caregivers for upcoming visits, including the AAP Parent Guide, Caseworker Guide, and Pediatrician Form found on the AAP Healthy Foster Care website.

We already have worked with our dental services provider, Avesis, to develop a methodology to provide sedation for children or youth who require it in order to overcome their previous trauma and anxiety and receive dental services safely.

IMPROVING COMMUNICATION WITH ENROLLEES THROUGH COLLABORATION WITH DMS, DCBS, AND DJJ

WellCare will work closely with our partners in DMS, DJJ, and DCBS toward the common goal of ensuring that all Kentucky SKY Enrollees receive the preventive physical and dental services they need for good health. In our monthly meetings we will collaborate on issues and ideas to communicate with and encourage Enrollees and their caregivers to maintain relationships with their PCPs and dentists. We will discuss best practices from our other plans serving this population and import those practices to Kentucky SKY where appropriate.

To maintain daily, transparent communications with DMS on time-sensitive issues and to develop a true collegial relationship, WellCare proposes to embed an FOC in each DCBS/DJJ office. Depending upon the number of Enrollees and the intensity of services required, the FOC may serve daily (five days per week) in the state office or on a routine schedule. The FOC will serve as the first WellCare contact for DCBS/DJJ when a child enters foster care and serve as a navigator for anything the field-based staff needs from WellCare to best serve Enrollees. FOCs will monitor the delivery of needed assessments and reports, especially for court-ordered reports, and bring WellCare resources to eliminate any local barriers to access.

Our Care Coordinators/Care Managers also will work closely with the Enrollee's assigned DCBS or DJJ Social Worker during the Assessment Team meeting on coordination of care issues. In cases where Enrollees have significant care gaps or have not been able to maintain a relationship with their PCP (and, for instance, use the Emergency Department or Urgent Care

routinely), we will coordinate with our state stakeholders on the best approaches for the individual Enrollee and their caregiver.

Encouraging Dental Appointment Compliance

WellCare gives the same priority to dental care for our children and youth as we do for physical and behavioral health services. For Kentucky SKY, our processes for encouraging Enrollees to schedule and attend regular dental appointments will be the same as those for PCP services as discussed above. We will outreach annually to encourage appointment scheduling and send reminders. Our staff will work to remove barriers to care such as transportation. Our dedicated call center staff will remind Enrollees and caregivers of needed preventive dental care. Provider Services will work with our dental network to alert them to the impact of trauma on the Kentucky SKY population.

We will assign a dentist to each Enrollee upon receipt of the 834 eligibility file either based on preference or auto-assignment, using the same process as for PCP assignment. Each Enrollee's Care Coordinator will coordinate with the dentist and, as appropriate, include the dentist on the Enrollee's Care Coordination team. We will contractually require our dental providers to involve DCBS or DJJ staff, the Enrollee's Foster Parents or Adoptive Parents, other dental specialists and non-dental professionals in coordinating the provision of dental care services, including complex dental services for Kentucky SKY Enrollees with special needs. Through our partnership with Avesis and Big Smiles, the largest mobile dental provider covering the entire Commonwealth, we will ensure that every foster child, adopted child and DJJ child has access to consistent dental services.

SKY Smiles

In 2018, nearly 12% of our foster care enrollees had not had a dental visit in the previous two years. As a result, WellCare launched a multi-modal outreach program (mailings, phone calls, text messaging) to increase dental exam utilization for these enrollees. We received approval from the Commonwealth for our proposed messaging to this population, which focuses on improving the health and lives of enrollees in foster care through regular dental checkups which helps keep their teeth clean, maintains oral health, and helps find problems early. Based on our dental benefits administration subcontractor's success rates with this outreach for other vulnerable populations with lapsed dental utilization, we anticipate increasing Annual dental visit rates by as much as 33% among our foster care enrollees who do not have record of a dental visit in the previous 24 months once this project has concluded.

Culturally Competent Outreach and Education. We will provide culturally and linguistically competent education and outreach for enrollees and their caregiver team on the importance of having a dental home, combined with targeted outreach to help ensure they are taking full advantage of their dental benefits.

Tele-dentistry. We will use tele-dentistry technology to help ensure Kentucky SKY enrollees and their dental home team can continue to work together, even if the enrollee needs to move to a foster home outside of the 50 miles/50 minutes access standards. Using synchronous modalities, we will connect Kentucky SKY enrollees with their dental home provider(s) by scheduling and deploying Public Health Hygienists to the enrollee's home, school or other

community-based location to help facilitate the virtual appointment. In the case that treatment in a brick and mortar provider office is required, care coordination will ensure that the best care is received in every instance. Included with care coordination is our ability to assist with scheduling so that our members are provided care at a time and location that is most convenient for them and their care providers. Finally, this set of tools ensures maintained engagement so that continuity of care is preserved, and our members maintain consistent progress in their treatment plans. Our use of tele-dentistry will be aligned with the Commonwealth's new tele-health regulatory requirements.

Dental Home: In 2020, every SKY Enrollee will be assigned to a primary care dentist and, if necessary, an orthodontic dental home. These dental assignments will follow the Enrollees through their foster care experience to maintain stability in this important caregiver relationships. The dental home will ensure continuous access to comprehensive and coordinated care for all preventive, acute, and ongoing oral health needs. If we are unable to maintain the Kentucky Sky Enrollee's relationship with their previous dental provider team, we will facilitate the transfer of care to their new providers and will pay for all treatment in progress.

e. Foster Care (FC) Enrollees and Juvenile Justice (JJ) Enrollees often experience changes in placement. These placement changes may require assignment of new PCPs and Dental Providers. Describe the Contractor's proposed process to assess a FC or JJ Enrollee's access to a PCP and Dental Provider timely after a change in FC Enrollee or JJ Enrollee placement and assigning a new PCP or Dental Provider if the prior Provider no longer meets access standards.

ACCESS TO PCP OR DENTAL PROVIDER AFTER CHANGES IN PLACEMENT

WellCare understands that unplanned placement changes for Enrollees in Kentucky SKY – while necessary – may be disruptive to their care as well as to other aspects of their young lives. With ours and our affiliates experience serving child welfare and juvenile justice Enrollees nationwide, we understand the reasons for and the results of placement changes. We already have processes in place to ensure ongoing delivery of service, access to PCP and dental providers, evaluation of access after a placement change and reassignment of providers when needed, continuity of care management and care plans, and transparent communications with our state stakeholders and the foster parents so critical to smooth placement changes.

ASSESSMENT OF ACCESS AFTER A PLACEMENT CHANGE

We will receive notification of a change in Enrollee placement from:

- As part of the high fidelity wrap-around plan or transition into permanency
- Direct telephonic notification from DMS or DCBS or DCBS official notification to our embedded FOC
- Direct contact with an Enrollee, caregiver, foster parent or adoptive parent during a change of address call
- The daily 834 enrollment file with notification of new address

We will assess the Enrollee's access to their currently assigned PCP and dental provider. Using Geographic Access standards as defined in the contract, we will determine if access standards are met at the Enrollee's new location.

If the PCP and/or dental provider no longer meet the access standards, we will notify the DCBS Social Service Worker, designated DJJ staff, caregiver, foster parent, adoptive parent, or Enrollee and request that a new PCP and/or dental provider be selected. If part of a planned transition, this process will be finalized the day the transition occurs. If the placement change is unplanned, this process will be finalized within two business days or we will auto-assign the Enrollee to a new PCP and/or dental provider. We will search our providers based on the Enrollee's preferences (i.e., gender, language, etc.) to offer informed choice and to meet the Enrollee's needs.

We expect that through our care coordination program and the co-location of our FOCs in each DCBS/DJJ regional office, the number of auto-assignments necessary after an unplanned placement change will be minimal. Since our care coordination team will have an ongoing relationship with care providers, parents, Enrollees and DCBS/DJJ staff, we anticipate this will expedite a more tailored selection of a new PCP or dentist.

Once the new assignment is made, we will reissue an ID card to the Enrollee with the name, address, and telephone number of the new PCP. In addition, Enrollees, their caregiver or our FOCs can print new Enrollee ID cards at any time from our ClearSKY app that WellCare will provide to foster parents.

f. Describe the Contractor's process for engaging Adoptive Parents who request to opt out of the Kentucky SKY program to stay enrolled, including:

WellCare's goal is to maintain Enrollees who are children of Adoptive Parents (referred to here as AA Enrollees) in Kentucky SKY. WellCare is well positioned to provide an array of physical and behavioral health services to the AA Enrollee, along with continuing care coordination, wrap-around services, 24-Hour Nurse and Behavioral Advice Line Support, and a network of providers who are sensitive to the unique needs of this population. While we understand that some Adoptive Parents may want to move their child away from all the trappings of their child's former life in Foster Care and we will refer Adoptive Parents or AA Enrollees who wish to disenroll from Kentucky SKY to DMS or its agent, it is also our role to help them understand the advantages of continuing coverage under the program in order to continue receiving specialized services. WellCare Care Coordinators who are working with foster youth and children who are in the process of being adopted will provide information and education to the adoptive parents about the benefits to the child of retaining their enrollment in Kentucky SKY.

WellCare understands that an AA Enrollee can elect to disenroll from Kentucky SKY without cause during the Open Enrollment period and for cause at any time, and that the Enrollee may remain with WellCare or select another MCO contracted with the Commonwealth's Medicaid program. An AA Enrollee may request disenrollment without cause during the 90 calendar days following the date of their initial enrollment in the program or the date DMS or its Agent sends the Enrollee notice of enrollment, whichever is later. AA Enrollees may request disenrollment without cause every 12 months thereafter.

i. Process for outreach and engagement of Adoption Assistance (AA) Enrollees.

ADOPTIVE PARENTS WHO WISH TO DISENROLL THEIR CHILD

When an AA Enrollee or Adoptive Parent nevertheless indicates that they wish to disenroll, our FOC will either take the parent's call directly or via a warm transfer from the call center or Care Coordinator. The FOC, using communications techniques and scripts to probe for underlying cause, discusses the AA Enrollee's reasons for the disenrollment request. In an engaging, non-judgmental manner, the FOC will discuss gently the reasons behind the request for disenrollment.

We have learned from experience in other state child welfare programs that sometimes AA Enrollees have misconceptions about health care coverage post-adoption. Some AA Enrollees believe they must switch plans or must take the coverage other family members have post-adoption in order to retain their coverage. They sometimes think that, if the family relocates to a different Kentucky county, they must switch coverage. They also may be under the misconception that, post-adoption, they may not continue with their current PCP and thus want to switch coverages to stay with the same PCP they have under Kentucky SKY or, conversely, may want a different PCP and do not understand they can select providers from our entire network. Some AA Enrollees may be entering college in another part of Kentucky and do not understand that they may keep their coverage even while in school.

Depending on the Enrollee's responses, the FOC shares information on the advantages of remaining in Kentucky SKY and clear up any confusion or misinformation. Our FOC also encourages the AA Enrollee to compare Kentucky SKY benefit and value-added benefits under WellCare with other coverages available to the Enrollee.

In other cases, the AA Enrollee may have a complaint or core issue with WellCare. Our FOC and Inquiry Coordinator will work with the Enrollee to resolve the issue, explaining that even if the Enrollee disenrolls, we are committed to our Enrollees' satisfaction and want to deliver on that promise. If the AA Enrollee still decides to disenroll after working with our staff, we refer them to DMS or its agent to complete the disenrollment and follow the Transition/Coordination of Care Plan contained in Appendix J Transition/ Coordination of Care Plan.

For example, a newly adoptive parent reached out to WellCare to disenroll a month after completing adoption of a medically complex foster child. The adoptive parent believed that the child would not be able to continue to receive the current services offered under WellCare's Medically Complex foster program. During the phone call, the child's Care Coordinator was able to explain that WellCare would continue to maintain a presence in the child's care, would continue benefits and that the current Care Coordinator would continue to work with the family post-adoption. The adoptive parent was surprised and happy to learn that the current benefits and care management assistance would continue and dropped the request to disenroll.

ii. Conducting surveys with AA Enrollees to determine the reason for opting out of the Kentucky SKY program.

WellCare will survey AA Enrollees post-disenrollment to determine the reasons for the disenrollment, to obtain feedback on our programs and services, and as part of continuous quality improvement. With DMS permission, we will develop an easy-to-complete but

comprehensive survey for AA Enrollees, mailed to their homes with a postage paid return. The mailed survey also will include an online address and unique password allowing the Enrollee to complete the survey at their leisure on line, with secure delivery to WellCare.

Using standard survey scales and best practices for question development, we recommend that the survey explore reasons for the disenrollment, both generic by category and specifically with space to write in a personal reply as well as utilizing a rating scale of 1 – 5 for level of satisfaction with the following:

- WellCare services
- Enrollee's Kentucky SKY PCP
- Other delivery services, such as dental and behavioral health
- Value-added services and Enrollee Rewards
- WellCare's Care Coordination services
- If the Enrollee would allow additional personal follow-up post-survey
- Open-ended question giving the Enrollee an opportunity to discuss any part of their experience with the Kentucky SKY program.

We will mail the survey to each disenrolled AA Enrollee within 30 days of verification of disenrollment and follow-up with one telephone call to request that the survey be completed either by mail or on- line or by calling the FOC directly to complete the survey and discuss their experiences with WellCare.

iii. Attempts for periodic re-engagement after disenrollment

Our program of re-engagement will include some or all of the following:

- Outbound calls to the former Enrollee by our FOC or Care Coordinator after a review of the Enrollee's record in CareCentral, our service management platform, and notes from the disenrollment interview discussed above to note any dissatisfaction or challenges during enrollment.
- Twitter and Facebook notices to former AA Enrollees about the benefits of re-enrolling in Kentucky SKY with an offer of assistance from our staff to assist with re-enrollment; and reminders that Kentucky SKY is available to them until age 26.
- Reminder post-card (or emails to those AA Enrollees who indicated email as their preferred method of contact while enrolled in WellCare) that re-enrollment in Kentucky SKY for former AA Enrollees is possible until age 26 and to contact us with any questions.
- For former Enrollees whose mail is returned as undeliverable or whose contact information is no longer valid, we will task our REACH program with trying to contact these "unable to contact" Enrollees.

iv. Include how the Contractor will use results from the survey to improve the program.

Survey results will be analyzed by our Quality Improvement Committee, which includes participation from all key operational and medical management departments, as part of our continuous quality improvement efforts. We will monitor data around the number of AA Enrollees who disenroll, their geographic locations and other personal demographics, their

utilization, and PCP selections to determine any patterns for commonalities that require further exploration. Survey results also will be shared with our Enrollee Outcomes Advisory Group and our Provider Panels.

We will require individual departments to investigate any specific concerns offered by the former Enrollee, such as a review by Provider Relations of any suggestion that a provider was not compliant with appointment access standards.

Survey results will be part of our Enrollee satisfaction analysis, along with other common quantitative reports such as the annual CAHPS Survey, data from our Enrollee call center, and care management surveys, and our qualitative Enrollee satisfaction analysis, such as from focus groups, work with community-based organizations, and our Enrollee Advisory Board.

We will share results with our Provider Advisory Panels and with DMS and other governmental partners in a format and frequency determined by DMS. We also will share with DMS any written information, anecdotal discussions and results of our disenrollment interviews with former Enrollees that will be useful for DMS planning.

Additional Review for Improvements

We also will engage community-based organizations involved in adoption, such as the Orphan Care Alliance, for advice on policies, perceived barriers, or issues that might be an obstacle for AA Enrollees' continued enrollment. Our experience has shown that the adoptive community sometimes has misunderstandings about the role of managed care organizations during the foster care and adoptive process that we may need to address to relieve adoptive parents of unwarranted concerns. The Orphan Care Alliance and similar community organizations also may have advice on the best methods of communication with adoptive parents to assist our engagement and re-engagement effort.

g. Provide the Contractor's proposed plan for providing Kentucky SKY Enrollees with ID cards in the required timeframes (be issued initially within five (5) Calendar Days of receipt of the eligibility file from the Department and reissued within five (5) Calendar Days of a request for reissue) in the following instances:

WellCare is committed to ensuring that we issue an accurate ID card to Kentucky SKY Enrollees within five calendar days of our receipt of the 834 enrollment file or a request for a reissue of the ID card for any reason. From our experience with children and youth in foster care, we know that ID cards for children in foster care may need to be reissued frequently due to placement changes, name changes, or other factors.

WellCare of Kentucky mails a new Enrollee welcome packet within the first five business days of Enrollment. The packet includes an Enrollee Handbook, a Quick Start guide, and an Identification Card (ID card) and letter (separate mailing). The ID card includes the PCP's name, the Enrollee's Identification Number, and the BIN/IIN and PCN number with the toll-free phone number for pharmacy provider assistance as well as Enrollee assistance.

When they need a reissued card, Enrollees or their caregivers can request it by calling the 24/7 telephone number of our dedicated Kentucky Sky Enrollee Services Call Center or via our Enrollee portal. They also can forward their ID card to their provider's office via our MyWellCare mobile app. For Kentucky SKY Enrollees, we offer the option that they can print it

themselves from our ClearSKY app provided to all caregivers. If needed, the Care Coordinator or FOC can assist them in printing it. Providers also can call our call center to confirm an Enrollee's active enrollment.

i. Report of a lost ID card.

When an Enrollee or Enrollee's caregiver reports to their Care Coordinator, FOC or DCBS or DJJ case worker that they have lost their ID card, we request they access the ClearSKY app on their issued tablet device to print a new card. If necessary, their Care Coordinator, FOC or case worker can use the ClearSKY app to print the new card. In addition, we will mail a new card within five calendar days upon request.

ii. A Kentucky SKY Enrollee Name Change.

When we are informed of an Enrollee's name change through an 834 enrollment file, that name change is reflected on the Enrollee's ID card available for printing through our ClearSKY app within five calendar days. They will automatically receive a new card reflecting the name change or can request one by calling the Enrollee Services Call Center or via the MyWellCare mobile app.

The Enrollee's Care Coordinator will provide information to adoptive parents or enrollees on DMS processes for documenting name changes. Once the DMS processes are complete, the Care Coordinator will work with enrollment services to "watch" the process take place and ensure that the correct information is loaded into the system and the Enrollee is able to receive the new ID card. The new Enrollee ID card will be mailed within five calendar days.

iii. A new PCP assignment.

When a new PCP is assigned, our system automatically generates a new ID card that is available for printing through our ClearSKY app within five calendar days. If necessary, their Care Coordinator, FOC or case worker can use the ClearSKY app to print the new card. A new card will be mailed within five calendar days.

iv. FC or DJJ Enrollee moves to a new placement or for any other reason that results in a change to the information disclosed on the Kentucky SKY Enrollee's ID card.

When a child or youth in foster care is moved to a new placement and the new placement results in either a change in the Enrollee's PCP or a change in residential address, our system automatically generates a new ID card that is available for printing through our ClearSKY app within five calendar days. If necessary, their Care Coordinator, FOC or case worker can use the ClearSKY app to print the new card. The new ID card will also be mailed within five calendar days.

h. Describe how the Contractor will address and manage crisis calls during business hours as well as after hours.

A crisis situation can occur at any time on any day. At WellCare, there is no "wrong door" when it comes to seeking help for a crisis. During business hours, Enrollees, providers, DCBS/DJJ staff, and parents will be directed through a warm hand-off to the care management team who can provide immediate assistance. The care management team immediately begins addressing the crisis by accessing additional local resources, identifying providers for immediate assistance,

calling emergency services, or scheduling a face-to-face appointment. The team works on developing a plan of care that addresses the crisis and includes follow-up steps for the Enrollee and their care team. We continue to work with the Enrollee, care provider, parent, and DCBS/DJJ workers until the crisis has stabilized, and ongoing support has been identified and established.

Both during and outside of business hours, WellCare of Kentucky operates a Behavioral Health (BH) toll-free crisis services hotline answered by highly qualified staff 24 hours per day, seven days per week, year-round throughout the Commonwealth. Our Enrollee Services Call Center representatives are also trained to correctly identify a crisis and work with the staff at our crisis services hotline. When a crisis call is identified, the representative conducts a warm hand-off, provides support for the remainder of the call, and ensures that information is documented in our system for immediate follow-up by a care coordinator/care manager.

BEHAVIORAL HEALTH (BH) CRISIS SERVICES HOTLINE

Applying a person-centered approach to service, our hotline associates provide crisis triaging to assess Enrollees' behavioral and physical health, pharmacy requirements, and social determinants of health needs, including need for crisis services. BH crisis line clinicians who assess, de-escalate, triage, and address specific BH emergencies are licensed and include Licensed Clinical Social Workers, Licensed Mental Health Counselors (LMHCs), Registered Nurses (RNs) and Intellectual/ Developmental Disability (IDD) professionals with advanced BH training.

Our call management system, including our Automatic Call Distribution (ACD) system, fully integrates our call center operations so that a caller may receive BH crisis support seamlessly even when calling the Enrollee Services line or our 24-Hour Nurse Line. Additionally, our service line professionals are able to get all the information they need for an Enrollee at "one touch" to facilitate quick resolution. This responsiveness supports on our "no wrong door" point of entry for calls supporting the caller regardless of the day or time of the call or the caller's need.

Our BH crisis line is always answered by trained staff. Calls are never answered by automated means, never receive a busy signal and are never put on hold. We have no maximum call duration limits and allow callers and our answering BH Clinicians take whatever time is necessary to resolve the Enrollee's issue completely. We provide extensive training to all call center staff across all lines in BH crisis protocols. Training reinforces the differences between the needs of a Kentucky SKY Enrollee compared with other Medicaid Enrollees, especially as related to trauma, Adverse Childhood Experiences (ACEs), and confidentiality of information and the caller authorization process.

Our BH crisis line meets or exceeds all contractual standards for metrics. During the first quarter of 2019, there were 408 calls to the hotline with 100% answered by the fourth ring, zero calls receiving a busy signal and zero calls placed on hold. The system can immediately connect a caller to the local Suicide Hotline telephone number and other Crisis Response Systems. During the first quarter of 2019 four calls were connected with the Suicide Hotline or emergency services. Our system has and our staff are trained to use patch capabilities to 911 Emergency Service.

In 2017, our call centers handled 12.7 million calls of all types with experience, care, and compassion and in December 2017 alone, our BH Services Hotline received 525,941 calls, of which 56 were emergent or life threatening. Please see our response to C. 23 for more information about our delivery of BH services during and after the crisis call.

We understand our obligation to contribute to a statewide emergency Behavioral Health hotline in an amount equal to our proportional share of Medicaid Enrollees per Contract year as sited in Section F. 33.6 of this Contract.

APPROACH TO ADDRESSING CRISIS CALLS

Enrollees (and their caregivers and providers) can reach our BH crisis line by telephoning the number found on our website, the ID card, and our Enrollee materials. They also can reach the BH crisis line by dialing our Enrollee call center line or via our 24-Hour Nurse Line. Since our dedicated Kentucky SKY Enrollee call center will operate 24/7, our trained representatives will be able to quickly assess whether the caller needs BH crisis support. If so, they will use our tested protocols and technology to swiftly deliver the caller to BH Crisis staff without delay, on-hold time, or call-backs.

Figure G.5-1 shows that our approach to addressing BH crisis calls from Kentucky SKY Enrollees will be the same no matter whether the call comes during business hours for the plan or after hours.

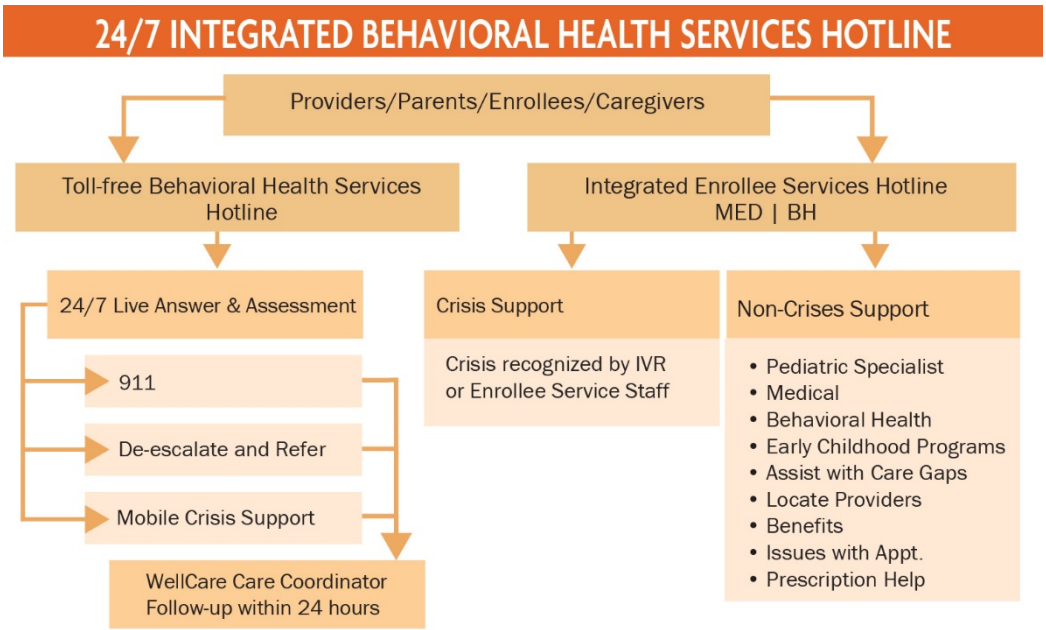

Figure G.5-1: BH Crisis Call Flow

The illustration demonstrates the simple process flow for any BH crisis call coming to our integrated service. Since all lines operate on the same technology platform with the same reporting capabilities, no call or its information is lost. All integrated lines have access to a language line for immediate language translation services, including access to American Sign Language interpreters and all staff receive cultural competency training at hire and annually.

On our crisis line, BH clinicians assess and make an immediate determination of an Enrollee's acuity level, document the call as either routine, urgent, emergent or life threatening and follow related protocols until the crisis is resolved. This includes activating emergency services or local mobile crisis providers when available, or helping the Enrollee de-escalate and connect to their Provider, depending on need. Crisis call procedures will be followed for all callers in crisis, regardless of eligibility or plan provisions.

FITT-Acute Crisis Intervention and Diversion Program

To address Kentucky's need for true mobile crisis treatment, we recently contracted with Lifecare to provide the FITT Program of virtual residential treatment for youth living with caregivers in a community setting. This is an intensive in-home program partnering with families to resolve crises, avoid out-of-home placement and provide skills for future crisis prevention. It also serves as a step down from inpatient or PRTF; and an alternative for youth at risk of hospitalization and PRTF. Just a few examples of what the FITT Program provides include:

- Door and window alarms
- Prescription lockboxes
- Respite for parents
- Access to a same-day prescriber

Care Management Follow-Up

For any crisis call received outside of normal business hours, Enrollees assessed with emergent needs will receive a follow-up call from our care management team within one business day. All calls are captured through a feed to our CareCentral clinical platform, a fully integrated system that logs, tracks, and displays individual Enrollee diagnoses, needs, utilization, and experience, across the full array of medical, behavioral, pharmacy and social service resources. Each BH Crisis Line call is documented as a change in the Enrollee's condition requiring expedited follow-up from the local care management staff within one business day, including connection with the Enrollee's providers.

Care Management supervisors are alerted daily of crisis calls received. The supervisor is provided a detailed description of the crisis call, Enrollee information, as well as the steps the clinician followed during the call. The supervisor immediately assigns the Enrollee to a Care Coordinator for follow up, if the Enrollee is not already engaged. The Care Coordinator follows up with the Enrollee within hours of the notification of the crisis, at least within 24 hours. As part of the follow up process, the Care Coordinator will research the Enrollee's medical record. Through this research, if the Enrollee is high risk on the LACE assessment, the Care Coordinator will include this information in the follow up process and assist the Enrollee in all identified needs once the crisis issue has resolved.

MANAGING BH CRISIS CALLS THROUGH SOPHISTICATED TECHNOLOGY

WellCare's telephone technology and desk-top tools assist our staff in managing every BH crisis call efficiently, so staff can concentrate on the caller's immediate need.

- CAREConnects, our call management platform, immediately generates emergency/crisis script guidance when our answering staff activate a red button. Staff uses the script to carry and document the call, beginning the de-escalation process, while CAREConnects automatically triggers a licensed BH clinician to join the call. There is no call transfer. Instead, a warm connection occurs between the licensed BH clinician and our Enrollee. The answering staff remains on the line and works with the clinician until the immediate situation is safely resolved or until released by the clinician from the call.
- Our word recognition program, Interaction Analyzer, automatically flags calls based on specific keywords that have been identified as high risk. For example, when a Enrollee mentions words or phrases such as “I’m going to kill myself,” “I’m having difficulty,” “Emergency,” or “Having a hard time,” the system recognizes the word and directs the WellCare staff member to immediately escalate the call to a supervisor or to the BH Crisis Line clinicians for prompt intervention and resolution. Our lexicon includes more than 100 key words and continues to be refined and expanded.
- WellCare’s NICE IEX workforce management platform ensures we have the right staff at the right time to handle all incoming Kentucky Enrollees calls, including on the BH Crisis Hotline. The platform pulls data from historical Kentucky call center volume and, based on experience, factors in predictable events that spike calls. With this predictive modeling capability, the platform generates optimal steady state staffing levels.
- Because answering BH crisis calls immediately is critical, our Genesys® instruments generate service level data every 30 seconds enabling our call center analysts to respond in almost real-time to any dips in performance, monitoring performance against contractual standards and maintaining efficient, speedy answer to every incoming call. We monitor and measure performance for the BH Services Hotline standards as required by this Contract and will submit performance reports summarizing call center performance as indicated. We also shall conduct ongoing quality assurance to ensure these standards are met.
- Our “one-touch” desktop tools allow for immediate access to all needed materials and supports. For example, our Knowledge Management platform provides staff with an entire Kentucky Medicaid library, including information about benefits, so they can delivery accurate, consistent answers to Enrollee questions. Our Integrated Enrollee assistance provides information across all the Enrollee’s domains including physical and BH services and providers, pharmacy, unmet social needs, and Enrollee history with WellCare.

i. Describe the processes, protocols and guidelines the Contractor will use to achieve maximum stability and the best outcomes for Kentucky SKY Enrollees in crisis as well as avoid inappropriate and unnecessary Emergency Care and hospital admissions. Describe how the Contractor will prioritize emergency and crisis calls over routine calls, protocols that will be in place to support warm transfers, and what technology the Contractor will have to enable direct telephonic/computer connectivity to emergent and crisis intervention resources.

ACHIEVING MAXIMUM STABILITY

Our processes, protocols and guidelines for achieving maximum stability and best outcomes for Kentucky SKY Enrollees in crisis include:

Expanding Our Network of Mobile Crisis Services

WellCare has an expansive network that includes every crisis services provider in Kentucky, but we are always seeking to improve the network, especially to address the growing need. As shown below, there has been an increase year over year of distinct Enrollee crisis service utilization.

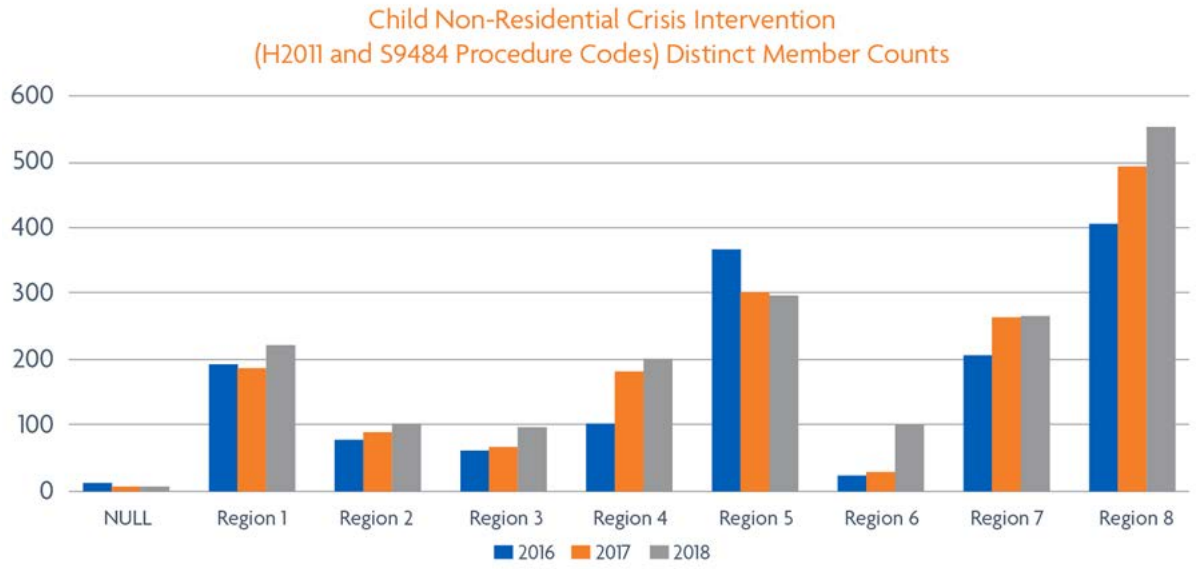

Figure G.5-2: WellCare Kentucky Use of Child Non-Residential Crisis Intervention

In addition to the recent partnership with Lifecare Solution described below, WellCare is undertaking efforts to develop a true crisis response team network. Given the lack of crisis services available in Kentucky, we are in discussion with potential out-of-state providers, such as Saint Francis Ministries, on expanding services to Kentucky. We continue our discussions with our contracted Behavioral Health Service Organizations (BHSO) providers on offering these services. We also are working with our community mental health centers across the state to expand crisis services. For example, we are in discussions with Lifeskills in Bowling Green to explore potential models for the delivery of crisis services, including a model WellCare partnered to create in Arizona of post-crisis transitional care for Enrollees who present in crisis at a psychiatric emergency care center.

BEST PRACTICE | WellCare in Arizona partnered with ***Connections Health Solutions*** to expand access to a new service they are launching for post-crisis transitional care, designed specifically for the General Mental Health/Substance Use population. Connections AZ has recently developed its ***Comprehensive Transitional Care Program for the Post-Crisis Episode*** for members who present in crisis at a Connections' psychiatric emergency care center. Their model focuses on short-term, high-touch interventions by an interdisciplinary team that includes peers, nurses, physicians and social workers. Post-crisis, members are still recovering and need extra time and attention to ensure that they get connected to the next level of care and support them while they recover from the crisis episode, such as helping them get their medications or make their next appointment. WellCare Arizona not only paid for these services but worked with Connections AZ to share data and coordinate post-crisis care for their members jointly. This helped to further reduce unnecessary ED holds.

FITT-Acute Crisis Intervention and Diversion Program

To address Kentucky's need for true mobile crisis treatment that has trended upward in certain Regions, shown in **Figure G.5-2**, we recently contracted with Lifecare to provide the FITT Program of virtual residential treatment for youth living with caregivers in a community setting. This is an intensive in-home program partnering with families to resolve crises, avoid out-of-home placement and provide skills for future crisis prevention. It also serves as a step down from inpatient or PRTF; and an alternative for youth at risk of hospitalization and PRTF. Just a few examples of what the FITT Program provides include:

- Door and window alarms
- Prescription lockboxes
- Respite for parents
- Access to a same-day prescriber

Avoiding Inappropriate ER and Hospital Admissions

WellCare has prioritized the reduction of inappropriate ER use and hospital admissions and tailored both network monitoring and care management interventions to increase stability for Enrollees in crisis. These interventions include:

- *Medical home:* Establishing a medical home for Enrollees is one of key interventions we can undertake to reduce inappropriate ER use and hospital admissions and increase stability. We will begin assigning PCPs to our foster care Enrollees beginning in July 2019 and will provide trauma training to all medical home providers. The medical home provider will be responsible to oversee and coordinate all services the Enrollee receives and our CC Team will support the medical home by facilitating information exchange, involving them in all Individual Health Plan (IHP) meetings, helping them locate appropriate specialists when needed, and providing scheduling and transportation assistance to ensure Enrollees access recommended care.
- *Crisis and Safety Planning:* For families and caregivers of children and youth involved in the child welfare system, it is critical to have a crisis and back-up plan, including the availability of back-up Care Coordinators. The back-up or crisis plan ensures children receive needed care for their safety and well-being. As part of our Care Coordination activities, our Care Coordinators work with Enrollees, families and caregivers to create a crisis and back-up plan as part of their plan of care. Included in the plan of care is family/guardian education on signs/symptoms of crisis, identification of a back-up Care Manager if the assigned Care Coordinator is temporarily unavailable, linkages to community-based crisis services, and access to our 24-Hour Behavioral Health Crisis Line and 24-Hour Nurse Line. Crisis and back-up plans are given to families and necessary medical professionals. Our Care Coordinators also encourage families to share the plans with those involved in the child's care and school.
- *Discharge Planning and Comprehensive Discharge Planning Support:* WellCare KY's transition of care process provides early identification of all medical, behavioral, and social issues that might require post-inpatient intervention, such as transportation, home health, medication, or durable medical equipment. The Enrollee-centric process involves the attending physician, facility discharge planner, our concurrent review professional staff, the

Enrollee and his/her caregivers, ancillary providers, care coordinators, when appropriate, and community resources. Discharge planners review the draft discharge plan and adjust it as necessary with each subsequent clinical review prior to the Enrollee's discharge. Under the Kentucky SKY program, if an Enrollee is admitted to an inpatient facility, our concurrent review staff will notify the Care Coordinator. Prior to an Enrollee being discharged, our BH Discharge Coordinators schedule outpatient follow-up appointments and continuing treatment to occur within seven days. They also provide telephonic appointment reminders and conduct outreach within 24 hours to Enrollees who miss an appointment. Please see our response to C.23 for further information about discharge planning.

- *Members Empowered to Succeed (METS):* Under this program, WellCare works with Enrollees who are stepping down from intensive services or who need more specialized services to tailor authorizations and services to the specific needs of the Enrollee and their family/caregiver, while recruiting natural and community supports as part of the care plan. In our Medicaid program, the METS program has resulted in a 6% reduction in ER use**.**

Educating Foster Families, Providers, Staff and Law Enforcement About Trauma-Informed Care

In partnership with the University of Louisville Kent School of Social Work, WellCare will develop and offer trauma-informed care training to Providers, our Enrollee-facing staff, law enforcement officials, courts, judges and attorneys. Working with the Orphans Care Alliance and Kentucky Partnerships for Families and Children, WellCare will offer foster parents training on intervention tools including Empowered to Connect, Trauma Competent Caregiving and Trust Based Relational Intervention (TBRI ®) and on training needs identified by foster and adoptive parents on our Foster and Adoptive parent advisory committee,

PRIORITIZING EMERGENCY AND CRISIS CALLS

In addition to directly accessing our BH Crisis Line or our 24-Hour Nurse Line, both available 24/7, Enrollees (and their caregivers and providers) can access emergency or crisis support by dialing our Enrollee call center line. Since our dedicated Kentucky SKY Enrollee call center will operate 24/7, our trained representatives will be able to quickly assess whether the caller needs crisis support. If so, they will use our tested protocols and technology to swiftly deliver the caller to BH Crisis staff or 24-Hour Nurse Line staff without delay, on-hold time, or call-backs.

We provide extensive training to all call center staff across all lines in crisis protocols. We train call center staff to listen for phrases and situations indicating that the caller is in crisis. This staff training is augmented by our word recognition program, Interaction Analyzer, which automatically flags calls based on specific keywords that have been identified as high risk. If the caller uses one of those keywords, the system recognizes the word and directs the WellCare staff Member to immediately escalate the call to a supervisor or to the BH Crisis Line clinicians for prompt intervention and resolution.

Once on our BH Crisis line or 24-Hour Nurse Line, BH clinicians (on the BH Crisis Line) or RNs (on the Nurse Line) assess and make an immediate determination of an Enrollee's acuity level, document the call as either routine, urgent, emergent or life threatening and follow related

protocols until the crisis is resolved. This includes activating emergency services or local mobile crisis providers when available, or helping the Enrollee de-escalate and connect to their Provider, depending on need.

Warm Transfers

CAREConnects, our call management platform, is set up so that there is no call transfer. Instead, when an Enrollee experiencing a crisis calls the non-clinical staff of the Enrollee Call Center, the staff activates the red crisis button on the system that immediately generates emergency/crisis script guidance. Staff uses the script to carry and document the call, beginning the de-escalation process, while CAREConnects automatically triggers a licensed BH clinician to join the call. If the crisis call is not a BH crisis, CAREConnects automatically triggers a RN from our 24-Hour Nurse Line to join. There is no call transfer. Instead, a warm connection occurs between the licensed BH clinician or RN and our Enrollee. The answering staff remains on the line and works with the clinician until the immediate situation is safely resolved or until released by the clinician from the call.

Technology/Computer Connectivity

On our crisis line, BH clinicians assess and make an immediate determination of an Enrollee's acuity level, document the call as either routine, urgent, emergent or life threatening and follow related protocols until the crisis is resolved. This includes activating emergency services or local mobile crisis providers when available, or helping the Enrollee de-escalate and connect to their Provider, depending on need. Crisis call procedures will be followed for all callers in crisis, regardless of eligibility or plan provisions.

j. Describe trainings and resources the Contractor will provide to call center staff related to recognition and management of crisis calls to ensure the most expedient and risk-reducing outcomes, including a description of the level and type of training.

Our "no wrong door" point of entry ensures that Enrollees can easily access support no matter which line they call, but it is crucial that our Enrollee Call Center staff are prepared are well-prepared and equipped to recognize and manage crisis calls when they receive them.

We provide extensive training to all call center staff across all lines in crisis protocols. Training reinforces the differences between the needs of a Kentucky SKY Enrollee compared with other Medicaid Enrollees, especially as related to trauma, Adverse Childhood Experiences (ACEs), and confidentiality of information and the caller authorization process.

RECOGNIZING A CRISIS CALL

Hotline Training Curriculum. Through WellCare University, our learning and development hub, our Enrollee Services staff train for 160 hours in a blended training environment. Training modules are delivered by Instructor-led Training, E-Learning, and supervised experiential training. Curriculum includes training on trauma informed care, recognizing a critical incident, steps needed to respond to a crisis, and words and phrases to listen for that may indicate a crisis. We provide scenario-based training curriculum for all non-clinical BH services hotline staff members, which includes a focus on identifying trigger words and crisis situations and requires that each staff associate passes an exam before transitioning to live support. The program includes self-led training curriculum and a designated "nesting period" where staff receive one-

on-one crisis call coaching by a qualified supervisor. Our BH clinicians also receive training in accessing emergency crisis services and in the treatment and management of BH conditions, including specific behaviors related to IDD individuals.

We train Enrollee Call Center staff to listen for phrases and situations including: directly expressing urges to harm themselves or someone else; suicide attempts; speech that is slurred, tangential or not making sense; Enrollees who are emotionally distressed and cannot be calmed down; and Enrollees unable to be assisted due to disposition.

This staff training is augmented by our word recognition program, Interaction Analyzer. When an Enrollee calls our Enrollee Call Center, Interaction Analyzer automatically flags calls based on specific keywords that have been identified as high risk. For example, when an Enrollee mentions words or phrases such as “I’m going to kill myself,” “I’m having difficulty,” “Emergency,” or “Having a hard time,” the system recognizes the word and directs the Enrollee Call Center staff to immediately escalate the call to a supervisor or to the BH Crisis Line clinicians for prompt intervention and resolution. Our lexicon includes more than 100 key words and continues to be refined and expanded.

MANAGING A CRISIS CALL

CAREConnects, our CRM (Customer Relations Management) platform, immediately generates emergency/crisis script guidance when our answering staff activate a red crisis button. Staff uses the script to carry and document the call, beginning the de-escalation process, while CAREConnects automatically triggers a licensed BH clinician to join the call. There is no call transfer. Instead, a warm connection occurs between the licensed BH clinician and our Enrollee. The answering staff remains on the line and works with the clinician until the immediate situation is safely resolved or until released by the clinician from the call. Please see **Attachment G.5.j Sample Crisis Call Script** (provided electronically) for an example of a WellCare call script. We will tailor new call scripts for our Kentucky SKY Enrollees.

Our BH crisis line system can immediately connect a caller to the local Suicide Hotline telephone number and other Crisis Response Systems. Our system has and our staff are trained to use patch capabilities to 911 Emergency Service.

Please refer to our response to C.16, Enrollees, Eligibility, Enrollment and Disenrollment, under Technical Approach, for additional information regarding our experience, processes, procedures and compliance to the requirements in the Draft Medicaid Managed Care Contract and Appendices.

G.5 SKY Enrollee Services

- Attachment G.5.c.vi Sample Notification to PCP of Assigned Kentucky Enrollees
- Attachment G.5.j Sample Crisis Call Script (Provided Electronically)

PHYSICIAN_NAME	PROVIDER_ID	MEMBER_ID	MEMBER_NAME	DATE_OF_BIRTH	ADDRESS_1	CITY	PLAN_TYPE	EFFECTIVE_DATE	ZIP_CODE	PHONE	ADDRESS_2	PLAN_DESCRIPTION	PLAN_CODE
Jones, Tom	1234567	9876543210	Jones, Tina	09/29/2004	4710 Maine Street	Bowling Green	WellCare of KY	02/01/2019	336346271	(555) 555-5555	N/A	WellCare of KY	Plan A
BANKS, ELIZABETH	1226379	876543210	Jones, Tom	08/29/2011	9530 Different Ave		WellCare of KY	01/01/2019	337772942	(777) 555-6666	APT A	WellCare of KY	Plan B

6. Provider Network

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G.6. PROVIDER NETWORK

a. Explain the Contractor's plan to develop a comprehensive Provider Network that meets the unique needs of Kentucky SKY Enrollees. The plan must address the following:

i. Approach to contract with PCPs and specialty Providers who are trained or experienced in Trauma informed Care and in treating individuals with complex special needs, and who have knowledge and experience in working with children in Foster Care and those children receiving Adoption Assistance.

ii. Recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, and carrying out recruitment efforts.

iii. Strategy for contracting and retaining specialists unique to the Kentucky SKY populations and perhaps different from those in the Medicaid managed care Provider network and how the Contractor will provide access to specialists not included in the Provider Network.

iv. Process for continuous network improvement, including the approach for monitoring and evaluating Provider compliance with availability and scheduling appointment requirements and ensuring Kentucky SKY Enrollees have access to care if the Contractor lacks an agreement with a key Provider type in a given DCBS Service Region or DJJ Community District.

v. How the Contractor will ensure appointment access standards are met when Kentucky SKY Enrollees cannot access care within the Provider Network.

b. Provide an example of how the Contractor has contracted for similar networks for similar populations in other programs. Provide a workplan to contract with Kentucky SKY Network Providers, with accountabilities and timelines.

G.6. PROVIDER NETWORK

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 41.0 Kentucky SKY Program of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

As an incumbent MCO, we currently serve the single largest concentration of Foster Care, Adoption and Adult Guardianship children across the Commonwealth with approximately 8,100 children relying on our passion for individualized and holistic care to empower them to reach their unique goals. Since 2011, our Enrollees have received comprehensive services through our existing **contracted network, currently more than 34,500 providers**.

In anticipating implementation of the Kentucky SKY program we have already reached out to each stakeholder, including the DMS, DCBS, DJJ and foster parents, to identify specific providers who are not already in our network for recruitment. We will also expand the network by adding new services around mobile crisis, in home services, telehealth, child-psychologists, child-psychiatrists, speech pathologists, occupational therapists and other key specialty providers. As part of network development, we will ensure each of the providers delivering services to

Kentucky SKY Enrollees have the training, knowledge and experience necessary to deliver services to this vulnerable population.

WellCare of Kentucky is committed to ensuring access to care for foster care children who often come into care with more intensive needs, a history of lack of access to care and unmet needs. See **Table G.6-1** for detail on our preliminary 2019 HEDIS performance for some of the key access measures for Kentucky SKY Enrollees.

Table G.6-1 Access to Primary Care Practitioners

Children's and Adolescents' Access to Primary Care Practitioners	2019 All Children*	2019 Foster Care*	2017 National Medicaid Mean
12-24 Months	98.0%	97.0%	94.6%
25 Months - 6 Years	92.0%	94.0%	86.6%
7-11 Years	96.0%	97.0%	90.0%
12-19 Years	96.0%	96.0%	88.6%

*(Preliminary Un-Audited Results)

a. Explain the Contractor's plan to develop a comprehensive Provider Network that meets the unique needs of Kentucky SKY Enrollees. The plan must address the following:

In delivering a comprehensive network, our aim is to ensure an appropriate statewide provider network with 24 hour emergency access and crisis services. This network will facilitate enhanced coordination of care and access to trauma-informed services, the completion of required assessments and health services within the mandated timeframes and the sharing of health records in a timely manner to reduce duplication of services.

Our Kentucky SKY network development activities are led by Bill Jones, Plan President; Kentucky SKY Behavioral Health Director Dr. Tim Houchin, with board certifications in Psychiatry, Child and Adolescent Psychiatry and Forensic Psychiatry; Kentucky SKY Medical Director; Provider Network Director Bonnell Gustafson Irvin; Executive Administrator Lori Gordon; and Provider Relations Liaison Leann Magre. Together this team has 30 years of combined Kentucky MMC program experience.

Our current Kentucky Medicaid network is fully compliant with Network Access and Adequacy standards as defined in Section 28.2 and is the **largest and most comprehensive network of all Kentucky MCOs, based on our review of online provider directories**.

We currently have **over 99.9% of all Kentucky Medicaid providers under contract**. See **Table G.6-2** for a sample of our top hospital systems and provider groups by region. Hospital systems include those PCP and Specialty providers associated with those systems.

Table G.6-2 Top Hospital Systems and Provider Groups by Region

Region	Hospital Systems and Provider Groups
Region 1	Hospital Systems: Baptist Health Paducah, Caldwell Medical Center, Crittenden County Hospital/Health Systems, Jackson Purchase Medical, Livingston Hospital and Healthcare, Lourdes, Marshall County, and Murray Calloway PCP Groups: ARCARE, Baptist Health Medical Group Paducah, Caldwell Medical Associates, Jackson Purchase Primary Care Hickman, Marshall County Surgical and Medical Group, Mercy Health, Murray Medical Associates, Pediatric Group of Paducah, Pinelake Physician Practice, Pennyroyal Family Health, Primary Care Medical Center Specialty Groups: Baptist Health Medical Group Paducah, Bloom Behavior Therapy, Physician Specialists of Murray, Four Rivers Behavioral Health, Marshall County Surgical and Medical Group, MD Partners, Mercy Health, Pinelake Physician Practice (Pediatric Cardiology), Recovery Works Paducah
Region 2	Hospital Systems: Baptist Health Madisonville, Deaconess Hospital, Deaconess Hospital, DBA The Heart Hospital, Jennie Stuart Medical Center, Methodist Hospital Community, Ohio County Hospital, Owensboro Health Muhlenberg, Owensboro Health Owensboro, St Vincent Hospital Evansville, Trigg County Hospital PCP Groups: Baptist Health Medical Group, , Community Health Centers of Western Kentucky, Bridgewater Medical, Regional Healthcare Affiliates, Vanderbilt Integrated Providers - PED Specialty Groups: A New Start, Bluegrass Family Allergy, Owensboro Health Medical Group, The Pennyroyal Regional Center, River Valley Behavioral Health, Sunrise Children's Services, University of Louisville Research Foundation Pediatric Hematology Oncology, Gastroenterology, and Neonatal.
Region 3	Hospital Systems: Baptist Health La Grange, Baptist Health Louisville, Breckinridge Memorial Hospital, Carroll County Memorial Hospital, Flaget Memorial, Hardin Memorial, Norton Audubon, Norton Brownsboro, Norton Children's, Norton Hospital, Norton Woman's and Children's, Kentucky One (Jewish Hospital Louisville, Jewish Hospital Shelbyville, St Mary and Elizabeth), Springview Hospital, Twin Lakes Regional Medical Center, University of Louisville PCP Groups: Bullitt County Family Practitioners, Brownsboro Park Pediatrics, Hardin Professional Services, Heartland Primary Care, Louisville Patient Centered Medical Home, Norton Community Medical Associates, Kentucky One Primary Care, Leitchfield Pediatrics, Park Duvall Community Health Centers, Family Health Centers (Americana, East Broadway, Fairdale, Iroquois, Phoenix, Portland, Southwest, West Market), JenCare, Shawnee Christian Health Center, One Pediatrics, Prospect Pediatrics, University of Louisville Physician's Specialty Groups: Bridgehaven, Centerstone, Children Heart Specialist, Home of the Innocence, First Urology, Hardin Professional Services, Isaiah House, New Beginnings Family Services, Pediatric and Neonatal Specialists, Pediatric Heartcare Partners, Recovery Works Elizabethtown, Sunrise Children's Services, StepWorks, ,

Region	Hospital Systems and Provider Groups
	Transformations, University of Louisville Research Foundation Pediatric (Hematology/Oncology, Pediatric Neurology, Infusion Center, Pediatric Nephrology), Uspiritus Inc.
Region 4	Hospital Systems: Casey County Hospital, Cumberland County Hospital, Jane Todd Crawford Memorial Hospital, Lake Cumberland Regional Hospital, Logan Memorial Hospital, Monroe County Medical Center, Russell County Hospital, TJ Samson, Taylor County Hospital, The Medical Center Bowling Green, The Medical Center at Albany, The Medical Center at Caverna, The Medical Center at Franklin, The Medical Center at Scottsville, Tristar Greenview Regional Hospital, Wayne County Hospital PCP Groups: A Plus Family Health Care, Bowling Green Internal Medicine, Butler County Family Care, Casey County Primary Care, Caverna Primary Care Clinic, CHC DBA Medical Center Primary Care, Cumberland Family Medical, Family Medical Center of Hart County, Fairview Community Health, Graves Gilbert Clinic, Lake Cumberland Physicians Network, Monticello Medical Associates, One Cross Medical Clinic, Primary Care Associates of Russellville, Somerset Internal Medicine, Southfork Medical Clinic, TJ Health Columbia, TJ Health Edmonton, TJ Health Greensburg, TJ Health Russell Springs, TJ Samson Family Medicine, Taylor Regional Pediatrics Specialty Groups: A New Beginning Achievement Center, Allergy Asthma and Immunology, Foothills Academy, Graves Gilbert Clinic, Hopebridge, Interventional Pain Specialists, Lake Cumberland Physicians Network, University of Louisville Research Foundation Pediatric Cardiology, Uspiritus, Inc.
Region 5	Hospital Systems: Baptist Health Systems (Lexington, Richmond), Ephraim McDowell Regional Medical Center (Danville, Stanford), LifePoint (Bluegrass Community, Bourbon Community, Clark Regional, Georgetown Community), Kentucky One Health (St. Joseph (Berea, Mt. Sterling, East Lexington, Lexington), and the University of Kentucky Medical Center PCP Groups: White House Clinics, Kentucky Medical Services Foundation, Baptist Health Medical Group, HealthFirst Bluegrass, Bates, Miller and Sims, Horizons Healthcare, Children's Clinic (Estill County), Sterling Health, Clark Regional Physician Practices, Danville Pediatrics and Primary Care, Kentucky One Health Medical, Ephraim McDowell, Danville Family, St Joseph Primary Care, Bluegrass Community Health Centers, Clay City Pediatrics, Fast Pace, Madison Primary Care, Annville Clinic, Cumberland Family Medical, Primary Care of the Bluegrass Specialty Groups: Bluegrass Orthopedics, Bluegrass.Org, KVC, Rebound Recovery, Advanced Dermatology, Lexington Women's Health, Kentucky Medical Services Foundation, Baptist Health Medical Group, Kentucky One Physician Services, Clark Regional Physician Practices, Ephraim McDowell Multispecialty Clinic, Sunrise Children's Services, Psychological and Behavioral Consultants, SAFY, Key Assets KY, Hopebridge
Region 6	Hospital Systems: St Elizabeth Healthcare (Edgewood, Florence, Ft. Thomas, Grant County), Cincinnati Children's Hospital Medical Center, Nationwide Children's Hospital,

Region	Hospital Systems and Provider Groups
	Mercy Health, Shriner's Hospital for Children, The Christ Hospital, TriHealth Hospitals, University of Cincinnati PCP Groups: St. Elizabeth Physicians, Health Point, Triad, The Christ Hospital Medical Association, University of Cincinnati Physicians, Ironton Health Care, SOMC Medical Care Specialty Groups: St. Elizabeth Physicians, Pediatrics of Florence, Health Point, River Hills Pediatrics, The Christ Hospital Specialists, University of Cincinnati Specialists, Cincinnati Children's Hospital Specialists, Children's Home of Northern KY, Holly Hill Children's Home, Diocesan Catholic Children's Home, MEBs Counseling, SAFY, Hopebridge
Region 7	Hospital Systems: ARH (Morgan County), Cabell Huntington Hospital, Fleming Co Hospital, King's Daughters Medical Center (Ashland and Portsmouth), Our Lady of Bellefonte, Three Rivers, St. Claire Regional PCP Groups: Lewis Primary Care, Community Family Clinic, Family Medicine Associates of Flemingsburg, Ohio Valley Physicians, Ashland Children's Clinic, Kid Care, Faith Family Practice, St Claire Regional Family Medicine, Lewis County Primary Care, KDMC Family Care Centers, Bellefonte Primary Care, Morehead Primary Care, ARH Clinics, King's Daughter Care Centers, Ashland Pediatric Associates Specialty Groups: ARH Specialists, Kentucky OneHealth Specialists, King's Daughters Medical Center, Bellefonte, Three Rivers, St. Claire Specialists, Ramey Estep, University Physicians (Cabell), Valley Health, Lighthouse Professional Counseling
Region 8	Hospital Systems: ARH (Our Lady of the Way, Barbourville, Harlan, Hazard, Mary Breckinridge, McDowell, Middlesboro, Tug Valley, Whitesburg), Baptist Corbin, Highlands Regional Medical Center, Kentucky River Medical Center, Kentucky OneHealth (St Joseph London), Paul B. Hall Medical Center, Physician Services of Memorial, Pikeville Medical Center, Williamson Memorial PCP Groups: Mountain Comprehensive Health Care, Primary Care Centers of Eastern KY, Big Sandy Healthcare, Quantum, United Clinics, Juniper Health Care, ARH, Mountain After Hours, Kentucky Mountain Health Alliance, Hometown Family Care, Harold Primary Care, Bright Future, Neil G. Barry, Parkway Pediatrics, Dr. Dahhan, Grace Community Health Center, East Bernstadt Medical Clinic, Clover Fork Clinic, Middlesboro Medical Mall, Ulrich Medical Clinic, Corbin Pediatric, Mercy Clinic, St. Joseph Health System, Newborn & Kids Health Center, Baptist Health Medical Group Specialty Groups: ARH, Baptist Health, Pikeville Medical Center, Highlands Regional, London Women's Care, Physician Services of Memorial, Cumberland Valley, Mountain Comprehensive, NECCO, Addiction Recovery Care, Odyssey, Sunrise Children's Services

Partnership

To support the unique needs of Kentucky SKY Enrollees and this contract we will outreach to each stakeholder, including the Department, DCBS, DJJ and foster parents, to identify specific providers who are not already in our network that we need to recruit. We will also expand the network by adding new services around

mobile crisis, in home services, telehealth, child-psychologists, child-psychiatrists and other key specialty providers. Specifics of our approach include:

- Interview stakeholders including DCBS, DJJ , foster parents and youth, teaching and children hospitals to identify key providers as well as any potential barriers to care
- Expand our network of mobile crisis services through the network expansion activity that has already occurred with Lifecare Solution in Louisville to develop a true crisis response team network. Lifecare is planning to expand service into additional Kentucky counties. Given the lack of crisis services available in Kentucky, we are also in discussion with potential out of state providers, such as Saint Francis Ministries, on expanding services to Kentucky. We continue our discussions with our contracted Community Mental Health Centers (CMHC) and Behavioral Health Service Organizations (BHSO) providers on offering these services

Private Child Care Providers
All Private Child Care providers with Medicaid numbers are currently in our network.

- Contract with Therapeutic Foster Care Providers which are not already in our network for in home services to SKY Enrollees. Our current assessment shows of the 43 Private Child Care Providers (with over 170 individual sites), 70% are already in our network. The remaining 30% are not Medicaid providers at this time. We have already begun introducing these providers to Medicaid managed care by personally outreaching to each to invite them to our recent Provider Summits. We understand the need to educate these new providers, including Bair Foundation, Home of the Innocents and KVC, early and often.
- Collaborate with DMS, DCBS and DJJ in the use of telehealth for any specialty to ensure access for Kentucky SKY Enrollees. Telehealth is a useful tool to mitigate wait times for key Kentucky SKY specialty providers such as psychiatry, child psychiatry, child psychology, pediatric neurology, neuropsychology and applied behavioral analysis.
- Provide telehealth equipment and support for foster parents to connect foster youth to behavioral health clinicians. In our Virtual Integration Program, PCP providers use a tablet enabled screening tool and refer, as needed, to a virtual behavioral health provider. Virtual behavioral health visits can happen immediately and follow-up can also occur from the youth's home via a device provided by WellCare of Kentucky. WellCare of Kentucky's telemedicine program aligns with legislative guidelines in KRS 205.559 and KRS 205.5591
- Integrate our dental vendor into all network development activities to ensure adequate access to a network of dentists and pediatric dentists, who are responsible for coordinating all dental care for Kentucky SKY Enrollees. This includes processes for Enrollees to access orthodontic care when they move
- Support the SKY network with a regional team of experts in the Kentucky SKY program who live in the communities they serve. This team will wrap supports around Kentucky SKY providers and assist them in all aspects of contracting and delivering services to Kentucky SKY Enrollees. Our SKY provider relations team includes our SKY Provider Liaison who is responsible for supporting the resolution of provider access and availability issues. Both the Provider Liaison and the regional SKY Provider Relations representatives will have detailed knowledge of Kentucky providers, including behavioral health providers, patterns of care/referral in Kentucky, the Kentucky SKY program, provider contracting, billing,

authorizations, and claims submission. In support of the Kentucky SKY program, our SKY provider engagement team also includes a **coding educator** will also work directly with SKY providers on coding practices beginning four months in advance of program go-live

i. Approach to contract with PCPs and specialty Providers who are trained or experienced in Trauma informed Care and in treating individuals with complex special needs, and who have knowledge and experience in working with children in Foster Care and those children receiving Adoption Assistance.

"On behalf of Saint Francis Ministries, a national and international child and family services provider and advocacy organization, it gives us great pleasure to write in support of WellCare of Kentucky's proposal to provide Medicaid managed care services, including those prevention and intervention services designed to improve the wellbeing of children and families impacted by issues of trauma.
WellCare has a trauma-informed, evidenced based strategy related to how to ameliorate these issues in collaboration with organizations seasoned in this practice such as Saint Francis Ministries."

– PAGE B. WALLEY, PH.D
PRESIDENT/CHIEF PUBLIC POLICY OFFICER, SAINT FRANCIS MINISTRIES

WellCare of Kentucky has an **existing provider network composed of approximately 5,500 PCPs, 26,000 specialty Providers and more than 2,300 behavioral health professionals**. We will build on our existing market expertise to catalog these provider's knowledge and experience. We will supplement that existing provider knowledge with training on Trauma informed care and the requirements for providing Health Care and Behavioral Health Services to Kentucky SKY Enrollees, as identified in Section 41.14.1. Training will include medical consent requirements, required timelines for services and assessments, specific medical information required for court requests and judicial review of medical care, the Care Coordination team and how to contact the Care Coordinator, to name a few. Existing regional teams will be supplemented our specialized regional team of SKY program experts who will onboard providers to the Kentucky SKY program.

"We applaud your efforts to deliver holistic, comprehensive, and integrative services to the most vulnerable in our society. We look forward to partnering with you to accomplish this critical need in Kentucky."

– BIBHUTI K. SAR, MSW, PHD
PRINCIPAL INVESTIGATOR/DIRECTOR, CENTER FOR PROMOTING RECOVERY AND RESILIENCE
KENT SCHOOL OF SOCIAL WORK, UNIVERSITY OF LOUISVILLE

We are partnering with the University of Louisville to implement a Trauma Informed Care training program across the Commonwealth. The University of Louisville has a well-regarded trauma-informed training program through the Kent School of Social Work. This partnership includes curriculum development, building capacity, launch and evaluation. Training will be conducted by Webinar or in person.

IDENTIFYING PROVIDERS WITH TRAINING AND EXPERTISE

As an incumbent MCO with the largest concentration of foster care children, we know which providers are engaging with foster care children and their level of training and expertise in Trauma informed Care, treating individuals with complex needs, and knowledge and experience in working with children in Foster Care and those receiving Adoption Assistance. We will catalog this knowledge using the market expertise of our internal staff including Provider Relations Liaison Leann Magre, Executive Administrator Lori Gordon, and their Care Coordination team.

We will also conduct interviews with teaching and children hospitals such as the University of Louisville, UK Health Care Kentucky Children's Hospital and Norton Children's Hospital, local DCBS and DJJ offices and foster parents to identify key providers.

Beyond contracting, we will launch an effort to transform and expand evidence-informed treatment throughout the Commonwealth through processes to systematically identify provider resources who have been formally trained in the use of behavioral health assessment instruments and the use of evidence-based practices like trauma-focused cognitive behavioral therapy (TF-CBT), dialectical behavioral therapy (DBT), parent-child interactional therapy (PCIT), rapid eye movement desensitization and reprocessing (rEMDR), and others. Our Kentucky Provider Network Development team has already identified approximately 600 behavioral health providers with evidence-based specialty training, including a recent launch of Multisystemic Therapy (MST) through Home of the Innocents. In addition, our Florida health plan used WellCare's enhanced processes to systematically identify and catalog more than 800 Florida providers who have essential subspecialty training and expertise that is used in coordinating care for children with special healthcare needs, especially those with serious behavioral health conditions.

CONTRACTING WITH PCPS

WellCare of Kentucky currently has contracts with most in-state PCPs so our primary focus here will be on reimbursement, partnerships for quality and extending additional training and support to these providers in their role as the single point of accountability and coordination, primarily for primary care.

Getting the Right Care
We have seen a 9.5% increase in PCP visits since 2016 and a 9.5% decrease in emergency room visits for the foster child population.

In preparation for assignment of the MMC foster child population to PCPs, we analyzed our PCP network to identify the PCPs currently delivering services to these Enrollees. Over 400 PCPs were identified with 27% of Enrollees seeing PCPs associated with the Kentucky Primary Care Association (KPCA) IPA and 6% seeing PCPs associated with Saint Elizabeth. We will be approaching both of these providers on models of care to best support the Kentucky SKY population, such as health homes or value based purchasing.

To ensure continuity of care for new Enrollees transitioning from other MCOs, we conduct a gap analysis using the claim history provided by DMS of PCPs rendering services to SKY Enrollees through other MCOs who are not in our network. We will include those providers in our Network Development work plan with personal outreach to discuss contracting. Transition

of care is our paramount concern for Kentucky SKY Enrollees since many of these children have been with their providers for years.

Enhanced reimbursement will be offered to PCPs managing Kentucky SKY Enrollees in the form of a care management fee. This fee is to compensate the PCP for the additional roles and responsibilities they are assuming. We will also offer a Partnership for Quality (P4Q) incentive program that incents a reduction in emergency room usage, timeliness of initial outreach by the PCP and the completion of assessments in a timely manner.

As the Kentucky SKY program matures, we will also **identify high-quality providers for a SKY Preferred Provider designation**. For example, year-one we will identify PCPs with large numbers of foster care children assigned to them and will conduct an assessment to identify their best practices for foster care. If the assessment identifies them as delivering high-quality services to their patients, they will be designated as a SKY Preferred Provider. Enrollees can be auto-assigned to Preferred Providers based on quality scores. We will also engage these providers for input on our training materials and for participation on our Kentucky SKY quality committees. In future years we will expand this SKY Preferred Provider designation to specialty providers.

BUILDING HEALTH HOMES FOR KENTUCKY SKY ENROLLEES

In collaboration with the DCBS and DMS, WellCare of Kentucky will establish a Health Home Pilot where PCPs receive an additional care management fee for enhanced behavioral health coordination. These **practices will conform to the standards set forth by the American Academy of Pediatrics recommendations for foster care**. As part of the pilot, the Kentucky SKY Care Coordination team will work hand in hand with the provider to ensure they have access to records for this enhanced coordination responsibility and assist with utilization management approvals.

We will expand this concept statewide based on the results of the pilot. We have had exploratory discussions with KPCA IPA about a health home pilot for Kentucky SKY Enrollees assigned to them. Our analysis shows that 27% of our current foster care population sees PCPs associated with the KPCA IPA.

We are also exploring value based purchasing (VBP) reimbursement through discussions with key providers such as Home of the Innocents, which offers foster care residential services as well as primary care and dental services. Home of the Innocents provides comprehensive services to both children who are cared for in their residential facility and to children in the surrounding community. They have a multitude of services available in their Open Arms Children's Health Center including primary care, behavioral health services, PT/OT/ST as well as imaging services. Additionally they address social determinants of health through a food bank and clothes closet onsite at their facility. Home of the Innocents leadership understands that a VBP agreement is essential for them in order to begin to move away from a fee-for-service model which is not sufficient to cover their costs into a shared savings and ultimately full risk agreement where they will be rewarded for managing care of our Enrollees. This is a new concept for them so we will move them along the continuum, sharing with them the data they need to efficiently manage the care of the children they are serving.

CONTRACTING WITH SPECIALTY PROVIDERS

WellCare of Kentucky currently has contracts with most in-state specialty providers so our primary focus here will be on extending access and availability through the use of telehealth and training our specialty providers on all aspects of the Kentucky SKY program, in accordance with Section 41.14.1. Trauma-informed training for Specialty providers will be conducted through the University of Louisville either in person or by webinar.

Getting the Right Care
We have seen a 22% increase in Specialty visits since 2016 and a 9.5% decrease in emergency room visits for the Foster Child Population.

As with PCPs, we will ensure continuity of care for new Enrollees transitioning from other MCO's using the claim history provided by DMS to conduct a gap analysis of Specialty providers rendering services to the SKY population who are not currently in our network. We will include those providers in our Network Development Work plan with personal outreach to secure contracts.

To incent specialty care we will offer financial incentives and value based purchasing to specialists involved in complex care and reward them for addressing care needs. In addition, Gold Carding will be offered to specialty and behavioral health providers who have a demonstrated record of cost efficiency and quality. For instance, while WellCare of Kentucky contracts with nearly all psychiatric and ABA testing providers in the Commonwealth, we know there is still opportunity to increase access for these types of providers by offering Gold carding, which incentivizes providers by relaxing prior authorization requirements for these services.

To increase access to specialty providers, we will collaborate with DMS, DCBS and DJJ in the use of telehealth to ensure access for Kentucky SKY Enrollees. Telehealth is a useful tool to mitigate wait times for key Kentucky SKY specialty providers such as psychiatry, child-psychiatry, child-psychology, pediatric neurology, neuropsychology and applied behavioral analysis.

Our Virtual Integration Program allows PCP providers use a tablet enabled screening tool and refer, as needed, to a virtual behavioral health provider. Virtual behavioral health visits can happen immediately and follow-up can also occur from the youth's home via a device provided by WellCare of Kentucky. We will provide telehealth equipment and support for foster parents to connect youth to behavioral health clinicians through this program.

We are currently laying the groundwork to address payments for behavioral health services applied to foster care children in private facilities

ii. Recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, and carrying out recruitment efforts.

As we develop our recruitment strategy, we first analyze our existing network to identify potential gaps in the provision of services to Kentucky SKY Enrollees using a variety of analysis tools, data sets and regional staff input. Through this comprehensive analysis, we review Enrollee needs and utilization patterns, including county-by-county waiver information; risk stratification data for all sets of services; and heat maps. We deploy our provider network recruitment strategy for all provider types, including PCPs, Specialty providers, hospitals,

FQHCs, Behavioral Health Multi-Specialty Groups, BHSOs, Psychiatric Residential Treatment Facilities (PRTFs), Residential Crisis Stabilization units, Therapeutic Foster Care Providers, CMHCs and Dental providers to ensure delivery of a comprehensive Kentucky SKY provider network.

IDENTIFYING NETWORK GAPS

Our identification process includes:

- Analyze GeoAccess Reports to evaluate that time and distance standards using DMS defined standards at the regional and county level
- Review claim history files provided by DMS to conduct a gap analysis of providers rendering services to Kentucky SKY Enrollees through other MCO and include them in our work plan
- Catalogue the market expertise of our internal staff including Provider Relations Liaison Leann Magre, Executive Administrator Lori Gordon, and their Care Coordination team to identify providers with the necessary training and expertise to manage the care of Kentucky SKY Enrollees
- Interview teaching and children hospitals such as the University of Louisville, UK Health Care Kentucky Children's Hospital and Norton Children's Hospital to identify key providers as well as any potential barriers to care
- Interview local DCBS and DJJ offices, foster parents and youth to secure the names of key providers in their region and identify any concerns or barriers to care
- Obtain input from our regional Provider Relations Representatives, Enrollee Service Representatives and Care Coordinators who serve as key resources for identifying any gaps in the network
- Catalog Therapeutic Foster Care Providers currently rendering therapy services to SKY Enrollees
- Review Out-of-Network and Closed Panel reports to identify potential gaps and opportunities to enhance our network

Our Existing Local Presence

WellCare of Kentucky currently supports the Kentucky MCC program through a dedicated Kentucky provider engagement team of nearly 75 associates who conduct network development and provider engagement in full support of the Department's goals. We will build on that existing presence as we implement the Kentucky SKY program.

In addition to the above data, we use Enrollee complaints and grievances, staff feedback, CAHPS survey data, and others to measure the adequacy of our provider network.

Periodically, our Kentucky SKY Medical Director, Care Coordination and Network Management team will conduct network assessments to ensure we are meeting the needs of SKY Enrollees. As part of these assessments, we engage local providers and community partners who routinely care for this population and with whom we have strong existing relationships, such as University of Louisville, UK Health Care Kentucky Children's Hospital and Norton Children's Hospital as well as the DCBS and DJJ to review and validate the information. Ongoing network assessments, including recommended actions, will be presented to our SKY Enrollee Outcomes Committee

and Collaboration Optimization Committee. These committees include DCBS, DMM, DMS, provider and foster parent participation.

DEVELOPING RECRUITMENT WORK PLANS

Using the results of this analysis we create detailed recruitment work plans to target providers and fill network gaps. Our recruitment work plans include frequent data feeds to test network progression using GeoAccess tools. We i**dentify** available providers and **target** them through the development of a recruitment work plan with timelines and accountabilities for each network development activity. We then **contract** by deploying a team of local resources to meet with non-participating PCPs, specialty providers and Therapeutic Foster Care providers. We comprehensively **train** all providers in our network to ensure they are ready to partner with us as active participants in the SKY program using our dedicated SKY Provider Relations representatives.

We know the best way to **recruit and retain** providers in our network is to fully support them so our dedicated SKY field teams and highly trained SKY Provider call center wrap support around the provider to ensure services are delivered and the providers are paid for the services they deliver. At program go-live and until stability is established, a team of experienced Provider services associates are available in a Command Center environment to respond immediately to provider questions and facilitate the prompt resolution of issues. Regional staff is also deployed to key providers with large Enrollee volume for rapid onsite resolution.

CARRYING OUT RECRUITMENT EFFORTS

Our recruitment efforts will be led by Provider Network Director Bonnell Gustafson Irvin, with the support of the entire Regional team. Our current Kentucky Network Development team includes a senior director, two managers and five associates. We will add additional team members as needed to meet Kentucky SKY program objectives. Meetings will be established with each of the Therapeutic Foster Care providers which do not currently participate in Medicaid. Our first step will be helping these providers secure a Medicaid number so they can complete contracting as well as explaining the contracting and credentialing process to them. We will also personally outreach to each non-participating PCP and specialty provider identified on the recruitment work plan to discuss participation in the Kentucky SKY network.

iii. Strategy for contracting and retaining specialists unique to the Kentucky SKY populations and perhaps different from those in the Medicaid managed care Provider network and how the Contractor will provide access to specialists not included in the Provider Network.

Our network strategy includes the specific recruitment of specialists unique to the Kentucky SKY populations which are not currently in our network. This includes providers delivering therapeutic foster care services to the Kentucky SKY population. As providers new to Medicaid, we will wrap local field support around them and assist with all aspects of contracting, including helping them secure a Medicaid number so they are eligible for contracting. We will also collaborate with DMS to expand access to Psychiatric Residential Treatment Facilities (PRTFs) to include PRTF 2's in addition to the PRTF 1's currently in network.

Our network assessment shows that of the 43 Private Child Care Providers (representing over 170 individual sites), 70% are already in our network. The remaining 30% are not Medicaid

providers at this time. **All Private Child Care Providers with Medicaid numbers are currently in our network.** We have already begun introducing these "new to Medicaid" providers to the SKY program by personally outreaching to each to invite them to our recent Provider Summits so they become familiar with Medicaid Managed Care. We understand the need to educate these new providers early and often.

Our regional team of Kentucky SKY experts will wrap supports around these providers to assist them in all aspects of enrolling in Kentucky Medicaid, contracting to become a provider with WellCare of Kentucky, delivering services to Kentucky SKY Enrollees, and billing and receiving reimbursement for services.

As we recruit our SKY Provider Relations Representatives, we will look for associates who have experience working with behavioral health providers and understand specialized billing services. These representatives will be responsible for teaching the basics of Medicaid to these nontraditional providers and helping them transition into an accredited BHSO status so they have the ability to bill for all they do. We will use our high touch Provider Engagement model to help the new BHSO providers understand all the needed processes to request, provide and be compensated for services provided.

When contracting with residential providers, as part of a BHSO, we will require evidence they meet the requirements of a Qualified Residential Treatment Provider (QRTP), as required under the Family First Preservation Services Act. We will also secure evidence that a provider is following the Building Bridges Initiative (BBI) principles by asking providers to complete the self-assessment and develop a work plan to move toward BBI improvement.

We understand the need to interface with the DJJ system as relates to care plans and access to services and that there will be a bridge between juveniles potentially moving in and out of DJJ residential homes. As part of network development, we will work closely with the DJJ to identify any unique providers which we need to contract with.

RETENTION STRATEGIES FOR SPECIALISTS UNIQUE TO KENTUCKY SKY

Our Providers Recommend Us
In our 2018 Provider Satisfaction survey, 93.4% of providers said they would recommend us to other providers.

WellCare of Kentucky's retention strategies are an integral part of our larger Provider Engagement Model. Through this model, we seek to advance quality-driven provider networks and support retention of high quality providers. Our experience has shown that non-traditional providers such as therapeutic foster care providers have varying degrees of size and sophistication, and that comprehensive support of these providers is necessary to assure the seamless delivery of Kentucky SKY services to our Enrollees. Many of these providers do not have Medicaid experience with billing or documenting medically necessity criteria.

Support for these providers will be anchored by a regional team of experts in the Kentucky SKY program who live in the communities they serve. This team will wrap supports around Kentucky SKY providers and assist them in all aspects of contracting and delivering services to Kentucky SKY Enrollees so they understand how to contract with us, how to bill for services, and are being reimbursed appropriately for the care they are providing. Our SKY provider relations

team includes our SKY Provider Liaison who is responsible for supporting the resolution of provider access and availability issues. Both the Provider Liaison and the regional SKY Provider Relations representatives will have detailed knowledge of Kentucky providers, including Behavioral Health providers, patterns of care/referral in Kentucky, the Kentucky SKY program, provider contracting, billing, authorizations, and claims submission. Our provider engagement team includes a **coding educator** who works work directly with SKY providers on coding practices beginning **four months in advance of program go-live**. This local team is supported by our and highly trained SKY Provider call center.

Our comprehensive suite of services is aimed at meeting these providers where they are to increase quality of care along with provider and Enrollee satisfaction. Components include:

- In person training by the SKY provider relations representatives (with expertise in authorization and billing) including helping the provider secure a Medicaid Number and providing the level of support needed to setup and use the secure provider portal to verify eligibility, view care needs and access clinical and administrative tools including no cost electronic claim submission, claim status, and claim editing/rebilling
- Advance training by our Coding Educator who works directly with SKY providers on coding practices starting four months prior to program go-live
- Regional forums, training partnerships with the DCBS and DJJ and a robust, in- person provider engagement and training model where we work one-on-one with providers.
- User friendly computer based training modules that are available on line 24/7 to accommodate busy schedules and a video training series to support ongoing education, in addition to in person training
  SKY provider relations representative support around authorizations, changes in fee schedule, training on medical necessity criteria and general training on how to ask for and get services approved

PROVIDING ACCESS TO SPECIALISTS UNIQUE TO THE KENTUCKY SKY NOT INCLUDED IN THE PROVIDER NETWORK

While we anticipate contracting with the vast majority of specialists unique to the Kentucky SKY populations, we realize there are instances where providers may choose not to participate in our network. The most common reasons we have encountered in our current Kentucky Foster Care population are:

- Providers not willing to accept Medicaid Enrollees
- Providers not willing to accept Medicaid rates

Solving Complex Access Issues Through Collaboration

WellCare of Kentucky successfully solved an access issue for a young adopted Enrollee with complex trauma and attachment issues. While this Enrollee has been in higher levels of care consistently, treatment progress was not evident and safely returning home was not possible. This Enrollee was preparing to discharge from a subacute hospital level of care but was not ready for a home environment. WellCare of Kentucky outreached to a private child care provider, usually only able to serve children in state custody, and asked if this provider might consider serving this Enrollee outside of the normal system process. WellCare of Kentucky also involved The Department as permission to step outside of the current system of care had to be secured. The provider accepted this Enrollee and through a single case agreement, WellCare of Kentucky and this provider agreed to a daily rate and Enrollee was admitted into their program. From this program, the Enrollee has since transitioned to another residential provider and is beginning to make treatment progress. Her adopted family is involved in her treatment and progress.

The most important thing is getting care for the Enrollee so we authorize out of network utilization. Typically this is accomplished by executing single-case, non-participating agreements which authorize care for a specific case and arranging any necessary transportation. The Kentucky SKY Provider Liaison is responsible for supporting the resolution of provider access and availability issues and will coordinate the out-of-network access.

iv. Process for continuous network improvement, including the approach for monitoring and evaluating Provider compliance with availability and scheduling appointment requirements and ensuring Kentucky SKY Enrollees have access to care if the Contractor lacks an agreement with a key Provider type in a given DCBS Service Region or DJJ Community District.

We monitor our network on an ongoing basis and engage in network development activities that expand our network beyond mere compliance with network availability and scheduling appointment requirements. Tools include a combination of GeoAccess reports, monthly out-of-network reports, network accessibility audits, open/closed panel reports, provider satisfaction surveys, Enrollee grievances, quality of care issues, utilization trends, HEDIS results, and more.

Our Kentucky SKY Medical Director, Behavioral Health Director Dr. Timothy Houchin, SKY Program Director, care coordinators, provider relations representatives, community partners and advisory boards serve as best sources for identifying opportunities to improve access.

Areas of improvement may be identified formally through our quality infrastructure or informally through inter-departmental connections. In such situations, our local medical directors, provider relations representatives, care coordinators and local quality teams work to implement corrective actions that are tailored to the specific issue identified and the cause. For example, a lack of access to a provider type in a specific area could lead to an investment opportunity where we may give incentives to providers to expand into the area or service type.

MONITORING COMPLIANCE WITH AVAILABILITY AND SCHEDULE APPOINTMENT REQUIREMENTS

WellCare of Kentucky's network providers are contractually required to comply with appointment availability and scheduling requirements. Providers, who continuously fail to meet contract requirements, following active, supported remediation efforts, may be terminated. We have processes in place to monitor, and resolve any issues with the timeliness of appointment access within our network which is described below:

Appointment Accessibility Surveys: Our Network Integrity Team partners with an external vendor to conduct telephone surveys to assess appointment availability, appointment wait time, and after-hours coverage. We re-audit any providers who fall short of standards and follow-up with a corrective plan as needed. Findings are shared with the Provider Relations Team to ensure appropriate follow-up and education is provided to providers failing to meet accessibility standards.

Getting Care Quickly
WellCare of Kentucky's 2018 Child Medicaid CAHPS results were outstanding with 88.71% of children Getting Needed Care and 94.75% Getting Care Quickly.

Enrollee and Provider Grievances/Complaints: Our associates (Enrollee Advocates, Enrollee Services Representatives and Service Managers) review, log and categorize grievances and complaints by cause, disposition and type for review and follow-up. Feedback generated from our Enrollee and Provider Advisory Groups also provide us with regional or systemic trends which are addressed by our Enrollee Advocates before a formal complaint is filed.

Grievance/complaint information is shared with WellCare of Kentucky's Network Integrity and Quality Improvement Teams to monitor access to care, used by our Network Development Team to identify the need and opportunities for expanding access to care, and allows our Provider Relations Team to follow-up and work with providers.

Enrollee and Provider Satisfaction Surveys: WellCare conducts annual surveys which include key questions about the quality and adequacy of our Provider network. Our Quality Improvement Team reviews the results of the survey and shares the results with our Network Development and Provider Relations Teams to identify areas of opportunities for additional contracting as well as service improvements.

Additionally, our health plans participate in the Consumer Assessment of Health Providers and Systems (CAHPS®) survey conducted annually by an independent National Committee for Quality Assurance (NCQA) certified vendor. Through this tool, we evaluate data related to Enrollees' perceptions of quality of care and service, including getting needed care and getting that care quickly.

Because the CAHPS results are anonymous, we implemented a "mock survey" which allows us to obtain the detail behind the results and thereby identify providers specifically. The mock survey allows us to determine areas of opportunity to improve access. These results are used to implement engagement activities (on-site visits, provider education, etc.) to address identified opportunities and work with providers to improve the Enrollee experience.

Closed Panel Reports: Our Provider Relations Team review monthly closed panel reports to identify providers with recently closed panels. Provider Relations Representatives outreach to each provider in an attempt to have them re-open their panel. Closed panel percentages are reviewed by specialty to determine if additional providers are needed. Our Provider Relations Representatives also visit our provider groups to review and verify their details, including panel status. We will also have a Provider Accuracy Audit in place that will samples network data reporting for analyzing and reporting on the information reported to us, including panel status.

Out-of-Network Paid Claims: The Network Development and Provider Relations Teams monitor out-of-network paid claim reports to identify providers that are not currently contracted with WellCare. This information is shared with the Network Development Team to begin recruitment activities.

WellCare of Kentucky Regional Staff: Our regional provider representatives, Enrollee Service Representatives and Care Coordinators serve as key resources for identifying any gaps in the network. Because they are regionally based, they understand the provider landscape across each Region.

Our reporting tools enable us to continuously monitor network performance and identify solutions to prevent or remediate access issues. Solutions include targeted outreach and education of providers failing to meet our contractual standards, followed by continuous monitoring. Providers, who continuously fail to meet contract requirements, or follow active, supported corrective action efforts, may be terminated.

Our comprehensive monitoring program has shown results, with PCP and Specialty appointment availability in the third quarter of 2019 far exceeding our goal of 90% compliance, as shown in **Table G.6-3**. Telephonic surveys measured the ability to schedule appointments within 30 days for routine care and 48 hours for urgent care.

Table G.6-3 Telephonic Survey Results (through Q3 2019)

Provider Type	Urgent	Routine
PCPs	95.20%	98.00%
Pediatricians	98.41%	95.24%
Specialty Care Providers	86.42%	93.83%

ENSURING ACCESS TO CARE WHEN AN AGREEMENT A KEY PROVIDER IN A REGION OR DISTRICT IS LACKING

Ensuring the quality of care and service delivered to our SKY Enrollees is our primary priority regardless of whether a provider is participating with us. While we prefer to leverage our contracted providers who have undergone credentialing, we understand SKY Enrollees may require access to out-of-network providers. This is especially true for SKY Enrollees where placement moves are common or where continuity is of paramount concern. Our utilization management program features an Enrollee and provider-friendly system for authorization of

out-of-network services. Our supporting policies, procedures, and systems provide the necessary flexibility for our staff to authorize care to out-of-network providers, and for our staff to continue to work with these providers in the ongoing coordination of our Enrollee's care. As requests for out-of-network care are found to be in our Enrollee's best interest, we take the necessary steps to authorize services, including assessing the quality of the provider, documenting expectations, coordinating care, and monitoring and assessing the care provided. If we lack an agreement with a key provider in a DCBS service region or DJJ community district, the case is referred to the Kentucky SKY Provider Liaison responsible for supporting the resolution of provider access and availability issues. The Provider Liaison has detailed knowledge of Kentucky providers, including Behavioral Health providers, and patterns of care/referral in Kentucky.

The Provider Liaison outreaches to the provider to arrange for a single case agreement to provide services to the Enrollee and work with the Enrollee's assigned Care Coordinator to authorize service. The Provider Liaison keeps the DCBS Service Region or DJJ Community District informed as to the resolution of the access and availability issue. At the same time, we facilitate coordination of transportation for Enrollees if they lack available transportation to the provider. In accordance with Section 29.3 Covered Services will be reimbursed at no more than 100% of the Medicaid fee schedule/rate unless the Covered Service falls under the EPSDT benefit.

In conjunction with the single case agreement, we extend provider contracts, discuss the benefits of participation in the SKY Network and seek to resolve the provider's reasons for not contracting with WellCare of Kentucky

v. How the Contractor will ensure appointment access standards are met when Kentucky SKY Enrollees cannot access care within the Provider Network.

WellCare of Kentucky's approach to measuring and verifying provider compliance with appointment access standards is described in our response to Question G.6.a.iv above and includes:

- Conducting annual appointment accessibility surveys
- Documenting, addressing and follow-up with SKY Enrollee and provider about appointment access grievances/complaints
- Conducting annual Enrollee and provider satisfaction surveys that help gauge accessibility
- Reviewing monthly closed panel reports
- Monitoring out-of-network paid claims reports
- WellCare of Kentucky regional staff field knowledge

In the rare instance the Enrollee is not able to access care within the SKY provider network we take immediate steps to ensure appointment access standards are met. The case is referred to the Kentucky SKY Provider Liaison responsible for supporting the resolution of provider access and availability issues. The Provider Liaison will uses his or her detailed knowledge of Kentucky providers and patterns of care/referral to identify a provider who can **deliver the needed service within the required timeframe** and outreach to the provider to arrange for a single case agreement to provide services to the Enrollee and work with the Enrollee's assigned Care Coordinator to authorize services. At same time will extend provider contracts and discuss the

benefits of participation in Kentucky SKY. In accordance with Section 29.3 Covered Services will be reimbursed at no more than 100% of the Medicaid fee schedule/rate unless the Covered Service falls under the EPSDT benefit.

b. Provide an example of how the Contractor has contracted for similar networks for similar populations in other programs. Provide a work plan to contract with Kentucky SKY Network Providers, with accountabilities and timelines.

WellCare of Kentucky and our affiliate Medicaid MCOs have more than 53 combined years of experience managing provider networks that care for children involved in the foster care or adoption assistance system. Today, our networks of more than 270,000 physical health, behavioral health and community-based providers throughout eight states, including Florida, Kentucky, New Jersey, Nebraska, Missouri, Michigan, Hawaii, and South Carolina, manage almost 28,000 Enrollees in the foster care or adoption assistance system, including the 8,100 currently enrolled in WellCare of Kentucky.

KENTUCKY EXPERIENCE

As an incumbent MCO in Kentucky, WellCare of Kentucky currently serves the single largest concentration of Foster Care, Adoption and Adult Guardianship children across the Commonwealth including all eligibility classes found in Section 41.2 Eligibility for Enrollment in Kentucky SKY.

WellCare of Kentucky has coordinated care for Enrollees involved in the foster care system since the inception of its contract to provide Medicaid managed care services for DMS in 2011. WellCare of Kentucky's statewide network of more than 34,500 providers cares for over 8,100 children and adolescents in foster care throughout the 120 counties in the Commonwealth. Contracted providers include PCPs, FQHCs, specialty providers, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

NATIONAL EXPERIENCE

CMS Health Plan

WellCare's most recent implementation involving foster care and special needs children is the Children's Medical Services (CMS) Health Plan, a plan for children with special needs that provides a comprehensive system of care that is centered around the family and caregiver. Under the contract with the Florida Department of Health, WellCare of Florida is the sole MCO for the CMS Health Plan, which went live February 1, 2019 and covers all 67 Florida counties. The CMS Health Plan covers children who are under age 21 and eligible for Medicaid or are under age 19 and eligible for Florida Kid Care, and have special health care needs that require extensive preventive and ongoing care. CMS Health Plan's network of 43,000 providers includes 350 Medical Foster Care Parent Providers as well as a network of Prescribed Pediatric Extended Care (PECC) providers for therapy services while at the PPEC. CMS Health Plan covers more than 68,000 children and adolescents, including 200 Medical Foster Care children and other foster care children in the general population.

CMS Health Plan's contracted providers include PCPs; FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, medical foster care parent providers, prescribed pediatric extended care, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations. In building this network, transition of care was our paramount concern since many of these children had been with their providers for years. WellCare of Florida worked closely with state agencies to identify the services these children were receiving through a series of reports by provider type. Network gaps were systematically identified and personal outreach occurred to secure contracts. As a result of these efforts, implementation occurred with minimal disruption to the Enrollees.

Florida Staywell

Our Florida Affiliate, Staywell, has coordinated services for foster care system-involved Enrollees since 1998 when they began their support of Medicaid Enrollees including those who were involved in foster care systems. Staywell's network of 59,400 providers cares for its more than 9,600 children and adolescents who are in the care of the state's foster care system. Staywell's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, home and community-based (HCBS) providers, long term services and support (LTSS) providers, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

Meridian

Our affiliate Medicaid plan, Meridian, has coordinated care for children involved in Michigan's foster care system through its contract to provide Medicaid managed care services for the Michigan Department of Health and Human Services since 2016. Meridian's network of 40,000 providers cares for nearly 1,900 Enrollees involved in Michigan's foster care system throughout 83 Michigan counties. Meridian's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

WellCare of New Jersey

Our New Jersey affiliate, WellCare of New Jersey, has coordinated care for foster care-involved Enrollees since the inception of its contract to provide Medicaid managed care services for the Department of Human Services (DHS) in 2014. WellCare of New Jersey's network of 29,300 providers cares for its nearly 300 children and adolescents who are in the care of the state's foster care system. WellCare of New Jersey's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, home and community-based (HCBS) providers, long term services and support (LTSS) providers, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

Ohana Health Plan

`Ohana Health Plan, our Hawai`i Medicaid affiliate, has coordinated care for children and adolescents in the state's foster care program since 2009, when it originally contracted with the Department of Human Services (DHS) to provide Medicaid managed care services. `Ohana's network of 9,600 providers cares for nearly 200 Enrollees who are in foster care. `Ohana's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, LTSS providers, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

WellCare of South Carolina

Our Medicaid affiliate in South Carolina, WellCare of South Carolina, has been contracted with the Department of Health and Human Services (DHHS) to provide Medicaid managed care services to foster care youth, as a WellCare company, since January 2013. WellCare of South Carolina's network of 29,000 providers cares for its nearly 100 foster care Enrollees who are under the care of the Department of Social Services (DSS). WellCare of South Carolina's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

WellCare of Nebraska (through 1/23/2020)

Previously, WellCare affiliate in Nebraska coordinated care for foster care-involved Enrollees since the inception of its contract to provide Medicaid managed care services for the Department of Health and Human Services (DHHS) effective January of 2017, WellCare of Nebraska's network of 23,500 providers cares for its more than 2,700 children and adolescents in Nebraska's foster care system across all 93 Nebraska counties. WellCare of Nebraska's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, retail, specialty and mail-order pharmacies, ancillary providers, acute care hospitals, facilities, home health and DME providers, LTSS providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

Missouri Care (through 1/23/2020)

Previously, Missouri Care coordinated care for children involved in Missouri's foster care system through its contract to provide Medicaid managed care services for the Division of Medical Services (now the MO HealthNet Division), as a WellCare company, since March 2013. Missouri Care's network of 34,800 providers cares for its nearly 2,700 Enrollees involved in Missouri's foster care system throughout 114 Missouri counties and the city of St. Louis. Missouri Care's contracted providers include PCPs, FQHCs, specialists, behavioral health providers, ancillary providers, acute care hospitals, facilities, home health and DME providers, urgent and emergency care facilities, and non-traditional community and faith-based organizations.

WORK PLAN FOR CONTRACTING WITH KENTUCKY SKY NETWORK PROVIDERS

Our work plan for contracting with Kentucky SKY Network providers is included as **Attachment G.06-b Work Plan for Contracting with Kentucky SKY Network Providers**. This work plan includes accountabilities and timelines.

Please refer to our response to C.17, Provider Network, under Technical Approach, for additional information regarding our experience, partnerships, processes, procedures and compliance to the requirements in the Draft Medicaid Managed Care Contract and Appendices.

G.6 Provider Network

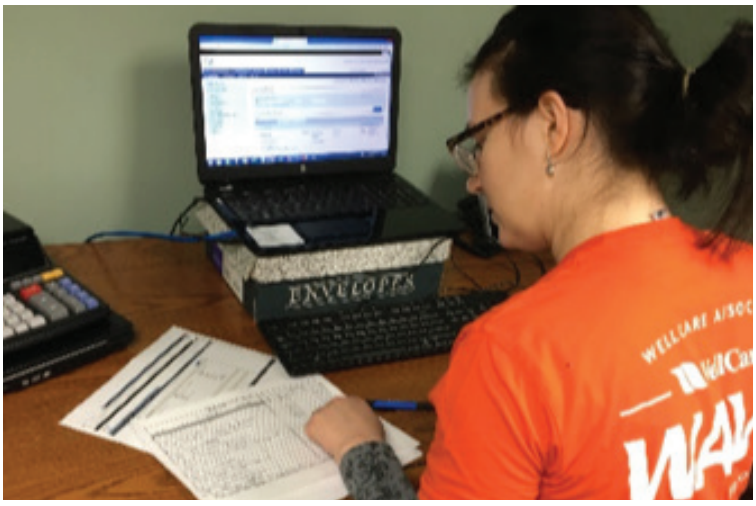
- Attachment G.6.b Workplan for Contracting with Kentucky SKY Network Providers

WellCare of Kentucky Workplan for Contracting with Kentucky SKY Network Providers			
Timeline	**Goals and Tasks**	**Accountability**	**Status**
June 2019	• Review RFP requirements related to provider network for any new requirements • Initiate development of Provider or service gap list based on specialty types and network access parameters • Determine network sizing for resource planning • Draft Provider Participation Agreement/Amendment • List of provider who have a signed contract	Business Development, Network Development, Provider Services	**Complete**
July/ Aug 2019	• Review list of providers who are currently serving SKY enrollees and determine those who are currently contracted with WellCare. • Determine capacity of in-network provider who are currently serving SKY enrollees • Meet with various advocacy agencies and DCBS/DHH and DBHDID to determine additional providers who may be needed for the network • Develop network access strategies for rural/underserved areas such as telehealth, provider incentives, etc.	Network Development, Business Development, Provider Services Legal	**In Process**
Sept 2019	• Further develop Provider list to ensure appropriate number of pediatricians, BH providers and providers with experience in trauma-informed care. • Obtain and analyze state fee-for-service file for additional prospective providers • Develop resource model to support network development and management activities	Network Development, Business Development, Provider Services	**In Process**
Oct 2019	• Submit Provider Participation Agreement to DMS for approval • Submit amendment to contract with existing Medicaid Providers for approval • Build out range of reimbursement options for fee-for-service, PPS for FQHC and RHCs shared savings and value-based purchasing	Business Development, Legal. Network Development, Provider Reimbursement	
Nov 2019	• Develop contract cover letter and marketing materials • Draft network recruiting phone script	Network Development	
Dec 2019	• SKY Provider Participation Agreements and Amendments approved and in place • Obtain approval for cover letter and marketing materials • Hire and train additional contracting staff to supplement current market resources • Hire and train additional PR staff and Provider Liason • Initiate contracting and amendments with key Providers through face-to-face meetings • Initiate negotiations with key facilities and Provider groups • Deploy field team for face-to-face outreach	Network Development, Provider Services, Provider Reimbursement	

Jan 2020	• Release Provider Mailing for SKY program information and offer to contract • Begin existing Medicaid network amendment process • Begin processing incoming amendments, contracts and credentialing applications • Establish weekly Geo-Access reports to track progress • Conduct weekly meeting to track progress, discuss barriers and remediation strategies • Ongoing telephonic and face-to-face contact with key Providers • Continue processing incoming documents • Ongoing weekly review of network development progress, including subcontractor networks	Network Development, Provider Services	
Feb 2020	• Ongoing telephonic and face-to-face contact with key Providers • Continue processing incoming documents • Ongoing weekly review of progress, • County-by-county blitz visits to non-respondents • Develop Provider training materials and Provider Welcome letter	Network Development, Provider Services	
March 2020	• Begin statewide regional Provider information forums • Conduct Webinars to answer provider questions • Ongoing telephonic and face-to-face contact with key Providers • Continue processing incoming documents • Ongoing weekly review of progress, • Access-compliant network contracts in house and in credentialing/configuration workflow for directory production and July 1, 2020 implementation	Network Development, Provider Services, Digital Communications	
April 2020	• Ongoing telephonic and face-to-face contact with key Providers • Continue processing incoming documents • Ongoing weekly review of progress, • Provider education material in place including Provider orientation, Provider resource guide, job aids and behavioral health toolkit	Network Development, Provider Services	
April/ May 2020	• Begin regional orientation sessions to continue 30 days post implementation. Includes program overview, question and answer period, job aids and quick guides with training material on the website • Provider Welcome Letters mailed • Online training and webinars in place	Network Development, Provider Services	
May 2020	• Ongoing telephonic and face-to-face contact with key Providers • Continue processing incoming documents • Ongoing weekly review of progress • Begin outreach by local Provider services representatives to conduct • training • Provider manual on website • Provider website and secure portal operational • Submit SKY network to the Division at least 60 calendar days prior to contract start date (or as specified	Network Development, Provider Services	

June 2020	• Provider Call Center operational • Activate Provider Engagement Model with ongoing field-based Provider support and training through field-based associates including Provider services representatives, operations account managers, SKY medical director, pharmacy director, quality practice advisors and patient care advocates • Ongoing telephonic and face-to-face contact with key Providers • Continue processing incoming documents • Ongoing weekly review of progress, including subcontractor networks	Network Development, Provider Services, Digital Communications	
July 2020	• Go Live and Command Center activated • Activate team of experienced Provider services associates in Command Center environment with regional staff deployment to key Providers • Ongoing training of newly enrolled Providers within 30 days of enrollment • Ongoing oversight of subcontractor networks in place	Provider Services, Quality	
August 2020 and ongoing	• **Provider network listing to the DMS – monthly** • **GeoAccess reports demonstrating compliance with Report 25 standards - quarterly** • **Targeted network recruitment to close identified gaps in services** • **Network Adequacy exception report – quarterly** • **Timely Access report - quarterly** • **Ongoing monitoring of Provider compliance with availability and scheduling requirements** • **Quarterly Provider forums in regional venues across the state with material also placed on Provider website** • **Create quick reference guides and refine specialized training for SKY program**	**Network Development, Provider Services**	

7. Provider Services



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G.7. PROVIDER SERVICES

Provide the Contractor's proposed approach to Provider outreach and education. Include a description of how initial training will differ from ongoing training. Describe proposed training materials including but not limited to:

a. Coordinating services;
b. Care Coordination Teams;
c. Training in Trauma-informed Care (include sample materials);
d. Crisis services;
e. Child and Adolescent Needs and Strengths (CANS);)
f. High Fidelity Wraparound approach;
g. Impact of ACEs;
h. Neonatal Abstinence Syndrome (NAS);
i. Six Seconds Emotional Intelligence (SEI); and
j. Screening for and identification of Behavioral Health needs.

G.7. PROVIDER SERVICES

Provide the contractor's proposed approach to provider outreach and education. Include a description of how initial training will differ from ongoing training. Describe proposed training materials including but not limited to:

WellCare of Kentucky will comply with the Department for Medicaid Services' (DMS) expectations and requirements as specified in Section 27 Provider Services and Section 41.14.1 Education and Training of Network Providers of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare Kentucky has over eight years of experience with six Regional offices and a proven, field-based, provider-facing outreach and education program with 18 Provider Relations representatives and managers established regionally across the state. WellCare's Provider Relations (PR) representatives live in the region where they support providers, giving them both proximity to the providers they support and familiarity with their communities. We will build on this foundation to serve the Kentucky SKY program, including the hiring of a Kentucky SKY dedicated PR Manager and two dedicated PR representatives, ensuring that we can meet the specific outreach and education needs of its providers.

PROPOSED APPROACH TO PROVIDER OUTREACH AND EDUCATION

WellCare Kentucky will build on the foundation of its robust MMC Provider Relations functions, establishing a separate Provider Relations team to serve the Kentucky SKY program, creating a provider services function that will act as the point of contract specifically for providers serving SKY Enrollees. WellCare will establish this separate PR team to best serve the new providers, including 30+ private child care providers who will be new to a managed care system and may need extra assistance learning new systems and resolving any issues that arise at intervention. The dedicated team will be augmented and supported by the larger provider relations team

particularly during implementation to rapidly deploy the proper training to all providers across the state. Both teams will be cross-trained on the Medicaid and SKY programs so they can assist each other during times of high provider demand.

PRIOR TO IMPLEMENTATION

Prior to implementation of the Kentucky SKY program, we will work with DMS, DCBS, and DJJ to develop and implement a series of provider and community summits to introduce the program, respond to questions and concerns and begin familiarizing providers with the tools and support available to them as they prepare for implementation. We will use a combination of our six regional offices and other local sites across the Commonwealth to provide the most convenient options for our provider. This is similar to the approach WellCare took at DMS' request prior to implementation of the State's waiver program.

Prior to Kentucky SKY implementation, we will host regional provider summits to answer questions and offer tools and supports to the network.

ONGOING OUTREACH AND EDUCATION

As required, WellCare conducts provider orientation within 30 Days after we place a newly contracted provider on an active status. During the launch of Kentucky SKY, our entire provider relations team will be mobilized to train and educate our new providers on how to interact with WellCare. This will include 18 Provider Relations representatives and managers and five Hospital Services specialists and managers who live throughout every region in Kentucky. Orientation is conducted in compliance with WellCare's SKY Provider Orientation and Education Plan, which we will submit within 60 Days of contract execution, when material changes are made, and annually. Our ongoing model of provider orientation relies on trainings held in the providers' offices during monthly on-site visits, a bi-weekly webinar of rotating topics based on provider needs and an annual Provider Summit. Our monthly, in-office, face-to-face meetings with providers are the primary way we communicate and train our providers.

PROPOSED TRAINING MATERIALS

Please see our response to **Question G.4** Kentucky SKY Contractor Educational and Training Requirements for additional information about provider training topics. WellCare Kentucky's provider education will cover the topics outlined in **Table G.7-1**:

Table G.7-1: Proposed Training Materials for Select Kentucky SKY Provider Education Topics

Proposed Training Materials	Initial vs. Ongoing
a. Coordinating Services	
• Our Provider Orientation materials including information about: • The importance of the provider's role in coordinating services, including behavioral health and physical health services • Tools available to providers to expedite coordination of services, including fax notifications when a patient is hospitalized.	Initial and then a periodic refresher webinar with any new information or guidance

Proposed Training Materials	Initial vs. Ongoing
b. Care Coordination Teams	
• Our Provider orientation materials, including information about: • Introduction to our interdisciplinary Care Coordination Teams with roles established according to American Academy of Pediatrics (AAP) guidelines • Assignment to Enrollees to meet individual needs • Roles and responsibilities	Initial and then a periodic refresher webinar with any new information or guidance
c. Training in Trauma-informed Care	
• Trauma-Informed Care in Kentucky, presentation by Diane Gruen-Kidd, LCSW; DBHDID • Webinars from The National Child Traumatic Stress Network: https://www.nctsn.org/resources/training/webinars?search=&resource_type=21&trauma_type=All&language=All&audience=30&other=All • Models of Trauma-Informed Integrated Care Part I: Comprehensive Care for Children and Youth in the Child Welfare System; and • Part II: Identifying and Responding to Early Childhood Trauma in the Pediatric Setting; and • Developmental and Medical Issues for Young Foster Children • Materials for Trauma-Informed Care training will be developed in conjunction with the University of Louisville Kent School of Social Work. Please see **Attachment G.7.c Sample Trauma Informed Care Training Materials**, provided electronically.	Initial and then a periodic refresher webinar with any new information or guidance
d. Crisis Services	
• Crisis Intervention: Helping Patients Regain Safety and Control; CE Direct Course CE582	Crisis Intervention: Helping Patients Regain Safety and Control; CE Direct Course CE582
e. Child and Adolescent Needs and Strengths (CANS)	
• Project SAFESPACE CANS Training for Clinicians • Kentucky Child Adolescents Needs and Strengths (KY-CANS) manual Older Child Version • Kentucky Child Adolescents Needs and Strengths (KY-CANS) manual Younger Child Version	Initial and then a periodic refresher webinar with any new information or guidance
f. High Fidelity Wraparound Approach	
• Training materials from the National Wraparound Implementation Center at https://docs.wixstatic.com/ugd/272564_229abdf2f2b94459813d6a7e87fcd16f.pdf	Initial and then a periodic refresher webinar with any new

Proposed Training Materials	Initial vs. Ongoing
	information or guidance
g. Impact of ACES	
• Webinar from the National Child Traumatic Stress Network: Understanding the Impact of Childhood Trauma, Adversity and Toxic Stress on the Body and Mind: The Role of Integrated Healthcare at https://www.nctsn.org/resources/training/webinars?search=&resource_type=21&trauma_type=All&language=All&audience=30&other=All	Initial and then a periodic refresher webinar with any new information or guidance
h. Neonatal Abstinence Syndrome (NAS)	
• Understanding Neonatal Abstinence Syndrome for the General Pediatrician; Providers Clinical Support System webinar developed by AAP; at https://pcssnow.org/event/understanding-neonatal-abstinence-syndrome-for-the-general-pediatrician/ • Neonatal Abstinence Syndrome: Off to a Shaky Start; CE Direct Course CE581	Initial and then a periodic refresher webinar with any new information or guidance
i. Six Seconds Emotional Intelligence (SEI)	
• Unlocking EQ at https://www.6seconds.org/certification/	One-time initial
j. Screening for and identification of Behavioral Health needs	
• WellCare BH Toolkit, Age 17 and Younger • WellCare BH Toolkit, Adult • SAMHSA Guide to Behavioral Health Integration for Safety-Net Primary Care Providers • https://www.integration.samhsa.gov/integrated-care-models/CIHS_quickStart_decisiontree_with_links_as.pdf	Initial and then periodic refresher webinar with any new information or guidance
Additional Training Building Bridges Initiative	
• Building Bridges Self-Assessment Tool • Instructional Guide: Strategies for Successful Implementation of the Self-Assessment Tool • Webinar: Overview of BBI • A BBI Guide: Finding and Engaging Families for Youth Receiving Residential Interventions: Key Issues, Tips and Strategies for Providers • BBI: Performance Guidelines and Indicators Matrix • All at http://www.buildingbridges4youth.org/products/tools	Initial and then periodic refresher webinar with any new information or guidance

KENTUCKY SKY PROVIDER RELATIONS FUNCTIONS

WellCare's provider outreach and education functions are an important element of our "high-touch, high-tech" Provider Engagement Model, which we will tailor to meet the specific needs

of providers in the Kentucky SKY program. Our PR representatives lead the Provider Engagement Model and are the first point of contact with providers. The field-based team of PR representatives is also supported by an existing team of cross-trained representatives to help as needed and an on-demand Provider Call Center staffed for the Kentucky SKY program. The fully-staffed call center will be available Monday through Friday 8:00 am – 6:00 pm Eastern Standard Time, including federal holidays. Finally, we also employ a Kentucky-based Operational Account Representative team of claim support specialists who provide local assistance with complex claims issues. This team is available to meet with providers when there is a claims dispute and discuss or adjust the issue in real time during the meeting.

Our call center callers are greeted by an Interactive Voice Response (IVR) system, which provides callers with clear, easy-to-follow instructions and includes provisions to speak to a live representative during normal business hours or leave a voice message anytime. CAREChannels, our telephone and communication platform, is designed to enhance the provider experience. Our enhanced speech recognition automated call distribution system effectively answers, routes, tracks and reports all calls and inquiries. Our secure provider portal allows providers to process authorizations 24 hours a day, 7 days a week. Authorizations are never required for emergency care. After-hour calls into UM are transferred directly to nurses on-call who address emergent needs. Should consultation be required with the Medical Director, the associate will outreach directly to the Medical Director by telephone to discuss the situation live.

Our secure Provider portal allows Providers to process authorizations, submit claims, manage their assigned Enrollees, and provider many other self-help features 24 hours a day, 7 days a week in a secure environment. The provider portal also includes innovative features like a chat function with claims support staff if the provider has a question. If the provider uses this online chat feature, their inquiry is pushed to the front of the support queue for a quick response. As we do today, we will continue to issue newly-contracted providers a Provider Manual within five business days from inclusion of the provider in our network and provide online access to the Provider Manual and any changes or updates. The Provider Manual and all provider materials are available both online and in hard copy format upon request of the provider.

Please refer to our response to C.17, Provider Services, under Technical Approach, for additional information regarding our experience, partnerships, processes, procedures and compliance to the requirements in the Draft Medicaid Managed Care Contract and Appendices.

G.7 Provider Services

- Attachment G.7.c Sample Trauma Informed Care Training Materials (Provided Electronically)

8. Covered Services

G.8. COVERED SERVICES

a. Describe the Contractor's approach for ensuring the successful completion of required assessments and screenings. Please include a description of the following:

i. How the Contractor will coordinate with Kentucky SKY Enrollees, the Department, DCBS, DJJ, and families. Address the involvement of any other sister agencies in the description.

ii. How the Contractor will ensure assessments are initiated immediately upon a Kentucky SKY Enrollee's Enrollment in the Kentucky SKY program.

iii. How the Contractor will meet standards for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening.

iv. Any challenges that the Contractor anticipates in completing required assessments and how it will mitigate these challenges.

v. Provide examples of how the Contractor has succeeded in providing assessments to individuals similar to those required for the Kentucky SKY Enrollees.

vi. Include examples of Trauma assessment or screening tools the Contractor would recommend the Department consider for the use in identifying Trauma in Kentucky SKY Enrollees.

b. Submit the proposed screening tool the Contractor will use to develop the Kentucky SKY Care Plan. Include a description of how the Contractor will use the results of assessments that sister agencies have conducted in developing the Care Plan. Provide examples of prior tools the Contractor has used for other similar programs and detail how these tools have contributed to the Contractor achieving program goals.

c. Describe its comprehensive approach to providing Crisis Services, including in home services, to Kentucky SKY Enrollees.

d. Describe the Contractor's experience in providing services through a holistic, person-centered approach, utilizing a High Fidelity Wraparound approach.

e. Describe how the Contractor will develop and provide interventions that will help develop resiliency in Kentucky SKY Enrollees who have been exposed to Trauma and ACEs.

G.8. COVERED SERVICES

a. Describe the Contractor's approach for ensuring the successful completion of required assessments and screenings. Please include a description of the following:

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 33.6 Behavioral Health Services Hotline, Section 34.3.C Enrollee Needs Assessment and Section 41.17 Required Assessments and Screenings of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically.

ENSURING SUCCESSFUL COMPLETION OF REQUIRED ASSESSMENTS/SCREENINGS

WellCare has several years of experience serving children and youth in foster care as part of the Medicaid managed care program with a high-touch comprehensive assessment process to identify needs and pinpoint the right services. As we prepare for implementation of the Kentucky SKY program, we are building on our experience and working with local and national experts to ensure that our screening and assessment processes incorporate the unique factors, such as trauma and placement change history, that impact children and youth in foster care.

We recognize that during the initial implementation of Kentucky SKY, there will be a larger-than-normal influx of Enrollees. Our implementation plan will include measures to ensure we are prepared to handle that influx smoothly. As part of our implementation plan, we will collaborate with DCBS and DJJ to identify and prioritize Enrollees with complex behavioral health and medical needs to ensure they are immediately assessed and have a plan of care in place. We will also work with the other managed care organizations who will be transitioning Kentucky SKY members to WellCare to identify and prioritize Enrollees with complex behavioral health and medical needs as part of the transition of care process. We ensure continuity of all approved services, medications, and durable medical equipment during and after the transition period. As an example of how we have handled this type of Enrollee influx, we will build on the successes and lessons learned by our affiliate, WellCare's Florida Children's Medical Services (CMS) Health Plan. Their sole source, statewide contract to provide services to 68,000 children and adolescents, including 200 medically complex children in "Medical Foster Care" and other foster care children in the general population went live Feb. 1, 2019. Because of the significant health care needs of this population, their top priority was quickly performing assessments to identify and coordinate care to address the most immediate service needs. They worked closely with involved state agencies to obtain pre-implementation reports by provider type on the services these children were receiving prior to implementation through a series of reports by provider type.

HEALTH RISK ASSESSMENTS (SCREENINGS) AS PART OF WELCOME CALLS

We will mail an Enrollee Welcome Packet within five calendar days of receiving the 834 file. It is our standard practice to conduct a New Enrollee Welcome call soon after that. During the Welcome call, our Enrollee Services Representative (ESR) will ask the enrollee or caregiver to confirm receipt of the Welcome Packet, verify their PCP assignment and allow us to help them make the Enrollee's first appointment, and conduct the Health Risk Assessment (HRA). We make multiple attempts to contact the Enrollee to conduct the HRA and may use text, email or direct mail to reach them.

As our trained ESR completes the Welcome call, CAREConnects, our customer relationship management tool, generates pop-ups on their desktop alerting them of open care needs including EPSDT screenings or overdue immunizations and make appointments with the Enrollee's legacy physicians, assign the Enrollee a new PCP, or find a specialist. Through the coordination by the ESR, we remove any barriers the Enrollee has to access care helping them get to their appointment including transportation, language assistance, or any other resources needed.

The telephonic New Enrollee Welcome call we describe above will work well for adopted Enrollees or former foster care Enrollees when the Kentucky SKY program is initially implemented. After the initial implementation of the Kentucky SKY Program, our experience indicates that new Enrollees coming into the program as children in foster care will require a more high-touch approach. In these cases, the WellCare Field Outreach Coordinator (FOC) will collaborate with the Enrollee's DCBS guardian and complete the HRA within one business day. In these cases, further automated outreach should not be necessary.

i. How the Contractor will coordinate with Kentucky SKY Enrollees, the Department, DCBS, DJJ, and families. Address the involvement of any other sister agencies in the description.

CURRENT APPROACH

As part of our guiding principle that services should be family-focused and youth-driven, we coordinate with Enrollees and families to work within a trauma-informed approach to completing screenings and assessments. We recognize that some children and youth entering foster care may not have been receiving medical care regularly, may be missing immunizations or assessments, and may be uncomfortable with medical or dental exams.

WellCare coordinates with DMS, DCBS and DJJ to receive referrals for screenings and assessments. Currently, there are multiple avenues through which WellCare may receive notification that a child or youth is entering foster care and requires screening and assessment. WellCare's Field Outreach (FO) coordinator receives many referrals directly from DCBS and DJJ regional offices. Other referrals come to our Care Coordinators during their quarterly meetings with DCBS regional offices. It is common, also, for WellCare's lead foster care staff to receive emails and calls from DCBS, DJJ, foster parents, adopted parents or private child care providers with referrals.

PROPOSED ENHANCED APPROACH

Under the Kentucky SKY program, we will enhance opportunities for collaboration by co-locating Field Outreach Coordinators (FOCs) into DCBS offices and meeting with DJJ offices on a regular basis to establish a collaboration plan that meets the specific needs of each region and office. We also propose exploring with DCBS and DJJ the use of a referral form that can be submitted electronically if DCBS and DJJ staff indicate that would be useful. Our FOCs will coordinate with our care management team to identify a care manager who is located closest to the Enrollee, care provider, provider, and/or parent for outreach, and to begin the assessment process.

OTHER CURRENT COORDINATION EFFORTS

Children's Review Board and DJJ Placement Services Division

WellCare works with the Children's Review Board as they refer and place DCBS foster children into private child care. For DJJ, WellCare works with the Placement Services Division as they identify placements for DJJ Enrollees. WellCare collaborates with these placement entities to ensure that assessments, medical records, and information needed is obtained for timely referral.

Office for Children with Special Health Care Needs

For medically complex children in foster care, WellCare coordinates with the Office for Children with Special Health Care Needs. The Enrollee's Care Coordinator participates in the child's Interdisciplinary Care Team (ICT) to coordinate assessments and plan services.

DCBS Recruitment and Certification Team – Wendy's Wonderful Kids Workers

We coordinate as necessary with the DCBS Recruitment and Certification Team, Wendy's Wonderful Kids workers. WellCare supports DCBS as they work on presentation summaries to prepare Enrollees for the adoption process.

Family Resource Centers

WellCare works with Family Resource Centers (FRCs) to assist with referrals and identify needed providers as service needs are identified.

ii. How the Contractor will ensure assessments are initiated immediately upon a Kentucky SKY Enrollee's Enrollment in the Kentucky SKY program.

WellCare of Kentucky is strongly positioned to ensure that we convene the Assessment Team that will conduct face-to-face assessments of all new Enrollees within ten days. The FOC in each regional DCBS office will be positioned to quickly learn when a child or youth enters foster care. The FOC will ensure that we **assign** a Care Coordinator within **one business day** and the Care Coordinator will in turn schedule an Assessment Team meeting within ten days of our notification of the enrollment. The Care Coordinator will request the DCBS and DJJ Service Plans, any assessment conducted by DCBS and DJJ (including the CANS screen), the CANS, the Criminogenic Needs Questionnaire, and the Risk and Criminogenic Needs Assessment. The Care Coordinator will set up appointments for any screenings and/or assessments that have not been completed or have been identified as needed from a previous screening or assessment.

As recommended by the American Academy of Pediatrics, within **72 hours** of a child entering foster care, a complete well-child visit will be conducted. A trauma assessment, identification of past medical and behavioral health history assessment, substance use assessment, suicide assessment, and social determinants of health assessment will all be conducted and updated. We currently serve the largest concentration of children and youth in foster care in the Commonwealth and because so many of the Kentucky SKY-eligible population will not have to change MCO at go-live, they will be able to retain their current providers, care plans and permanency plans.

For Kentucky SKY Enrollees who are currently enrolled in another Medicaid MCO, we propose that in addition to electronically sending a list of their existing SKY-eligible Enrollees, transferring MCOs also identify those with a Medically Complex designation or other agreed indicators of immediate need and provide information about those Enrollees' needs and care. As required, our Care Coordinator, assigned within one business day, will ensure that the Assessment Team has the information it needs to make timely and appropriate authorizations and referrals. To do so, the Care Coordinator will follow up as needed, including holding case conferences to discuss the Enrollee's needs and care and will conduct outreach to current providers to obtain additional information to inform the assessment and care planning process once the child or youth is enrolled in WellCare.

For new Enrollees we haven't previously identified, our embedded FOCs will closely collaborate with the staff of the regional DCBS office to quickly identify when a child newly enters the foster care system. This will enable them to quickly convene an Assessment Team meeting,

assign a Care Coordinator, work with the Enrollee and family to identify and assign a PCP and conduct the required assessments.

iii. How the Contractor will meet standards for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening.

WellCare is highly invested in ensuring that the children we serve receive timely and appropriate health screening, preventative care and necessary treatment. We promote EPSDT services, including screenings, by providing education and training to parents and caregivers, providers, and community partners and by offering incentives to caregivers to ensure that Enrollees receive this preventive care. Kentucky SKY will utilize the American Academy of Pediatrics Healthy Foster Care America health care standards that include the following fundamental principles:

- Children and teens in foster care should be seen early
- Children and teens in foster care should be seen often upon entry into foster care
- Children and teens in foster care should have an advanced health care schedule
- Children and teens in foster care should be seen often while they are in foster care
- Children and teens in foster care should have comprehensive evaluations

CAREGIVER EDUCATION

Throughout our Enrollee-facing materials, we provide information on the availability and importance of EPSDT services, including developmental screenings. We will continue to highlight EPSDT services as we prepare Enrollee-facing materials for the Kentucky SKY program. For example, our New Enrollee Packet and our SKY Enrollee Handbook will include the information. Enrollees will receive a letter from WellCare during their birthday month listing the EPSDT screens appropriate for their age. On our ClearSKY app, caregivers will receive "push" notifications of any gaps in care, including EPSDT screenings. We provide Healthy Rewards incentives to Enrollees' caregivers to encourage them to ensure that the children in their care complete their well-child visits and receive required EPSDT screens.

In addition to the above techniques, which the Kentucky SKY program will share with our Medicaid program, we will rely on the Enrollee's Care Coordinator to ensure that EPSDT assessments are performed on a timely basis. During the comprehensive assessment, the Care Coordinator will discuss with the Enrollee and their caregiver the importance of EPSDT screenings, outline with the caregivers the appropriate screenings and preventive services appropriate to the child and work with the caregiver to schedule the first appointment with the PCP. The Care Coordinator will follow up with the caregivers of Enrollees to ensure that an appointment with the PCP has occurred within the first 30 days.

PROVIDER EDUCATION

At enrollment and on an on-going, monthly basis, WellCare will provide a "push" notification to each PCP of their EPSDT eligible children who are missing EPSDT services, including screenings and assessments. Each PCP's Provider Relations representative confers with them often over the list of patients with care gaps and works with PCPs to ensure that Enrollees have received services, screenings and assessments within the first 30 days, operating within the context of a

trauma-informed approach. We conduct medical chart audits and corrective action plans with providers on a consistent basis and during this process check to ensure that providers are providing required EPSDT screenings.

iv. Any challenges that the Contractor anticipates in completing required assessments and how it will mitigate these challenges.

WellCare has been providing services to children and youth in the foster care system since 2011 and we have experience in addressing barriers and challenges in completing required assessments. For example:

- It isn't uncommon for a child or youth newly into care to arrive at their provider for services such as an EPSDT screening and for the provider to encounter difficulties verifying the Enrollee's eligibility or enrollment information. WellCare will assign a temporary identification number for these Enrollees and will be available 24/7 to help providers resolve these issues. We train our staff to assure the provider that they can go ahead and provide the service and we will pay the claim.
- Although transportation is the responsibility of the Enrollee's caregiver, if there are transportation issues that present a barrier to an Enrollee accessing timely assessments, WellCare will coordinate non-emergency transportation services.
- Sometimes services take longer than anticipated or the Enrollee struggles to be able to engage through the entire appointment. WellCare will support providers as they work to complete necessary assessments and exams for Enrollees' complex needs. If additional time, extra appointments or other interventions are needed, WellCare will work with the provider, the care provider and Enrollee to authorize the time needed and the frequency needed to complete appointments. Examples of situations where Enrollees may need multiple appointments include Enrollees with an autism diagnosis, Enrollees with high levels of trauma, and Enrollees with multiple complex issues.

v. Provide examples of how the Contractor has succeeded in providing assessments to individuals similar to those required for the Kentucky SKY Enrollees.

WellCare has experience providing assessment to similar populations, including children with special health care needs.

- Upon contract start-up, WellCare NJ successfully completed Comprehensive Assessments for all new LTSS Enrollees and subsequently updated care plans for all Enrollees at a high risk level within 90 days and other Enrollees at lower risk levels within 180 days of the contract go-live date.
- Upon contract start-up February 1, 2019, WellCare's Florida Children's Medical Services (CMS) Health Plan quickly performed assessments for 68,000 children and adolescents, including 200 medically complex children in "Medical Foster Care" and other foster care children in the general population. They collaborated with involved state agencies to obtain as much information as possible on these children prior to implementation and were able to achieve a smooth transition for these high-needs children.

vi. Include examples of Trauma assessment or screening tools the Contractor would recommend the Department consider for the use in identifying Trauma in Kentucky SKY Enrollees.

WellCare proposes to work with DMS, DCBS and DJJ to evaluate trauma assessment and screening tools and select the tool(s) that best meet the needs of SKY Enrollees. We recommend reviewing several different assessment tools that are nationally-recognized, evidence-based and person-centered and allow providers to select and use the tool that they feel is most appropriate to meet the needs of the child or youth.

Assessment tools for evaluation might include the Trauma Symptom Checklist of Children (TSCC) or the Child PTSD Symptom Scale. Samples of these tools are provided in **Attachment G.8.a.vi-1 Child PTSD Symptom Scale, Attachment G.08.a.vi-2 Review of Child and Adolescent Trauma Screening, Attachment G.8.a.vi-3 CYW ACEQ User Guide** (provided electronically)**, Attachment G.08.a.vi-4 TSCC Description** and **Attachment G.08.a.vi-5 KY SKY Trauma Questions** (provided electronically)**.**

b. Submit the proposed screening tool the Contractor will use to develop the Kentucky SKY Care Plan. Include a description of how the Contractor will use the results of assessments that sister agencies have conducted in developing the Care Plan. Provide examples of prior tools the Contractor has used for other similar programs and detail how these tools have contributed to the Contractor achieving program goals.

WellCare will assume that all children and youth coming into the Kentucky SKY program have complex needs and require care coordination**.** Our Comprehensive Enrollee Needs Assessment tool will include all required elements including assessment of:

- Enrollee's immediate, current and past health care, mental health, history of suicide attempts, and SUD needs
- Past trauma, including history of abuse, neglect, grief/loss, and violence
- Psychosocial, functional, and cognitive needs;
- Social Determinants of Health, including employment and housing status, and frequent moves or disruptions of care
- Ongoing conditions or needs that require treatment or care monitoring
- Current care being receiving, including health care services or other care management
- Current medications, prescribed and taken
- Support network, including caregivers and other social supports

In addition, we propose to include:

- Caregiver screening
- Placement history
- Biological family history, including mental health, SUD, and suicide
- Support system
- Cultural and educational needs
- Developmental history
- Prior behavioral health and medical history
- Prior time in foster care
- History of prevention services

- Current family stressors
- Family history of trauma, secondary trauma, violence

We will require Primary Care Providers (PCPs) to complete screenings for Adverse Childhood Events (ACEs) on all Enrollees.

Please see **Attachment G.8.b Proposed Screening Tool to Develop the Kentucky SKY Care Plan** (provided electronically).

ASSESSMENTS FROM SISTER AGENCIES

When our embedded FOC learns that a child or youth is entering foster care and we assign a Care Coordinator and convene the Assessment Team meeting, our Care Coordinator will ensure that the Assessment Team has the information it needs to make timely and appropriate authorizations and referrals. To do so, the Care Coordinator obtain the results of assessments that sister agencies have completed. For example, the Care Coordinator will obtain any previous assessment by the Children's Review Board to determine level of care or the Placement Services Division of DJJ. For medically complex children in foster care, the Care Coordinator will ensure the Assessment Team has access to previous assessments, including the most recent Individual Health Plan (IHP) and latest encounter summaries. The Care Coordinator will follow up as needed, including holding case conferences to discuss the Enrollee's needs and care and will conduct outreach to current providers to obtain additional information to inform the assessment and care planning process.

In addition, we propose to assist sister agencies in performing required assessments by:

- Engaging a clinician to perform a CANS assessment if the DCBS screening indicates a full CANS assessment is necessary and a licensed therapist is not otherwise available to perform the assessment timely to inform the Enrollee's plan of care attached to CANs assessment, refers to therapist for CANS, which drives plan of care.
- Completing the required assessment after 30 days to verify the level of care required when an Enrollee is placed with a Qualified Residential Treatment Provider (QRTP).

PRIOR TOOLS FOR SIMILAR PROGRAM

Launched at our Hawaii affiliate plan, WellCare's Healing Futures program is designed for our pediatric population experiencing adverse childhood experiences (ACEs). Its mission is to raise awareness and provide education around ACEs leading to pediatric trauma, to promote trauma-informed care (TIC), and ultimately to improve long-term social, physical health, and behavioral health outcomes. The program elements include early identification, referrals to professional treatment, and connections to community resources. This newly created specialty program aims to accomplish the following;

- Improve behavioral health follow up and EPSDT (Early and Periodic Treatment, Screening, and Diagnosis) follow up for pediatric Enrollees with PTSD and acute stress reaction diagnoses and at-risk populations (e.g., foster care)
- Grow the number of trauma informed care providers, including behavioral health, in our network and increase referrals, as appropriate

- Increase closed-loop referrals to our Community Connections program for Enrollees with PTSD and acute stress reaction diagnoses to connect them with social services resources available in their local area.

In addition, WellCare New Jersey (NJ) has successfully used a proprietary Care Needs Screening tool to identify Enrollees who potentially need and are eligible for long-term services and supports. The Care Needs Screening tool includes questions about LTSS-like needs by exploring an Enrollee's ability to perform Activities of Daily Living (ADLs), such as getting out of bed, bathing, dressing, toileting, and feeding oneself and Instrumental ADLs (IADLs) like preparing meals and managing money. Screening questions help us discover whether or not an Enrollee needs assistance with daily tasks from a family member, caregiver, or other natural or professional supports. The Enrollee's response to each question about ADLs, IADLs, and cognition is assessed for the level of assistance needed, e.g., no assistance, supervision only, limited assistance, extensive/max assistance, and total dependence.

c. Describe its comprehensive approach to providing Crisis Services, including in home services, to Kentucky SKY Enrollees.

WellCare provides a comprehensive approach to providing Crisis Services, including in home services, to its current Enrollees. Under Kentucky Sky, we will enhance and expand this approach to better serve the total Foster Care, Juvenile Justice, and post-adoption population state-wide. Because of our experience, we know that the approach to providing crisis services must begin at enrollment with the development of a comprehensive care plan developed in collaboration with the Enrollee's entire circle of support. We ensure that care planning is youth guided and family driven, and that it includes all appropriate supports in an effort to prevent a crisis from occurring. We ensure that if a crisis does occur, its impacts on the Enrollee and the caregivers are mitigated, especially because we know that placements often can be adversely affected by an Enrollee's crisis. We include as part of our total support extensive personal education for caregivers with emphasis on Foster Parents, Adoptive Parents, and Fictive Kin who may not have enough experience to understand the warning signs or triggers for their child's crisis.

Crisis Services

Ethan, age 8, was experiencing a crisis, displaying aggressive behaviors at home and at school trying to self-harm. He'd been living at home with his adoptive mother since he was six weeks old, but now she had given him into state care as a dependency case because she felt she couldn't meet his complex needs. He had been placed at Home of the Innocents but had been hospitalized on several occasions. Laura N., his WellCare Care Coordinator, stepped in and took a high-touch approach to working with Ethan's case manager, therapist, education coordinator, program manager, and adoptive mother to complete assessments and develop a plan of care for Ethan. Laura N. worked closely with our METS team to identify specific goals to demonstrate Ethan's progress towards recovery and authorize evidence-based approaches to help him step down from repeated hospital admissions.

Our comprehensive approach includes

- Face-to-face Emergency Services available twenty-four (24) hours a day, seven (7) Days a week
- 24/7 availability of telephonic licensed clinical support from our Nurse Line and Behavioral Health Crisis Line for routine, urgent, and emergent issues
- In-community mobile crisis intervention services and in-home services
- Development of a care coordination plan by the Multidisciplinary team and in collaboration with DCBS and DJJ, caregivers, providers, and Enrollee's circle of support such as Residential Placement Staff, with a crisis plan as part of total coordination
- Education for caregivers on what to do and whom to contact during a crisis and how to implement the crisis plan, along with guidance on what constitutes both a BH and a physical health crisis for their particular Enrollee
- Provider education on acceptable after-hours telephonic support for Enrollees so that an incident does not become a crisis
- Discussions, no less than quarterly, with the Department and DBHDID on the efficacy of our existing crisis response for Enrollees and to receive feedback on changes or additions to service.
- Extensive training and refreshers for all Enrollee-facing staff in the management of an Enrollee or caregiver crisis call, including for care management and care coordination staff, training on recognizing unmet social needs and their effect on total wellbeing

IMMEDIATE LINK TO CRISIS SERVICES: OUR BEHAVIORAL HEALTH CRISIS LINE

We are experienced in the delivery of crisis services required by Enrollees in the Foster Care and Juvenile Justice system and the need for comprehensive, compassionate, and rapid response. Our 24/7 BH Crisis Line, already serves as a gateway to all needed BH crisis support for Enrollees and their caregivers in Kentucky Medicaid. With "no wrong door," the BH Crisis Line staff take calls directly from Enrollees and caregivers, from any WellCare staff who believes an Enrollee is or may soon be in crisis and from providers and our state partners, such as DJJ Social Workers. Our BH Crisis Line also provides the BH clinical expertise for our 24-Hour Nurse Line and our Enrollee Services line, taking crisis and urgency calls via warm transfer on a shared call platform for speed and safety.

We staff our BH Crisis Line with Licensed Mental Health Counselors, Registered Nurses and IDD professionals with advanced BH training, and licensed social workers. Using scientifically valid and tested protocols, they immediately assess the caller's acuity level and then triage and address the specific BH emergency or urgency. Following the protocol for life-threatening, urgent, or routine intervention, the clinicians deliver care selected for the Enrollee from our full array of comprehensive services and in accordance with access standards established by DMS. This includes:

- Using patch capabilities to activate local 911 Emergency Services
- Immediately connecting to the local Suicide Hotline or other local Crisis Response system
- Dispatching local mobile crisis providers to the Enrollee
- Arranging an urgent assessment with a community provider

- Bringing the Enrollee's BH provider to the call and/or arranging follow-up services from the provider
- Arranging treatment with a BH provider within
- Bringing an on-call Care Manager into the call, if needed, for personal support

All Enrollee contacts with our BH Crisis Line are captured through a feed to our CareCentral clinical platform. The call is documented as a change in the Enrollee's condition requiring expedited follow-up on the next business day by a local BH care manager to determine if additional services are required. This allows for comprehensive review of the circumstances for the call to the BH Crisis Line with a goal of maintaining the Enrollee's stable placement and wellbeing.

ENHANCING EXISTING CRISIS SERVICES

Currently, WellCare contracts with every Kentucky-based mobile BH crisis unit to serve our existing Enrollees. In addition to the recent partnership with Lifecare Solution described below, WellCare is undertaking efforts to develop a true crisis response team network. Given the lack of crisis services available in Kentucky, we are in discussion with potential out-of-state providers, such as Saint Francis Ministries, on expanding services to Kentucky. We continue our discussions with our contracted Behavioral Health Service Organizations (BHSO) providers on offering these services. We also are working with our community mental health centers across the state to expand crisis services. For example, we are in discussions with Lifeskills in Bowling Green to explore potential models for the delivery of crisis services, including a model WellCare partnered to create in Arizona of post-crisis transitional care for Enrollees who present in crisis at a psychiatric emergency care center.

FITT-Acute Crisis Intervention and Diversion Program

To address Kentucky's need for true mobile crisis treatment, we recently contracted with Lifecare to provide the FITT Program of virtual residential treatment for youth living with caregivers in a community setting. This is an intensive in-home program partnering with families to resolve crises, avoid out-of-home placement and provide skills for future crisis prevention. It also serves as a step down from inpatient or PRTF; and an alternative for youth at risk of hospitalization and PRTF. Just a few examples of what the FITT Program provides include:

- Door and window alarms
- Prescription lockboxes
- Respite for parents
- Access to a same-day prescriber

Preventing a Crisis

WellCare understands that preventing the need for crisis services, especially for the Kentucky SKY population, is as much a priority as managing the Enrollee's crisis. As part of crisis prevention, we use our clinically sound, multi-dimensional, data analysis and risk stratification model, Identification and Stratification (ID/Strat). We identify Enrollees at the highest risk level, those who are being discharged from any BH facility, including Residential Placement, and Enrollees with special needs for additional preventive strategies, recognizing that even the perception of a crisis may be enough to trigger a caregiver's request for placement change or discourage a Foster Parent or Fictive Kin. Then, we deploy a range of services that may include:

- **WellCare at Home**, an integrated team approach that supplements the Enrollee's multi-disciplinary team and supports providers in the delivery of care management and high-quality care to improve health outcomes while reducing inappropriate use of the emergency room, inpatient settings and other higher cost services. This locally-driven care management model with a single line of accountability, a single integrated technology system, and coordination for social service gaps and unmet needs ensures the administration of a seamless continuum of care management with a goal to reducing or eliminating the need for in-facility services.

Among our SKY-eligible Enrollees with co-occurring mental health and substance use issues, ER visits/1000 decreased by 14%, inpatient mental health admits/1000 increased by 3%, PCP visits/1000 increased by over 7%, and specialist visits/1000 increased by 84% from 2016 to 2019.

- **Medical home**: Establishing a medical home for Enrollees is one of key interventions we can undertake to reduce the likelihood of a crisis. We will begin assigning PCPs to our foster care Enrollees and will provide trauma training to all medical home providers. The medical home provider will be responsible to oversee and coordinate all services the Enrollee receives and our CC Team will support the medical home by facilitating information exchange, involving them in all Individual Health Plan (IHP) meetings, helping them locate appropriate specialists when needed, and providing scheduling and transportation assistance to ensure Enrollees access recommended care.
- **Crisis and Safety Planning**: For families and caregivers of children and youth involved in the child welfare system, it is critical to have a crisis and back-up plan, including the availability of back-up Care Coordinators. The back-up or crisis plan ensures children receive needed care for their safety and well-being. As part of our Care Coordination and Case Management activities, our Care Coordinators work with Enrollees, families and caregivers to create a crisis and back-up plan as part of their plan of care. Included in the plan of care is family/guardian education on signs/symptoms of crisis, identification of a back-up Care Coordinator if assigned Care Coordinator is temporarily unavailable, linkages to community-based crisis services, and access to our 24-Hour Behavioral Health Crisis Line and 24-Hour Nurse Line. Crisis and back-up plans are given to families and necessary medical professionals. Our Care Coordinators also encourage families to share the plans with those involved in the child's care and school.
- **Members Empowered to Succeed (METS)**: Under this program, WellCare works with Enrollees who are stepping down from intensive services or who need more specialized services to tailor authorizations

As of June 2018, **WellCare achieved the following quality and cost outcomes for our Members Powered to Succeed program** for Medicaid Enrollees in our Kentucky, Florida, and Georgia markets:

- Behavioral health inpatient admissions were **reduced by 6.7%**
- Behavioral health outpatient visits were **reduced by 51%**
- **Increased pharmacy claims for Enrollees by 5.2%** due to increased medication adherence
- Overall behavioral health expense was **reduced by $227** PMPM
- Achieved an estimated program **savings of $2,709,522** for participating Enrollees

and services to the specific needs of the Enrollee and their family/caregiver, while recruiting natural and community supports as part of the care plan. In our Medicaid program, the METS program has resulted in a 6% reduction in ER use.

- **Discharge Planning and Comprehensive Discharge Planning Support**: WellCare KY's transition of care process provides early identification of all medical, behavioral, and social issues that might require post-inpatient intervention, such as transportation, home health, medication, or durable medical equipment. The Enrollee-centric process involves the attending physician, facility discharge planner, our concurrent review professional staff, the Enrollee and his/her caregivers, ancillary providers, care coordinators, when appropriate, and community resources. Discharge planners review the draft discharge plan and adjust it as necessary with each subsequent clinical review prior to the Enrollee's discharge. Under the Kentucky SKY program, if an Enrollee is admitted to an inpatient facility, our concurrent review staff will notify the Care Coordinator. Prior to an Enrollee being discharged, our BH Discharge Coordinators schedule outpatient follow-up appointments and continuing treatment to occur within seven days. They also provide telephonic appointment reminders and conduct outreach within 24 hours to Enrollees who miss an appointment. Please see our response to C.23 for further information about discharge planning.
- To appeal to youth who may be reluctant to reach out for assistance before a crisis is triggered, we offer digital, interactive clinical support through mobile and online supports to empower our youth in addressing their BH issues. MyStrength, an evidence-based platform, provides Enrollees with interactive programs on depression, anxiety, stress, substance use, chronic paint, and sleep challenges. It also supports the spiritual aspects of whole-person care. MyStrength's integrated model includes CBT, mindfulness, motivational interviewing and ACT protocols with personalized pathways that facilitate user interaction, mood trackers, and additional tools to measure effectiveness and improvement.

MyStrength has shown a 43% rapid symptom reduction within the first two weeks of engagement, proving to be 83% as effective as face-to-face therapy at a fraction of the cost and reducing total paid claims for engaged members by 70%

Our **My WellCare Mobile App** provides access for Enrollees, families, and caregivers to our digital health library, which includes information on mental health, substance use, self-help tools such as computerized Cognitive Behavioral Therapy (cCBT), and our vignette series of *People Like M*e with stories from those with lived experience with mental health and substance use.

We also are piloting a new program in collaboration with JOOL Health Coach, a personal coaching smartphone application that encourages youth to check in with their peers and engage in healthcare services. With tailored tracks specific to different populations, Enrollees have access to a transition-aged youth pathway for those with SUDs, including SUD assessments, resources and referral information to help youth and their families learn about their SUD and local available treatment options.

d. Describe the Contractor's experience in providing services through a holistic, person-centered approach, utilizing a High Fidelity Wraparound approach.

WellCare has experience in Kentucky using the holistic, person-centered Wraparound approach and, nationally, using a High Fidelity Wraparound approach to serve similar populations.

KENTUCKY EXPERIENCE

WellCare participates in the IMPACT program which employs a wraparound approach to improve outcomes for children and youth with Serious Emotional Disturbance (SED). This program through the Community Mental Health Centers is funded primarily through the Department of Behavioral Health and Developmental and Intellectual Disabilities. While WellCare is not funding the service provided by the Wraparound Coordinator, the services and supports identified through the Enrollee's wraparound service plan are covered by WellCare. WellCare works in collaboration with the Enrollee's Impact team and supports the plan and care developed. WellCare participates in Regional Interagency Council meetings, RIAC, as a member of the community and is engaged in shared work toward improving access and availability of services for children and their families. Through this collaboration with RIAC, WellCare can better leverage our Community Connection program to support any identified needs. Prior experience of the Wraparound Model comes from LeAnn Magre, our Provider Relations Liaison. LeAnn worked with Kentucky Partnership for Families and Children and the Department of Behavioral Health and Developmental and Intellectual Disabilities to create and train the Wraparound model for Impact and Impact Plus Care Coordinators and behavioral health professionals.

NATIONAL EXPERIENCE

In addition, the WellCare in Florida implemented a High Fidelity Wraparound approach as a tailored mental health approach for those who have experienced or been exposed to violence and trauma. WellCare partnered with Children's Home Society in Region 11 of Florida to offer this as an In Lieu of service.

Preparing for high fidelity wraparound

In preparation for implementing a High Fidelity Wraparound approach, WellCare Kentucky is prepared to provide training on the approach to our Enrollee-facing staff, network providers, the courts, judges and attorneys. Please see our response to G.4 Education and Training for additional information.

e. Describe how the Contractor will develop and provide interventions that will help develop resiliency in Kentucky SKY Enrollees who have been exposed to Trauma and ACEs.

We propose to adopt the evidence-based approach recommended by the Annie E. Casey Foundation. The Foundation believes that the three key ingredients for building resilience and helping young people success are: 1) caring relationships; 2) high expectations; and 3) opportunities to participate and contribute. They recommend a framework that emphasizes: 1) competence and strengths; 2) developing assets rather than focusing on reducing risks; 3) fostering pathways to resiliency, not just resilient behaviors; and 4) interventions that focus on families, schools and communities.

The role of WellCare in this framework is to promote stability, so that the young person can develop caring relationships with adults who, in turn, will provide high expectations and opportunities for the youth to participate and contribute. To promote stability, we will develop and provide interventions focused on families, schools and communities.

PROMOTING STABILITY

We will promote stability by providing supports to families and providers so that placements aren't disrupted. Our interventions to promote stability will include:

- *Respite* – In addition to providing access to respite services, we will help Enrollees and families identify and implement natural supports available to provide respite to caregivers consistent with a high fidelity wraparound approach. If natural resources are not available, the WellCare will work with community resources to identify potential support services through foster parent support groups, etc.
- *Peer Support* – WellCare has partnered with Orphan Care Alliance (OCA), giving them $15,000 to support their OCA Connect Groups, which support foster and adoptive parents around the state. OCA Connect is an opportunity for foster and adoptive parents to journey together by meeting monthly for support and encouragement. Each meeting is led by a professional that guides the discussion to create a safe community for sharing stories and offering encouragement. OCA Connect conversations don't leave the room and parents will know they aren't alone in their challenges. While OCA Connect Groups have been well established in Lexington and Louisville, OCA hopes to provide these services in Paducah, London, Pikeville, and Ashland. In addition, WellCare is partnering with Kentucky Partnerships for Families and Children to ensure training for youth and parent peer support is offered and available. Through the training offered by KPFC, not only will WellCare ensure adequate training for peer support positions, but also will offer youth and their families the opportunity to attend the youth and family leadership training conferences provided by KPFC. These conferences and training opportunities assist youth and families to be engaged as leaders within the child welfare system.
- *Foster Parent Education* –Through OCA, we will offer foster parents trainings on trauma-informed care based on various intervention tools including Empowered to Connect, Trauma Competent Caregiving and Trust Based Relational Intervention (TBRI ®) with one of four TBRI ® Practitioners. In addition to the training and support offered by OCA, WellCare will engage KPFC to assist in training development needs for foster and adopted parents. Through our Enrollee Outcomes Advisory Committee, WellCare will hear directly from foster parents and adopted

WELLCARE'S MENTAL HEALTH FIRST AID (MHFA) INITIATIVE

Raise awareness of mental health issues within our own organization and position "champions" across the company who can be of assistance to their peers.

Better equip our non-clinical staff who have regular contact with our enrollees to be able to recognize and respond appropriately to those experiencing and demonstrating mental health related symptoms.

Train our partners in the community (such as providers, schools, and non-clinical employees of community-based organizations) in MHFA in order to better serve our enrollees in the community.

parents and work with them and their communities to identify and address the needed supports and training.

- *Support for School Environment* – In our experience, trouble in the school environment is often the trigger for a disruption in a child's placement. In addition, engaging natural supports through the Assessment Team meeting and High Fidelity wraparound support model is key to successful implementation of an Enrollee's care plan and one of the natural supports is the Enrollee's school and social circle. We propose to partner with the Family Resource Centers to identify ways in which we can complement the services they provide to families in the school-based setting. We will work to identify key school personnel who are connected to Enrollees and engage them in the care planning process. As we learn about the important supports that schools may need to assist in maintaining an Enrollee's success, WellCare can effectively work to identify resources to assist to meet the need.

f. Describe the role of non-medical factors (e.g., placement changes) that may drive inappropriate utilization of medical resources and how the Contractor will account for those factors in the delivery approach. As part of the response, include how the Contractor will identify and leverage non-Medicaid resources that may be available in a community environment, including how it will assist such community-based resources that may serve an important role in the Kentucky SKY Enrollees' overall physical and Behavioral Health care needs and goals even if they are not traditional Medicaid services. Provide examples of any community organizations that the Contractor anticipates involving to provide services to support Kentucky SKY Enrollee' needs and goals.

NON-MEDICAL FACTORS DRIVING UTILIZATION

Enrollees in the Kentucky SKY population share the social determinants needs of other Medicaid populations. For example, Enrollees over 18 may need assistance with housing, job skills training, secondary education, and connection to food pantries and completing SNAP applications.

Placement Disruptions

In addition to SDOH, as we've served children and youth involved in the child welfare system, we've observed that placement changes are very disruptive to services for children and youth in foster care and may lead to overutilization of resources. It is emotionally draining for a child or youth to be displaced, which may lead to behavior changes, including violence and delinquency. It also is disruptive to the logistics of a child's care. When a child moves:

- Their prescription drugs may be left behind at their old location, meaning they must be replaced at the new home
- Their medical information may not follow them, which can lead to duplication of services that have already been provided, including immunizations and other preventive services.

ACES

Every Kentucky SKY Enrollee has experienced Adverse Childhood Experiences (ACEs) and trauma. Removal of a child is a last resort and by the time removal occurs, many children have experienced significant neglect or the impact of physical abuse either to them or a parent or sibling. Some have never felt safe: according to the University of Louisville's CANS pilot, about

20% of the Commonwealth's foster care population reported being a victim or witness to criminal activity and 10% to community violence. These children experience further trauma from being removed from their homes and separated from parents and siblings.

Accounting for These Factors

Youth-guided, family-driven care planning is the key avenue to account for these non-medical factors. Working with the Enrollee's circle of support, the Enrollee's Care Coordinator will carefully plan to address these factors. For example, if there are SDOH barriers that may prevent the Enrollee from appropriately accessing care, the Care Coordinator will mitigate them, often by calling on non-Medicaid resources.

SOCIAL DETERMINANTS OF HEALTH

WellCare Care Coordinators identify SDOH needs during the comprehensive assessment process, which includes the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation's Accountable Health Communities Health-Related Social Needs (HRSN) Screening Tool. This tool provides ten simple questions that ask about living situation, food, transportation, utilities, and safety. For foster and adoptive parents and for Enrollees age 17 and older, we use the additional supplemental questions that ask about financial strain, employment, family and community support, education, physical activity, substance use, and mental health. The information is captured in CareCentral, our care coordination platform.

Care Coordinators then work with our trauma-trained Community Action Team to outreach to the Enrollee/family to address the unmet social resource need, documenting all additional identified needs and the resources provided in the Enrollee's CareCentral record.

PREVENTING DISRUPTIONS IN PLACEMENT

As discussed in Subsection e above, we will pursue several interventions designed to try to prevent the disruption of placements, including:

- Respite for caregivers
- Peer support for foster and adoptive parents
- Foster parent training on trauma-informed care
- Partnering with Family Resource Centers in the school to complement their work

ADDRESSING THE IMPACT OF TRAUMA

WellCare will address the impact of trauma by:

- Providing education and training to WellCare staff, providers, law enforcement and courts as well as families and caregivers about ACES and about trauma-informed care.
- Reducing the stress of transitions and new experiences by providing opportunities for children to visit face-to-face with a new family prior to moving, to engage in "getting to know you" activities and allowing practice outings and practice visits.
- Engaging resources to promote relationship development and strengthening each child's sense of belonging. That might take the form of providing transportation a child's school

even after a placement change has moved them out of their previous neighborhood boundary or to school sporting events to encourage peer relationships.

- Working with the Enrollee and family to develop a safety and crisis plan, identifying and planning to ameliorate anticipated Enrollee and family needs.

IDENTIFYING AND LEVERAGING NON-MEDICAID RESOURCES

Community Impact model

In 2008, WellCare launched Community Connections to proactively identify Enrollees with unmet social service needs, remove barriers to appropriate access and healthy lifestyles, and build strong community partnerships we can leverage to benefit Enrollees and families. Since launching our Community Connections Program in Kentucky, we have connected more than 31,000 people to over 165,000 services across the Commonwealth. A ***Robert Wood Johnson Foundation study documented a 53% reduction in inpatient spending among individuals who accessed a social service through Community Connections.*** We continue to invest in new technology, training, and operations to enhance our model and our ability to identify and address social barriers to health.

WellCare Works

WellCare will connect youth who are preparing to age out of foster care with tools, training and other resources to prepare to enter the workforce. In addition to helping them prepare to test for a General Education Diploma, build a resume and prepare for interviews, our WellCare Works program facilitates access to community-based education and supported employment resources, volunteer opportunities that can help them network and build work experience, and connects them to community supports that address barriers to working like transportation.

Examples of Community Organizations Engaged to Provide Services

- WellCare has partnered with Orphan Care Alliance (OCA), giving them $15,000 to support their OCA Connect Groups, which support foster and adoptive parents around the state. While OCA Connect Groups have been well established in Lexington and Louisville, OCA hopes to provide these services in Paducah, London, Pikeville, and Ashland.
- WellCare also is engaging OCA to offer foster parents trainings on trauma-informed care based on various intervention tools including Empowered to Connect, Trauma Competent Caregiving and Trust Based Relational Intervention (TBRI ®) with one of four TBRI ® Practitioners.
- WellCare is partnering with Kentucky Partnerships for Families and Children (KPFC) to ensure training for youth and parent peer support is offered and available.
- WellCare also is engaging KPFC to work with our Enrollee Outcomes Advisory Committee to develop training for foster and adopted parents.
- Roo's Wish provides clothing to children in foster care; through their partnership with Orphan's Care Alliance, can also fulfill larger needs, such as beds.

Please refer to our response to C.20, Covered Services, under Technical Approach, for additional information regarding our experience, partnerships, processes, procedures and compliance to the requirements in the Draft Medicaid Managed Care Contract and Appendices.

G.8 Covered Services

- Attachment G.8.a.vi-1 Child PTSD Symptom Scale
- Attachment G.8.a.vi-2 Review of Child and Adolescent Trauma Screening Tools
- Attachment G.8.a.vi-3 CWY ACEQ User Guide (Provided Electronically)
- Attachment G.8.a.vi-4 TSCC Description
- Attachment G.8.a.vi-5 KY SKY Trauma Questions (Provided Electronically)
- Attachment G.8.b Proposed Screening Tool to Develop the Kentucky SKY Care Plan (Provided Electronically)

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The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

_____

Length of time since the event:

_____

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

1.	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2.	0	1	2	3	Having bad dreams or nightmares
3.	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)
4.	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5.	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6.	0	1	2	3	Trying not to think about, talk about, or have feelings about the event
7.	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
8.	0	1	2	3	Not being able to remember an important part of the upsetting event
9.	0	1	2	3	Having much less interest or doing things you used to do
10.	0	1	2	3	Not feeling close to people around you
11.	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)

12.	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

13.	0	1	2	3	Having trouble falling or staying asleep
14.	0	1	2	3	Feeling irritable or having fits of anger
15.	0	1	2	3	Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class)
16.	0	1	2	3	Being overly careful (for example, checking to see who is around you and what is around you)
17.	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

The Child PTSD Symptom Scale (CPSS) – Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

	Yes	No	
18.	Y	N	Doing your prayers
19.	Y	N	Chores and duties at home
20.	Y	N	Relationships with friends
21.	Y	N	Fun and hobby activities
22.	Y	N	Schoolwork
23.	Y	N	Relationships with your family
24.	Y	N	General happiness with your life

Review of Child and Adolescent Trauma Screening Tools

Title	Acronym	Source	Year of Pub	#Items	Ages	Respondant	Cost/Accessibility	Language(s)	Interpretation Considerations	Approach	3 Es	CEBC Grade/Empirical Support
Acute Stress Checklist for Children	ASC-Kids	Kassam-Adams	2006	29	8-17	Youth	Free; Author requests to be contacted and that those who use it, "reference it appropriately."	English, Spanish	There is no manual for the ASC-Kids it is used in the same way as other self report scales and is self explanatory.	Designed to assess child acute stress reactions within the first month after exposure to a potentially traumatic event	Experiences	2 studies providing evidence for appropriate R/V of English version and 1 study supporting R/V of Spanish version.
Child and Adolescent Needs and Strengths - Trauma Comprehensive Version	CANS-Trauma Version	Kisiel, Lyons, Blaustein, Fehrenbach, Griffin, Germain, Saxe, Ellis; Praed Foundation, & National Child Traumatic Stress Network	2011	110	0-18	Clinician	Free	English	Manual/Video available for administration training	A multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of service	Effects	While certain psychometric properties have been established for the CANS-MH (CBEC: B), currently there are few published articles examining the psychometrics of the CANS Trauma or NCTSN CANS. Publications are in process.
Child PTSD Symptom Scale	CPSS	Foa, Johnson, Feeny, Treadwell	2001	Part 1: 17 / Part 2: 7	8-18	Youth	Free	English, Korean, Russian, Spanish	Clinical training recommended Suggested Cut Off: 11	17-item PTSD symptom scale and a 7-item functional impairment scale	Experiences/ Effects	CEBC: A; Randomized trials with ethnically diverse children suggest that the measure can detect change in PTSD symptoms that are due to treatment; 2013: Good R/V with adolecent female sexual assault survivors
Child Reaction to Traumatic Events Scale - Revised	CRTES	Jones, Fletcher, Ribbe	2002	23	6-18	Youth	Free	English, Spanish	Prior Experience Psych Testing/Interpretation suggested	Assess psychological responses to stressful life events: arousal, avoidance, and intrusion symptoms	Experience/ Effects	Poor psychometric support for use of 15-item version and 23-item version is in development.
Child Report of Post-traumatic Symptoms	CROPS	Greenwald & Rubin	1999	25	7-17	Youth	$15-20 -both CROPS and PROPS with unlimited permission to copy	English, Bosnian, Dutch, Finnish, French, German, Hindi, Italian, Kinyarwandan, Marathi, Persian, Spanish	Prior Experience Psych Testing/Interpretation	Measure of a child's post-traumatic stress symptoms for the previous 7 days	Experiences/ Effects	> 2 studies: good internal consistency, test-retest reliability, criterion validity, convergent and discriminant validity, and sensitivity to change although more research is needed examining the use of the measure with clinical samples.
Child Stress Disorder Checklist - Screening Form	CSDC-SF	Saxe	2004	4	2-18	Caregiver	Free	English	Does not require specialized training for administration or interpretation; It is recommeded that children with a score of 1 or more be referred for a more comprehensive assessment (Bosquet et al., 2004).	Observer report measure designed for use as a screening instrument to identify children at risk for having or developing Acute Stress Disorder (ASD) and/or Posttraumatic Stress Disorder (PTSD).	Experiences/ Effects	Initial development data and further peer-review assessment indicate adequate reliability and validity among child and adolescent burn victims or with accute injuries. The measure has yet to be examined in terms of relationship to diagnostic classifications or for sensitivity/specificity. Has not be examined with youth younger than 6 years old.
Child Trauma Screening Questionnaire	CTSQ	Kenardy, Spence, Macleaod	2006	10	7-16	Youth	Free; Author requests to be informed of the intended use.	English, Arabic, Croatian	A score equal or above 5, indicates the child is at high risk of developing PTSD. Sensitivity Rate Score: At 1 month: 0.85 (0.65-1.04). At 6 months: 0.82 (0.59-1.05) Specificity Rate Score: At 1 month: 0.75 (0.67-0.82). At 6 months: 0.74 (0.66-0.82)	The CTSQ assesses for reexperiencing (5 items) and hyperarousal symptoms (5 items). Child version of adult version (TSQ) which has	Experiences	Some early evidence for R/V among youth with medical trauma although more evaluation needed with samples for different types of truama. CTSQ was developed as a predictive screening and was significantly better than chance at predicting PTSD symptoms at six months. Majority of items refer to an "accident" which may limit use with non-accidental events that lead to trauma.
Children's PTSD Inventory	C-PTSD-I	Saigh	2000	Interview - 18 minute administration	6-18	Youth	$161 Introductory Kit (includes 25 administrations); $70 each additional 25 administrations	English, French, Spanish	Training of the administrator entails <4 hours of supervised analog training with feedback. Diagnostic cutoffs for each symptom cluster and overall diagnosis based on DSM-IV criteria. Sensitivity Rate Score: 0.87 Specificity Rate Score:0.95 Positive Predictive Power: 0.72 Negative Predictive Power:0.98	1st subtest: assesses potential exposure to traumatic events (if youth does not meet the criteria, interview is terminated). 2nd-4th subtests: symptoms of reexperiencing, avoidance and numbing, and increased arousal. 5th subtest: areas of significant distress.	Events/ Experiences/ Effects	Strong psychometric results suggest good potential for this brief interview intrument, including with ethnically diverse youth. It's usefulness is enhanced by the combination of information on exposure to specific stressful or traumatic events as well as the existence of PTSD symptoms.
Diagnostic Infant and Preschool Assessment - PTSD Section	DIPA-PTSD	Scheeringa	2004	63; semi-structrued interview	0-6	Caregiver	Free	English	4 Hours Training by Experienced Clinician	An interview for caregivers to describe/endorse several domains associated with PTSD	Events/ Experiences/ Effects	In 2010 study with 1-5 year olds, researchers supported preliminary R/V of PTSD scale. Additional research needed with larger and more diverse sample.
Diagnostic Interview for Children and Adolescents - Acute Stress Disorder Module	DICA-ASD	Saxe	2004	58; semi-structured interview	7-18	Youth	Free	English	4 Hours Training by Experienced Clinician	Measures acute traumatic stress symptoms and provides a diagnosis of ASD in children and adolescents	Experiences/ Effects	Psychometric support ongoing, but preliminary support for R/V. Measure is important, as it yields both ASD symptomatology and diagnostic information obtained through Child Self-Report.
Dimensions of Stressful Events Rating Scale	DOSE	Fletcher	1996	50	2-18	Clinician	Free; Contact author	English	26 items assessing aspects of the stressful event and 24 items specific to sexual abuse; measure is completed by a clinician who is familiar with the child/caregiver. A score of 24 or higher on the DOSE was found to maximize the sensitivity-specificity tradeoff when predicting clinically significant posttraumatic stress according to the TSCC PTS scale, with a sensitivity of .73 and a specificity of .52.	Assesses aspects of stressful experiences that are likely to increase the chance of posttraumatic stress reactions and is intended to help characterize the level of distress associated with stressful events and better delineate the specific traumatizing aspects of such events	Events/ Experiences	With 2 studies examining the measure, DOSE shows promise as a valid and reliable measure of the traumatic potential associated with diverse stressful experience
Global Appraisal of Individual Needs (short)	GAIN-SS	Dennis, Feeney, & Stevens	2005	20	13-17	Youth	$100/year per agency for 5 years unlimited use of paper assessment; $500/year for access to web application	English, Spanish	Online training for the GAIN Short Screener is available, but not required. There is no certification process for the GAIN-SS, and reading the GAIN-SS Administration and Scoring Manual is often sufficient instruction. The manual is free to download for licensed GAIN users and can be accessed by logging into our secure site.	Responses to items provide screening information that loads onto 4 subscales: Internalizing Disorder, Externalizing Disorder, Substance Disorder, Crime/Violence.	Expereinces/ Effects	Although the measure has good support for R/V as a screening tool, few items are specifically related to trauma-screening.

Life Event Checklist	LEC	Blake, Weathers, Nagy, Kaloupek, Charney, & Keane	1995	17	18-99	Adult	Free	English	Measure can only distributed by qualified mental health professionals and researchers	Respondent checks whether the event (a) happened to them personally, (b) they witnessed the event, (c) they learned about the event, (d) they are not sure if the item applies to them, and (e) the item does not apply to them.	Events	No evaluation for use of measure with children. The LEC has demonstrated adequate psychometric properties as a stand-alone assessment of traumatic exposure, particularly when evaluating consistency of events that actually happened to an adult.
Lifetime Incidence of Traumatic Events, Student/Parent Forms	LITE-S/P	Greenwald & Rubin, Sidran Institute	1999	16	8-99	Caregiver or Youth	$15-20 - both version (S/P) with unlimited permission to copy	English	Simple and easy to administer/interpret	The LITE is a screening tool designed for clinical and normative settings (i.e., mental health, school, and medical settings). It was developed to be a brief and easy to use one-page measure to screen for stressful and/or traumatic events.	Events	Limited empirical support for use. Authors report preliminary support for R/V, but recommend using discretion with measures until further evidence of R/V is provided.
Los Angeles Symptom Checklist - Adolescent Version	LASC - Adolescent Version	Foy, Wood, King, King, & Resnick	1995	43	13-18	Youth	Free	English, Spanish	Simple language, short phrases. No event or functioning items.	Symptom checklist tool that includes 17 PTSD symptom items as well as items related to abusive drinking, girlfirend problems, and excessive eating.	Experiences/ Effects	1 study that reported appropriate levels of reliability and measure appeared to detect distress and PTSD as a function of trauma exposure among 639 adolescents.
Parent Report of Post-Traumatic Stress Symptoms	PROPS	Greenwald & Rubin	1999	32	7-17	Caregiver	$15-20 - both CROPS and PROPS with unlimited permission to copy	English, Bosnian, Dutch, Finnish, French, German, Italian, Kinyarwandan, Persian, Spanish, Ugandan	Prior Experience Psych Testing/Interpretation; Cutoff Score of 16 indicates cause for clinical concern. Unlike many other measures of PTSD, PROPS appears to be equally sensitive to PTSD symptoms of both genders.	Measure of parent report of the child's post-traumatic stress symptoms for the previous 7 days.	Experiences/ Effects	> 2 studies: good internal consistency, test-retest reliability, criterion validity, convergent and discriminant validity, and sensitivity to change although more research is needed examining the use of the measure with clinical samples.
Pediatric Emotional Distress Scale	PEDS	Saylor, Swenson, Reynolds, Taylor	1999	21	2-10	Caregiver	Free	English, Spanish	The measure yields scores on the following scales: 1) Anxious/Withdrawn, 2) Fearful, and 3) Acting Out. Limited age range; Evidence for use with ethnically diverse sample; No support to differentiate trauma from MH problems	Screening tool (not diagnostic). Items assessing symptoms observed in past month (some of which are anchored in traumatic event).	Expereinces/ Effects	Some promise for psychometric support, however, more research is needed. Ohan, Myers, & Collett (2002) suggest more research is needed to determine whether the PEDS can distinguish between trauma exposed children and other clinical samples.
Post Traumatic Symptom Inventory for Children	PT-SIC	Eisen	1997	30	4-8	Youth	Free	English	Prior to administration or interpretation, training by experienced clinician (<4 hours) suggested.	Interview with child assessing their endorsement of common symptoms for children who have experienced trauma.	Experiences	Very limited psychometric evaluation. Poor evidence for test sensitivity; No evidence for use in ethnically diverse settings
PTSD Checklist (child and parent forms)	PCL-C/PR	Ford	1999	17	6-18	Caregiver	Free	English	Can be easily administered; interpretation should be completed by a clinician	Assessment of symptoms indicative of post-traumatic stress.	Experiences/ Effects	Two studies provide initial evidence for reliability and concurrent validity among medically injured youth and youth in an opt psychiatric clinic.
PTSD in Preschool Aged Children	PTSD-PAC	Levendosky, huth-Bocks, Semel, & Shapiro	2002	18	2-5	Caregiver	Free	English	There is no training required to administer and only minimal trainng by a psychologist needed to interpret. One would need familiarity with the DSM-IV criteria for PTSD to adequately interpret the measure	The PTSD-PAC is a measure of PTSD symptoms in young children. It measures symptoms from the DSM-IV criteria B, C, and D. It also includes items from the DC: 0-3 criteria for PTSD in infants and very young children. It should be used for PTSD screening purposes only.	Experiences	The measure has been used with only one small sample of children and has limited evidence supporting psychometric characteristics.
SCARED Brief Assessment of Anxiety and PTS Symptoms	SCARED brief version	Muris, Merchelbach, Korver, Meesters	2000	9	7-18	Youth	Free	English	Does not require specialized training for administration or interpretation. Suggested cutoff scores: Anxiety: 3+ = clinical PTSD: 6+ = clinical	Brief assessment of Anxiety and PTSD	Experiences/ Effects	Preliminary results based on school children in Netherlands support further examination of measure and suggest the measure may have promise (evidence for R/V).
Trauma and Attachment Belief Scale	TABS	Pearlman	2003	84	9-99	Self	$121 Inro Kit (includes 25 youth administrations; $48 for 25 additional forms)	English	Suggested guildines for interpretation includes manual/video and prior experience psych testing/interpretation	Based on Constructivist Self-Development Theory; assesses 5 domains: safety, trust, independence, power, intimacy, and self esteem	Expereinces/ Effects	Limited empirical support for use. Differences in mean scores based on ethnic group; more widely used to assess vicarious trauma than direct trauma.
Trauma Symptom Checklist for Children	TSCC	Briere, PAR	1996	54	8-16	Youth	$172 Inro Kit (includes 25 youth administrations; $66 for 25 additional forms)	English, Spanish	Interviewers need to be thoroughly familiar with the manual. A higher score reflects greater symptomatology. T scor es at or above 65 for any clinical scale are considered clinically significant. Not designed as diagnostic tool.	Assesses the effects of childhood trauma	Experiences/ Effects	Psychometrics strongly supported by research. Considered one of the "gold standard" measures for trauma assessment.
Trauma Symptom Checklist for Young Children	TSCYC	Briere, PAR	2005	90	3-12	Caregiver	$230 Intro Kid (includes 25 administrations; $50 for 25 additional forms)	English, Spanish	Interviewers need to be thoroughly familiar with the manual. A higher score reflects greater symptomatology. T scor es at or above 65 for any clinical scale are considered clinically significant.	Evaluate acute and chronic posttraumatic symptomatology in young children	Experiences/ Effects	Normative data; Psychometrics supported by multi-site sample of children exposed to mulitple forms of trauma. Spanish version not evaluated for psychometric characteristics.
Traumatic Events Screening Inventory - Revised	TESI-CRF-R/ TESI-PRF-R	Ippen, et al.	2002	24	6-18	Youth (parallel parent report form available)	Free	English	Prior Experience in Psych Testing/Interpretation suggested.	Interview screening tool that assesses a number of potentially traumatic events and the child's reaction to the event.	Events/ Experiences	Measure has not been evaluated for psychometric characteristics.
UCLA PTSD Reaction Index	UCLA PTSD-RI	Pynoos, Steinberg	1998	48	6-18	Youth	$1.20-1.30/instrument or other discounted fee for federal, state, county or agency-wide uses.	English, Arabic, Armenian, Chinese, Farsi/Persian, Filipino/Tagalog, French, German, Greek, Hebrew, Japanese, Norwegian, Russian, Spanish	Revised version of CPTSD-RI. Prior Experience in Psych Testing/Interpretation suggested.	Questionnaire to screen for exposure to traumatic events and assess PTSD symptoms in school-age children and adolescents. Items connected to intrusion, avoidance, and arousal criteria.	Experiences	Several stidies have supported psychometric characteristics of measure, although further assessment of the measure with moderate sample sizes and in other adolescent PTSD screening samples with similar or different PTSD base rates is essential to further establish the instrument's reliability and validity.

Violence Exposure Scale for Children - Revised	VEX-R	Fox & Leavitt	1995	25	4-10	Youth (parallel parent report form available)	Free	English, Hebrew, Spanish	Training for administration inclues < 4 Hours Training by Experienced Clinician	Measure of community violence exposure that includes drawings to accompany questions and thermometer-type rating scale. Questions about minor and severe violence victimization and witnessing violence in the home, school, and neighborhood.	Events	Very limited psychometric support for measure.
When Bad Things Happen Scale	WBTH	Fletcher	1992	90	7-14	Youth (parallel parent report form available)	Free; Contact author	English		Latest version, R4, measures PTSD, anxiety, depression, dissociation, omens, survivor guilt, self-blame, fantasy, denial, self-destructive behavior or thoughts, antisocial behavior, risk taking, and changes in eaching habits.	Expereinces/ Effects	Limited and mixed empirical support for psychometric strength. Existing evaluations of measure include very small samples.
Young Child PTSD Screen	YCPS	Scheeringa	2010	6	3-6	Caregiver	Free	English	Of the 17 PTSD symptoms, two of them are rarely if ever endorsed (sense of a foreshortened future and lack of memory for the event). If youth have five of the 15 remaining symptoms, the ratio of endorsed symptoms is one out of three. Thus, the minimal number of symptoms in the screen could be three symptoms but to ensure a margin of confidence it was decided to include six symptoms and require two symptoms to be endorsed for a positive screen.	Intended to screen shortly following an acute traumatic event (2-4 weeks).	Experiences	There is some evidence for content validity, however, the measures has not been used in a research study and no other psychometric information is available.

"3 E's" - Event, Experience, Effects
Event (e.g., checklist of potentially traumatizing events)
Experience (e.g., avoidance, intrusive thoughts, trauma-specific reactions that suggest traumatized response to an event)

Effects (e.g., general symptoms that do not clearly suggest traumatized response, but are possibly or likely related)

CEBC Assessment Ratings

A - Reliability and Validity Demonstrated - 2 or more published, peer-reviewed studies have demonstrated that the measure is reliable and valid.

B - Reliability and/or Validity Level Above Face Validity Demonstrated - 1 published, peer-reviewed study demonstrates that the measure is reliable and/or valid beyond the level of face validity.

C - Does Not Reach Acceptable Levels of Reliability and/or Validity - A preponderance of published, peer-reviewed studies have shown that the measure does not reach acceptable levels of reliability and/or validity

NR - Not Able to Be Rated - Adequate published peer-reviewed studies demonstrating reliability and/or validity are not yet available for this measure.

Created in connection with the California Screening, Assessement, and Treatment (CASAT) Initiative, Rady Children's Hospital-San Diego, Chadwick Center for Children and Families

Suggested Citation: Crandal, B. & Conradi, L. (2013). Review of Child and Adolescent Trauma Screening Tools. San Diego, CA: Rady Children's Hospital, Chadwick Center for Children and Families.
For questions or comments please contact Brent Crandal, PhD: bcrandal@rchsd.org

Trauma Symptom Checklist for Children - Alternate Version

Briere, J.
1996

Description of Measure

Purpose

To assess the effects of childhood trauma through the child's self-report.

Conceptual Organization

The 54-item Trauma Symptom Checklist for Children (TSCC) consists of two validity scales (Underresponse and Hyperresponse), six clinical scales (Anxiety, Depression, Post-traumatic Stress, Dissociation, Anger, and Sexual Concerns) and 8 critical items. The measure is written at a level appropriate for the language and reading capabilities of children 8-16 years of age (Briere, 1996).

The TSCC-Alternate Version (TSCC-A) is a shortened version of the TSCC that excludes the 10 items that comprise the Sexual Concerns scale and one critical item relating to sexual issues. The TSCC-A addresses human subjects concerns that children might be upset by reference to sexual issues. It is recommended that the TSCC be used in clinical and forensic settings where sexual victimization is more likely to be found, and the TSCC-A be used in school settings (Briere 1996).

Item Origin/Selection Process

The TSCC is the children's version of the Trauma Symptom Checklist for adults. Items for both measures were selected based on factor analyses and consultation with experts in the field of psychopathology (Briere, 1996).

Materials

Test and manual are available from the publisher.

Time Required

10 minutes

rev. 3/14/2011

9. Health Outcomes

G.9. HEALTH OUTCOMES

Describe what measures beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS) scores the Contractor would recommend to determine that its Care Management, Care Coordination, and Utilization Management services and policies are having a meaningful impact on the health outcomes of Kentucky SKY Enrollees.

G.9. HEALTH OUTCOMES

Describe what measures beyond traditional healthcare effectiveness data and information set (HEDIS) scores the contractor would recommend to determine that its care management, care coordination, and utilization management services and policies are having a meaningful impact on the health outcomes of kentucky sky enrollees.

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 19 Quality Management and Health Outcomes and Section 41.9 Quality Management and Health Outcomes of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare of Kentucky will build on a strong foundation of positively impacting the health outcomes of our Enrollees in foster care, the juvenile justice system, and receiving adoption assistance.For the past three years, our HEDIS scores for these Enrollees have been higher on many measures for our overall Child HEDIS results. This fact is notable because this population has more intensive needs and worse health on average than the overall child population due to the impact of trauma and a history of lack of access to care and unmet needs prior to entering foster care.

For example, in 2018 HEDIS scores for our Kentucky SKY-eligible population compared to scores for our overall child population were:

- Equal to or higher than 54% of all child measures.
- Higher on nine of 19 Childhood Immunization Status measures, including influenza and MMR.
- Higher on Immunizations for Adolescents Combo 2, as well as for HPV which also exceeded the national Medicaid mean.
- Higher on Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, and Adolescent Well-Care Visits.
- Equal to or higher than scores for three of the four age groups for the Children and Adolescents Access to Primary Care Practitioners . These 2019 preliminary scores, provided in **Figure G.9-1**, were also higher than the 2017 national Medicaid mean for all four age groups.

Children's and Adolescents' Access to Primary Care Practitioners	2019 All Children*	2019 Foster Care*	2017 National Medicaid Mean
12-24 Months	98.0%	97.0%	94.6%
25 Months - 6 Years	92.0%	94.0%	86.6%
7-11 Years	96.0%	97.0%	90.0%
12-19 Years	96.0%	96.0%	88.6%

*(Preliminary Un-Audited Results)

Figure G.9-1: Access to Primary Care Practitioners

We understand that determining our impact on the health outcomes of the Kentucky SKY population requires measures beyond traditional HEDIS that reflect the unique needs of these Enrollees and the barriers that impede stability and permanency. We will use HEDIS but will also use measures that reflect what we have learned over the past eight years about these children and youth, how the Kentucky system of care works, and how we can most effectively apply Care Management, Care Coordination, and Utilization Management services and policies to support health and permanency goals.

MEASURES

ER visits/1000 for our SKY-eligible enrollees fell by 3% and Primary Care Visits/1000 improved by 8% from 2016 to 2019.

Our SKY Director of Quality, Kathryn Miller, will spearhead our collaboration with DMS, DCBS, and DJJ to develop and implement performance measures that will help us determine our impact on health outcomes. Other leadership that will participate include our pediatrician Medical Director, Behavioral Health Director Dr. Timothy Houchin, Provider Relations Liaison LeAnn Magre, Executive Director Lori Gordon, and our Senior Director of Quality Improvement Laura Betton. Our SKY Enrollee Outcomes Committee (described below) will also provide input into measure development. Our Quality Improvement Committee will review, adopt, and oversee implementation of the measures.

We have developed a preliminary set of proposed measures we will use to provide meaningful insight into our impact on well-being, health, stability, and permanency for SKY Enrollees. These measures, described below, align with the types of measures and reports required by the current contract, incorporate key aspects of care that we know are important for this population, and reflect stability and permanency. We may also use these measures to identify providers with specialized expertise and outstanding performance to recommend to DCBS, Enrollees, and caregivers as preferred providers for SKY Enrollees.

WellCare understands that the SKY program represents a new and innovative approach for this population. We are prepared to partner with DMS, DCBS, DJJ, and DBHID to develop a comprehensive reporting dashboard, inclusive of mutually agreed upon metrics, that will be easily interpreted and demonstrative of how WellCare is impacting the health outcomes of SKY Enrollees.

Operational Measures

We will track and evaluate operational measures that help us determine the impact of our services and policies related to timeliness and effectiveness. Examples of operational measures include the following.

Sample Operational Measures	
% of new Enrollees who have care plans developed within 30 days	#/% Enrollees in each level of Care Coordination
% of Enrollees receiving ID cards within 5 business days of enrollment or any other qualifying event	% Enrollees with ER use outreached within 24 hours
#/% Enrollees assigned a Care Coordinator and CC Team within 1 business day of notification/enrollment	% Enrollees with inpatient discharge outreached within 24 hours (PH and BH)
#/% new Enrollees assigned to a PCP within 24 hours of notification/enrollment	Length of stay in complex and intensive tiers of Care Coordination
#/% foster parents completing WellCare of Kentucky training by topic or engagement in training programs	% Enrollees who meet care plan goals and are moved to a lower Care Coordination tier
Average # of business days for completion of clinical and dental services for new Enrollees (also identifying those that were not completed within the timeframe)	Average # of business days for completion of Trauma Assessment for new Enrollees (also identifying those that were not completed within the timeframe)

Utilization Measures

In addition to the utilization measures we track for all Enrollees, there are a number of utilization measures that provide particular insight into our impact on this population's outcomes. The table below provides some key examples but is not exhaustive.

Sample Utilization Measures	
Decertification of services • # PA requests • % PA requests approved/denied • % appeals upheld/overturned w/dispositions	**Psychotropic medication utilization** • #/% overall and by age range with 1+ psychotropic prescription (denominator – all FC Enrollees)

<table>
<tr><th colspan="2">Sample Utilization Measures</th></tr>
<tr><td>High Levels of Care
ED utilization
PH admissions, discharges, 30 day readmissions
BH/PRTF admissions, discharge, 15/30 day readmissions
ALOS by level of care</td><td rowspan="2">#/% overall and by age range with 1+ psychotropic prescription (denominator – FC Enrollees prescribed psychotropics)
Utilization by key diagnoses (such as ADHD), or lack of specific diagnosis
Average # of psychotropics prescribed (denominator - # Enrollees prescribed any psychotropic)
#/% Enrollees by age ranges with 4+ psychotropic prescriptions (by overall FC pop and by FC Enrollees with a prescription)
Utilization by dosage amount
% Enrollees with psychotropic prescription and no therapy</td></tr>
<tr><td>Telehealth
Number and types of services using telehealth
Provider types accessed using telehealth</td></tr>
<tr><td rowspan="2">Seclusion and Restraints
%/# of Enrollees in facilities for whom seclusion is used
%/# of Enrollees in facilities for whom restraints are used (physical and chemical)
% reduction in use of seclusion and restraints (physical and chemical)</td><td>Crisis Services
# calls to crisis line per month
#/% Enrollees receiving mobile crisis services per month</td></tr>
<tr><td>Other
% of Enrollees with ER use who saw PCP within 48 hours of ER visit</td></tr>
</table>

Evidence Based Practice Measures

We will track measures based on a wide range of evidence-based practices (EBPs), such as the American Academy of Pediatrics/Child Welfare League of America recommendations for the increased frequency and intensity of preventive and primary care services for children and youth in foster care. Critically, we will measure how many Enrollees are receiving care from providers with certification in trauma-informed care and ongoing trauma training our network providers receive. We also plan to add measures that reflect improvement using evidence-based tools such as the CANS, Child Report of Post-traumatic Symptoms (CROPS), and the Ohio Youth Problems, Functioning, Satisfaction Scales.

We will evaluate provider adherence with EBPs as described in our response to Question G.10 Population Health Management and Care Coordination. In addition, WellCare of Kentucky will track Enrollee assessments and ensure they are placed with Qualified Residential Treatment Providers when the CANS and other assessments indicate the Enrollee can only be served adequately in a QRTP environment. Under the Family First Preservation Services Act, all Enrollees placed in a residential setting must be assessed to meet specific criteria to remain in this setting instead of a home-based setting.

Sample Measures for Evaluating Use of Evidence Based Practices	
% Enrollees receiving EPSDT services per the AAP guidelines for periodicity for children in foster care, by age group	% new Enrollees with PCP visit within 5 days
% Enrollees receiving recommended number of High Fidelity Wrap Around contacts within specified timeframes	% private childcare providers with completed Building Bridges self-assessment on EBPs implemented as required for qualified residential treatment provider requirements
% Enrollees receiving treatment from a provider certified in trauma-informed care, by provider type and service type	#/% providers, by type, completing trauma-informed care training annually
% Enrollees showing improvement over time according to evidence-based assessment tools	% providers with documented adherence to EBP, by EBP by provider type
% of Enrollees in QRTP who meet criteria per assessment	% of Enrollees in QRTP when home environment is indicated by assessment

Placement Stability and Permanency Measures

Stability and permanency measures will be critical in evaluating our impact. Everything we do will be aimed at the ultimate goal of achieving permanency for the child or youth through maximizing health outcomes and wrapping services and supports around the Enrollee and family. Below we provide examples of stability and permanency measures we recommend tracking and evaluating.

Sample Stability/Permanency Measures	
#/% Enrollees with out-of-home placement	#/% Enrollees with transfer out of residential facilities
#/% Enrollees with placement changes	#/% Enrollees with transfer out of foster homes
#/% placement changes due to medical/BH issues	#/% Enrollees with transfer from facility to community
Average # placements by age group, tenure in foster care	#/% planned adoptions completed
#/% Enrollees with incidence of maltreatment, by placement type	#/% Enrollees exiting foster care
#/% Enrollees with incidence of maltreatment reoccurrence, by placement type	#/% Enrollees exiting foster care with permanency goals met

Sample Stability/Permanency Measures	
Quality of life, including improvement in schoolwork or activities and emotional well-being, as assessed on the Short Form (SF) 10	#/% Enrollees who return to foster care system following transfer out
#/% Enrollees maintained in community for 6, 12, 18 months following discharge	Average length of time between transfers out and re-entry into foster care

Other Measures

Other types of measures we know are important for this population include continuity with a PCP and caregiver satisfaction with the training we provide. Enrollee and caregiver satisfaction with our Care Coordination services as well as overall customer service and performance will also be important to measure.

Sample Other Measures	
Average # PCP changes	% Enrollees with same PCP for 6, 12, 18 months
CAHPS measures	Satisfaction with Care Coordination
Satisfaction with training	# Complaints and grievances per month by topic

PERFORMANCE IMPROVEMENT PROJECT

WellCare of Kentucky will collaborate with DMS, DCBS, and DJJ on design and implementation of Performance Improvement Project (PIP). Based on our experience with this population, we have identified use of seclusion and restraints in inpatient settings to be an important target for improvement. Below we provide a summary of our planned PIP, which is detailed in **Attachment G.9 WellCare of Kentucky SKY Performance Improvement Project**, provided electronically.

Rationale

The use of seclusion and restraints is now viewed as a crisis intervention technique to be used only as a last resort when less restrictive measures have failed. Evidence indicates the use of seclusion and restraints should be reduced, with continued effort to raise awareness of the potential harm that use of seclusion and restraints can cause, especially in those individuals who have already experienced trauma in their lives (U.S. Department of HHS, 2010). During the first quarter of 2019, WellCare of Kentucky used published data from the Joint Commission to identify incidents of the use of seclusion or restraint. We identified twelve facilities reporting such incidents, indicating opportunities for improvement.

Scope

We will implement an enhanced educational program targeted to the twelve identified facilities to reduce use of seclusion and restraints through increasing use of evidence-based alternatives. In future years, we will use contracting strategies to encourage enhanced compliance.

Target Population

All Kentucky SKY Enrollees receiving behavioral health treatment at the identified facilities.

Improvement Goals

By the final measurement year, reduce reported incidents of the use of seclusion and restraint by behavioral health facilities by 25% compared to the baseline measurement year (403 for 1st quarter 2019). This goal is based upon Center for Medicare and Medicaid Services (CMS) recommendations for attainable comparison rates that reflect meaningful improvement.

Interventions

Regular communication, monitoring, auditing, training, development of prevention tools, and feedback, following seclusion and restraint guidelines established CMS, JCAHO, SAMHSA, and National Association of State Mental Health Program Directors (NASMHPD). Interventions will be focused on supporting facilities to implement NASMHPD*'s Six Core Strategies© Approach to Reduce the Use of Seclusion and Restraint* to minimize conflict and facilitate immediate resolution when conflict occurs to prevent escalation of behavior.

- Conduct face-to-face meetings with behavioral health facility leadership to partner and collaborate on ways to develop/train staff, identify violence prevention as a priority, develop a violence and seclusion and restraint prevention plan, and improve oversight of untoward events.
- Collaborate with behavioral health facility partners to establish consistent definitions of violent events; guidelines for the use of seclusion and restraint; recognition of imminent danger; identify reportable injuries and appropriateness of stat medication administration; compile historical data by events/hours; and to mandate ongoing compiling of data for analysis to effect positive change.
- Collaborate with behavioral health facilities to develop and implement staff training in matching interventions with behaviors; use of prevention tools to de-escalate a potentially violent situations; introduction of trauma-informed services; and the importance of debriefing after the use of seclusion and restraint.
- Collaborate with behavioral health facilities to develop and implement violence, seclusion and restraint prevention tools to include: assessing the risk factors for violence and the use of seclusion or restraint; assessing risk factors for potential injury or death; implementation of a universal trauma assessment form; development of safety and crisis plans; and directives to identify triggers and preferences.
- Collaborate with behavioral health facilities to include a debriefing phase as a part of their process whenever seclusion or restraints are used. This debriefing process should include: an analysis of each critical event; examination of what occurred before during and after the event; and determine what could have been done to prevent the event from occurring again and what could have been done better during the event.

Monitoring and Evaluation

Quality Improvement staff will use the Behavioral Health JCAHO Report on Use of Seclusion and Restraint to monitor and track the percentage of reported incidents of the use of seclusion and restraint by behavioral health facilities among SKY Enrollees receiving behavioral health

treatment. Data collected will be reviewed, analyzed, and reported for the performance indicator and for the quarterly Intervention Tracking Measures (ITMs). Any identified plateaued or decreasing trends will be further analyzed to identify the root cause and any addition barriers with interventions revised and/or added as needed. Any changes will be included in subsequent PIP reports.

Increasing or Sustaining Improvement

We will use results to inform practice through sharing data and feedback, including comparison with peers, during joint operating committees with each provider. We will also provide feedback acknowledging best practices and encouraging providers to evaluate changes in staff turnover, staff injury, and Enrollee/staff satisfaction as reduction in seclusion and restraint occurs. In addition, we will develop contracting strategies to reward high performing providers and collaborate evaluating the effectiveness of measures adopted and our impact

EVALUATING THE EFFECTIVENESS OF MEASURES ADOPTED AND OUR IMPACT

We will incorporate all final measures as well as our PIP within our Quality Management Plan. This includes tracking and trending in the Quality Work Plan and comprehensive review as part of our Annual Evaluation.

To ensure specialized focus on the health and other outcomes of our Kentucky SKY Enrollees and address SKY operational and quality metrics and processes, we are incorporating internal and external expertise with this population into our Quality Management Committee (QIC) structure. We will add two new committees to our existing QMC structure: a Collaboration Optimization Committee and a SKY Enrollee Outcomes Committee. Each committee will report into the QMC oversight committee.

SKY Collaboration Optimization Committee

This committee will monitor the effectiveness of collaboration and coordination among WellCare of Kentucky, DMS, DCBS, and DJJ across all operational areas and issues. The committee will recommend policy and process changes to facilitate our joint cooperative performance to improve quality and outcomes.

Committee membership will include:

- 1 DMS representative
- 2 DCBS representatives including one from a Service Region office
- 2 DJJ representatives including one from a Community District office
- WellCare of Kentucky SKY Provider Relations Liaison LeAnn Magre (Chair)
- WellCare of Kentucky SKY Executive Director Lori Gordon
- WellCare of Kentucky SKY Medical Director
- WellCare of Kentucky SKY Behavioral Health Director Dr. Tim Houchin
- WellCare of Kentucky SKY Quality Improvement Director Kathryn Miller
- WellCare of Kentucky Enrollee Services Manager Elizabeth Starr
- Residential treatment provider

- PCP
- Foster and adoptive parents
- Former Foster Enrollee

The Committee will meet monthly for the first six months post-implementation and quarterly thereafter. Meetings will include formal reviews for two to four cases of collaboration and coordination among WellCare of Kentucky and our cabinet partners. Cases to review will be identified by Committee members or by WellCare of Kentucky if none are identified. Committee members will discuss opportunities to improve communication, handoffs, operational policies, and training to improve the Enrollee experience and contribute to improved health outcomes.

The Committee will also review key process metrics relating to the ability of Enrollees to receive timely and effective care such as speed of notification, enrollment, health assessments, and provider visits for new or transitioning Enrollees.

SKY Enrollee Outcomes Committee

This committee will monitor the quality of care and service for all Kentucky SKY Enrollees receiving Medicaid services and the network of providers who deliver services.

Committee membership will include:

- WellCare of Kentucky SKY Medical Director (Chair)
- WellCare of Kentucky SKY Behavioral Health Director Dr. Tim Houchin
- WellCare of Kentucky SKY Provider Relations Liaison LeAnn Magre
- WellCare of Kentucky SKY Executive Director Lori Gordon
- WellCare of Kentucky SKY Quality Improvement Director Kate Miller
- WellCare of Kentucky SKY Provider Services Manager, Tony Piagentini or Provider Network Director, Bonnell Irvin
- PCPs
- Specialists
- Foster and adoptive parents
- Former Foster Enrollee

The Committee will meet quarterly to review key metrics as identified by WellCare of Kentucky, DMS, DCBS, and DJJ including identification of potential new metrics to address potential gaps in care or service. The Committee will also identify training opportunities for staff, providers, and foster and adoptive parents. Summary findings will be reported to the QMC, which will incorporate findings into required reporting to DMS on whether Kentucky SKY Enrollees' health outcomes improved as a result of our Care Coordination activities.

Ongoing Evaluation

Ongoing, we will identify modifications to initial measures as well as additional measures that are needed. In addition to evaluation through our quality program, we will identify needed changes through our continuing collaboration with DMS, DCBS, and DJJ. We will work with our cabinet partners to review both our performance on all adopted measures as well as the extent

to which the measures are providing meaningful information on our impact the Kentucky SKY Program and Enrollees. We will also leverage our analytics team, which will review our performance along with performance of WellCare plans serving this population in other states. Our team of statisticians will complete quarterly quality analytics and semi-annual comprehensive population profiles to evaluate both our performance on adopted measures and the usefulness of the measures in evaluating our overall impact.

G.9 Health Outcomes

- Attachment G.9 WellCare of Kentucky SKY Performance Improvement Project (Provided Electronically)

10. Population Health Management and Care Coordination

WellCare Launches Digital Life Coach Program for At-Risk Foster Youth in Kentucky

WellCare
Beyond Healthcare. A Better You.

G.10. POPULATION HEALTH MANAGEMENT AND CARE COORDINATION

a. Describe plan for identifying and coordinating care for those Kentucky SKY Enrollees with the most immediate service needs leading up to and immediately following implementation of the Kentucky SKY program.
b. Describe how the Vendor would identify and monitor new Kentucky SKY Enrollees with high physical or behavioral health needs to ensure continuity of care.
c. Describe how the Vendor will stratify Kentucky SKY Enrollees into tiers for Care Management services.
d. Provide a description of the Vendor's targeted evidence based approaches applicable to the Kentucky SKY populations. Provide details on the Vendor's approach for ensuring Network Providers' compliance with evidence based approaches mandated by the Vendor for Kentucky SKY Enrollees.
e. Provide a description of the Vendor's approach for ensuring Network Providers are providing Trauma-informed Care to Kentucky SKY Enrollees.
f. Describe how the Vendor will use telemedicine and telehealth to improve quality or access to physical and Behavioral Health services.
g. Describe how the Vendor will capture data related to Social Determinants of Health and incorporate this information into its Care Management approach.
h. Describe how the Vendor will coordinate with DMS, DCBS, DJJ, and physical and Behavioral Health Providers to ensure each Provider has access to the most up-to-date medical records for Kentucky SKY Enrollees.

G.10. POPULATION HEALTH MANAGEMENT AND CARE COORDINATION

a. Describe plan for identifying and coordinating care for those Kentucky SKY Enrollees with the most immediate service needs leading up to and immediately following implementation of the Kentucky SKY program.

WellCare of Kentucky will comply with DMS of Medicaid Services' (DMS) expectations and requirements as specified in Section 34 Population Health Management Program, Section 41.10 Utilization Management, Section 41.19 Population Health Management Program, and Section 41.20 Kentucky SKY Enrollees with Medically Complex Needs of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

WellCare of Kentucky today provides population health management and Care Coordination services to approximately 8,100 Kentucky SKY-eligible children and youth, the single largest concentration of any Medicaid MCO in the Commonwealth. Our Provider Relations Liaison, LeAnn Magre, leads our dedicated team of field-based Care Coordination professionals with a true passion for helping these Enrollees improve health outcomes, build resiliency, maintain stability, and achieve their permanency goals.

WellCare is the only Kentucky Medicaid MCO that has already implemented a field-based model for these Enrollees, having recognized several years ago that effectively managing this population requires a high touch approach and strong relationships and processes with DCBS, DJJ, and other stakeholders.

As a result, we have improved outcomes such as the following for our foster care, juvenile justice, and adoption assistance Enrollees.

- From 2017 to 2019 HEDIS scores for well-child visits in the third, fourth, fifth and sixth years of live increased 10%. Adolescent well-care visits increased 28%. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents had a significant increase for all ages and is in the top 75 percentile and had a 68% increase. The use of first-line psychosocial care for children and adolescents on antipsychotics increase (12-17 years) 9%. HEDIS scores for all five Immunizations for Adolescents measures, Adolescent Well Care, Timeliness of Prenatal Care, and Chlamydia Screening increased from 2017 to 2019.
- Among those with co-morbid physical and behavioral health (BH) issues, inpatient admissions/1000 decreased by 11%, ER visits/1000 decreased by 13%, and specialist visits/1000 increased by 29% from 2016 to 2019.
- Among those with co-occurring mental health and substance use issues, ER visits/1000 decreased by 14%, inpatient mental health admits/1000 increased by 3%, PCP visits/1000 increased by over 3%, and specialist visits/1000 increased by 7% from 2016 to 2019.

As DMS places its trust in a single point of accountability for our children and youth, WellCare is uniquely positioned as a leader to bring the vision of the Families First Prevention Services Act to life and support our Commonwealth partners in moving the program forward.

Below we provide an overview of how we have customized our Population Health Management model and Care Coordination approach for Kentucky SKY, followed by our responses to Question G.10.a-Question G.10.h.

CUSTOMIZING TO MEET THE UNIQUE NEEDS OF THE KENTUCKY SKY POPULATION

Our model for Kentucky SKY builds on our experience working in the field with our current SKY-eligible Enrollees, their caregivers, DCBS, DJJ, and other stakeholders to address the unique factors that make population health management (PHM) and care coordination for this population different than it is for other Medicaid populations.

Over the past eight years, we have continually refined our PHM model and care coordination approach to align with the goals, needs, and processes of the DCBS, the Children's Review Program (CRP), and DJJ. Fundamentally, our task is to integrate Medicaid with the child welfare system of care and support every child and youth to achieve their permanency, placement and safety goals. This has included WellCare's ongoing collaboration with DCBS and CRP for program development and our strategy development for the next stage of the Foster Care Program. For example, to address the increasing role that parental substance abuse plays in the need for foster care in Kentucky, a key strategy is implementation of services to adhere to the Families First Prevention Service Act by 2021.

Customized Population Health Management Model

PHM for a foster care population includes the components included for any Medicaid population (as described in our response to Question C.24 Population Health Management). However, to effectively meet their needs, our PHM model will go beyond standard PHM in some key ways.

Population Trauma Management. Every Kentucky SKY Enrollee has a history of trauma, which influences health, behavior, ability to participate in care, and other factors that impact their outcomes, placement stability, and permanency. Everything we do and all stakeholders will be grounded in trauma-informed care and approaches.

Expanded Approach to Preventive Care. Preventive and well-child services will be provided at a greater frequency and intensity as recommended by the American Academy of Pediatrics and Child Welfare League of America. The AAP/CWLA standards are built into our model through provider contract requirements, provider training, our approach to defining and identifying care gaps, Care Coordination requirements, and our quality assessment and performance improvement approach. Our Missouri plan already uses these standards for the foster care Enrollees they serve.

ER visits/1000 for our SKY-eligible enrollees fell by 3% and Primary Care Visits/1000 improved by 8% from 2016 to 2019.

Our prevention approach will incorporate prevention of placement disruption, which requires family preservation services and coordination with DCBS in working with Enrollees and their biological, foster, and adoptive families and fictive kin to promote stability and achieve permanency goals. Our approach will also include abuse, neglect, and maltreatment prevention efforts, such as education, training, peer support, and connection to respite for family caregivers. As noted above, WellCare will implement the Families First Prevention Services Act as of October 1, 2019, earlier than the 2021 requirement.

Population-Specific Approach to Utilization Management. In addition to the AAP/CWLA standards, we will use numerous evidence-based guidelines that go beyond what is typical for a traditional Medicaid child population (see our response to G.9). Additionally, our UM approach will reflect that strict adherence to medical necessity is not always in the best interests of children in this population. For example, it may be necessary to authorize continuing inpatient care when medical necessity criteria is no longer met because an appropriate post-discharge placement is not yet available, and "social transportation" to keep a child in the same school following placement changed to a residence in a different part of town.

Figure G.10-1 depicts our overall Kentucky SKY PHM model.

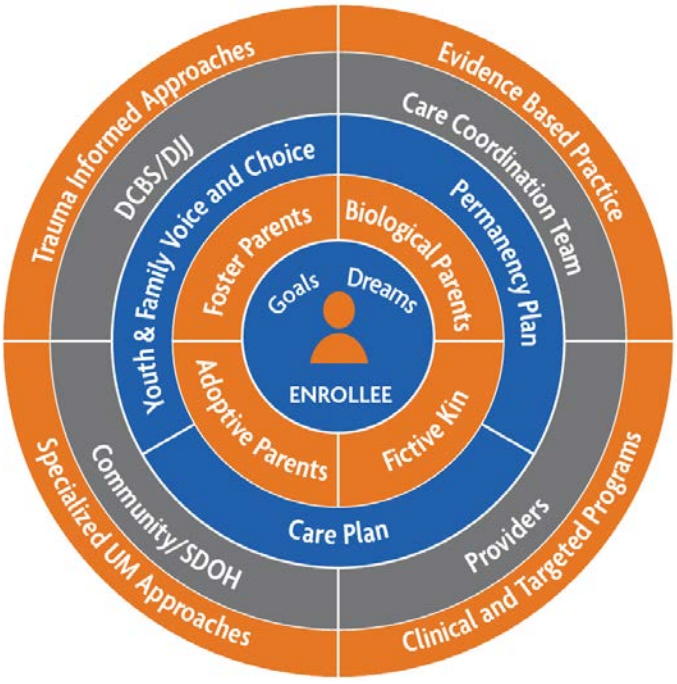

Figure G.10-1: WellCare Kentucky SKY Population Health Management Mode

CUSTOMIZED CARE COORDINATION

Our Care Coordination approach and processes, which we describe throughout the response to this question, reflect the many ways in which working with this population requires a tailored approach. **Table G.10-1** provides some of the key examples of the unique factors we have addressed in customizing our Care Coordination approach for Kentucky SKY.

Table G.10-1: Unique Factors in Providing Care Coordination to Kentucky SKY Enrollees

Need to initiate Care Coordination services prior to receipt of the enrollment file.
Multiple, changing stakeholders to coordinate with and educate on Enrollee condition and needs.
Consent issues can slow the process of planning, coordinating, and monitoring care.
More transitions to coordinate due to placement changes.
Impact of caregiver needs and capabilities on utilization of and lengths of stay in higher levels of care.
May need to coordinate with out of state providers, caregivers, and other stakeholders.
More intensive needs of the population drives additional staffing needs.
Transition age youth and former foster care Enrollees require significant support for self-advocacy, maintain Medicaid, and accessing social determinants resources as they age out.
The care plan must support and be integrated with the permanency plan, which requires an enhanced approach to goal setting, implementation, and monitoring.
The MDT must carefully weigh all care plan and permanency plan goals to ensure that services are effective and must approach service modifications holistically.
Court expectations and timeframes often drive treatment. It is critical to educate and include judges and court system staff on the MDT to provide the frame of reference needed for decision making. For example, some judges order services that cannot be covered by Medicaid unless medically necessary, but a court order does not in itself support medical necessity.

PLAN FOR IDENTIFYING AND COORDINATING CARE FOR IMMEDIATE SERVICES NEEDS PRE/POST IMPLEMENTATION

WellCare of Kentucky is strongly positioned to ensure continuity of care for Kentucky SKY Enrollees at program implementation. Our experience transitioning Kentucky children and youth with immediate services needs includes those with immediate service needs such as children with special health care needs (SHCN), significant BH conditions, prescribed medications, ongoing courses of treatment, scheduled surgeries, dependence on ventilators or other technology, in residential care, or other critical needs that require ongoing services with no gaps when changing service delivery systems. In our experience, a significant percentage of children entering the foster care system have immediate service needs.

Because so many of these children and youth are already our Enrollees, a significant portion of the Kentucky SKY-eligible population would not have to change MCO at go-live and could

continue with their current providers and care plans with no impact whatsoever. However, it is not our Enrollee concentration alone that distinguishes us from other MCOs.

We have worked intensively with DCBS, DJJ, the Office of the Commission for Children with SHCN (Children's Commission), the Children's Review Program, the court system, and the Children's Alliance to establish partnerships and put effective processes in place to improve health outcomes and promote resilience, stability, and permanency for these children and youth. Our foster care enrollment continues to grow, increasing by 30% in 2018**. This is strong evidence that WellCare is highly trusted and is the preferred MCO for DCBS caseworkers.**

Below we describe our plan for identifying and coordinating care for those with the most immediate service needs leading up to and after implementation.

Quickly Identifying and Coordinating Care for Enrollees with Immediate Service Needs

WellCare's most recent implementation involving foster care and children with special health care needs (SHCN) is the Florida Children's Medical Services (CMS) Health Plan. Through this program, which went live February 1, 2019, WellCare of Florida holds a sole-source, statewide contract to provide comprehensive, enrollee and family-centered services to over 68,000 children and adolescents. This includes 200 medically complex children classified as "Medical Foster Care" and other foster care children in the general population. WellCare's CMS network includes, among others, 350 Medical Foster Care Parent Providers as well as a network of Prescribed Pediatric Extended Care providers for therapy services. Because of the significant health care needs of this population, our top priority was quickly identifying and coordinating care for the most immediate service needs to ensure continuity and prevent gaps in care. WellCare of Florida worked closely with involved state agencies to obtain pre-implementation reports by provider type on the services these children were receiving prior to implementation through a series of reports by provider type. Collaboration with our state partners and intensive care management outreach and coordination with enrollees, families, and providers achieved a smooth transition for these high needs children.

COLLABORATIVE PRE-IMPLEMENTATION PLANNING

Ensuring continuity and preventing gaps for Enrollees with the most immediate needs requires collaborative pre-implementation planning with all system stakeholders. Our Kentucky SKY leadership team (described in detail in our response to Question 2.c Staffing), with assistance from our dedicated Kentucky SKY Care Coordination staff, will work with DMS, DCBS/DJJ, other MCOs, and other important system partners to develop a comprehensive and effective plan to identify and coordinate care for Enrollees with immediate needs. We recommend a multi-phase planning process to begin upon contract award.

Phase 1

The first phase will include defining, collectively as partners, what is meant by "most immediate service needs" so not one Enrollee falls through the cracks. WellCare will share our experience identifying foster care Enrollees with the most immediate needs and some key indicators we

use. This phase will also include but not be limited to designing work flows and processes, including those related to the transition of clinical and non-clinical Enrollee information.

Examples of Indicators of Immediate Needs

- Medically Complex designation
- Behavioral health admission within last six months
- Technology-dependent
- Current prescriptions
- Existing care plans
- Open authorizations, including for PRTF and acute/subacute levels of care
- Scheduled surgeries
- Waiting for placement in facilities
- Enrollees currently living outside of Kentucky

For example, WellCare will provide technical support and participate in development of a process to generate a temporary Medicaid ID within 24 hours of a court order. This will allow us to open a record in CareCentral and begin collecting and integrating information about the child's needs and previous care prior to receipt of the 834, which will enhance our ability to provide timely, appropriate, coordinated services. We will also provide our ClearSky solution for secure, HIPAA-compliant access by DCBS and DJJ staff to an integrated view of critical information about children for whom they are responsible, such as the Medical Passport and care plans/Individual Health Plans. In addition, we will finalize an approach for locating our Field Outreach Coordinators (FOCs) onsite at DCBS regional offices and protocols for FOCs and Care Coordinators to work onsite with DCBS and DJJ staff.

Phase 2

This phase will involve planning and implementing comprehensive outreach and education on the transition plan to providers, stakeholder groups, and foster and adoptive parents as well as former foster care youth. We recommend a concurrent approach to ensure all are on the same page at the same time. WellCare will collaborate with DMS, DCBS, DJJ, and selected network providers that serve on our quality committees as well as key statewide provider organizations such as The Children's Alliance and stakeholder organizations such as the Kentucky Foster and Adoptive Care Association to develop outreach and education timeframes, methods, locations, messaging, materials, and responsible parties. *The overriding message to providers and stakeholders will be to continue providing and accessing care during and after implementation with no changes until a new assessment and care plan are completed and new authorizations put in place.*

Providers. We recommend holding educational sessions in each area of the Commonwealth to reach providers of varying size, geographic reach, and services offered. We will partner with experts essential to our success, such as the Children's Alliance; Bart Baldwin's Agency; Children's Review Board; and large private childcare providers and foster home providers, many of which have multiples offices throughout the Commonwealth. We also will partner with DMS and other MCOs to outreach to providers serving other Kentucky SKY-eligible Enrollees that are not in the WellCare network to ensure they participate in education opportunities. We will encourage provider participation by providing education sessions in local, easy to access sites, posting training materials on WellCare's provider Portal, and providing virtual connection opportunities.

Stakeholders, Foster/Adoptive Parents, Former Foster Care Youth. Educational sessions for stakeholders groups, foster and adoptive parents, and former foster care youth at multiple site locations and times make them as accessible as possible. For instance, we recommend delivering presentations at state regional offices to ensure foster and adoptive parents know that the transition information is supported by DCBS and DJJ. We also will recruit the assistance of other MCOs to outreach to the parents of their Enrollees who will transition to WellCare. We will share materials from these sessions through WebEx presentations and virtual connection opportunities. Our education focus areas for foster and adoptive parents will include information about WellCare, Kentucky SKY, key staff contacts, Enrollee specific material, and specific contact information for questions, ensuring that they have current information on the resources available to ensure successful and timely transitions.

Phase 3

The third phase will be deploying the workflows and processes designed to begin identifying and coordinating care for Enrollees with the most immediate needs. We describe our proposed approach to this phase below.

LEADING UP TO IMPLEMENTATION

Identification

Because we are already familiar with the needs of our existing Enrollees, we will place a heightened focus on those who will be new to WellCare. However, we will also have a process to identify current Enrollees with immediate needs.

Enrollees Who Are New to WellCare

A key element of pre-implementation identification will be review of information for Kentucky SKY eligibles who are currently enrolled in another Medicaid MCO. While other MCOs will be required to electronically send a list of their existing SKY-eligible Enrollees prior to go live, WellCare proposes that they also identify those with a Medically Complex designation or other agreed indicators of immediate need and provide information about these Enrollees' needs and care. This information would include but not be limited to:

- The most recent Individual Health Plan meeting documentation
- Open authorizations with information on the treating provider
- Care plans
- Recent assessment results
- Medication history and current filled medications.

Our Care Coordination staff will immediately begin reviewing all received information from MCOs along with the one year of recent claims data provided by DMS. Our staff will follow up as needed with other MCO staff and providers we are able to identify, including requesting case conferences to discuss the Enrollee's needs and care. Critically, we will also use these conferences and other interactions to obtain information we would not get through electronic records transfer, such as personal information based on their interactions with the Enrollee and/or their support networks. This type of information exchange will give us the opportunity

to understand the Enrollee's story by moving beyond paper to real life interactions that provide insight into root causes and underlying needs.

Current WellCare Enrollees

Prior to implementation, WellCare will stratify current Enrollees to prioritize for outreach and assessment by identified level of risk. The CCT will begin to assign Enrollees based on their current level of risk, anticipating the Enrollees who may need a specific level of care management from the date of go live. In addition, we will implement an outreach campaign with adopted and former foster Enrollees, alerting them to the new program and to expect Care Coordinator outreach.

Coordination

We will begin coordinating care prior to go-live. As we identify open authorizations, our Care Coordination staff will work with our Utilization Management (UM) team and the relinquishing MCO to pre-load authorizations into our system. UM staff will create tasks in CareCentral to outreach to providers with the new authorization information to ensure authorizations are in place on Day 1.

Care Coordination staff will review Enrollee information against placement location, if known, so that we can pre-assign as many Enrollees as possible to an appropriate Care Coordinator and CCT. Team composition may change after we complete a comprehensive assessment, but initial assignment of a team will facilitate outreach to existing providers and integrated review of Enrollee information to identify any potential gaps or issues with the current care plan.

The assigned Care Coordinator will begin outreaching to current providers to obtain additional information that will identify immediate needs as well as inform the assessment and care planning process once the child or youth is enrolled in WellCare. This will include any specialists providing treatment as authorized by the prior MCO. Care Coordinators will also reinforce with providers the importance of continuing to provide existing services with no change until after a comprehensive assessment is completed and a new care plan is developed and authorized. Our provider Relations team will assist with this education and will offer non-network providers serving SKY-eligible individuals a WellCare contract to ensure continuity of care. For those non-network providers unwilling to contract with WellCare, SCAs will be completed.

IMMEDIATELY FOLLOWING IMPLEMENTATION

Identification

While we anticipate identifying a high percentage of new Enrollees with immediate needs through the process outlines above, our Care Coordinators will continue to seek additional or more recent information that may be available about the child's needs. For example, an Enrollee may have developed a new or changed need since the prior MCO last reviewed the care plan. In addition, our staff will thoroughly review all of the information provided by DCBS at implementation as well as information contained within the enrollment file to identify any additional immediate needs. As described in more detail in our response to Question G.5 Enrollee Services, our Field Outreach Coordinator (FOC) co-located at DCBS regional offices will

assist us to identify new Enrollees with immediate needs that we may not previously have identified through completing an initial screening and interaction with DCBS staff.

We will conduct face-to-face assessments of all new Enrollees within five to seven days to validate the information received and to identify additional needs of previously identified Enrollees. We will use the information obtained prior to go-live to prioritize outreach. Additionally, we will also use the initial face-to-face meeting to identify other Enrollees with immediate needs who were not identified through the process above.

Our Clear SKY solution will provide DCBS, DJJ, and foster and adoptive parents with secure, HIPAA-compliant access to an integrated view of critical Enrollee information such as the Medical Passport and the care plan or Individual Health Plan.

The Care Coordinator, through educational sessions, phone calls, and in-person meetings, will ensure Enrollees providers, Foster Parents, Adoptive Parents, and other members of the Enrollee's support network have the information and community resources available to meet their needs in preparation for their transition. For example, we will provide Foster Parents with secure, HIPAA-compliant access to our ClearSky mobile application to view the child's Medical Passport, care plan/IHP, and other key information and support such as the nurse line, BH line, and Care Coordinator contact information. If the parent does not have their own device, we will provide a tablet, and internet access if needed, to ensure they can access ClearSky.

Coordination

Upon implementation, Care Coordination will review all available information for new Enrollees to validate Care Coordinator and CCT assignments for those already identified and to determine appropriate assignment for those not previously identified. All Enrollees will be assigned a Care Coordinator and CCT within one business day of enrollment into the program.

Pre-loaded authorizations will be effective as of go-live. Our Care Coordinators will work with the UM team to outreach to providers of new Enrollees to ensure they have the records, authorizations, and relevant information needed to immediately initiate services. All new Enrollee information will be available to providers via the medical passport which they can access on the provider Portal

During our initial face-to-face assessment, the Care Coordinator will determine whether the Enrollee has any other immediate needs that require rapid initiation of services and ensure the Care Coordination Team (CCT) has the information it needs to make the timely and appropriate authorizations and referrals for the Enrollee. For those not previously identified with immediate needs, the Care Coordinator will contract prior MCOs and providers for information needed to coordinate care plan/IHP development. Using all available information, the Care Coordinator will facilitate development of the care plan or IHP, as applicable, as described in response to Question G.10.c below. We will ensure approved care plans and authorizations are communicated to providers, DMS, DCBS, and DJJ by electronic or direct communications. All information will be documented in CareCentral and automatically loaded into the Medical Passport.

b. Describe how the Vendor would identify and monitor new Kentucky SKY Enrollees with high physical or behavioral health needs to ensure continuity of care.

WellCare already has several years of experience identifying and monitoring care for high needs foster care Enrollees in Kentucky to ensure continuity of care. Currently, 9% of our foster care Enrollees are in our top two case management tiers, and we serve 44 Enrollees who have been designated as medically complex by the Children's Commission.

> **Of our current Kentucky SKY-eligible enrollees, 15% have co-morbid physical and behavioral health conditions and 4% have co-occurring mental illness and substance use.**

Our Care Coordinators already routinely participate in Individual Health Plan (IHP) meetings, working work hand-in-hand, and often face-to-face, with the Children's Review Program and the Children's Commission to ensure continuity and appropriate treatment and placement for Kentucky's children and youth in foster care. We also currently serve 50 Enrollees in the juvenile justice system, many of whom have high physical and/or behavioral health needs, and our Care Coordinators work closely with DJJ regional leadership to ensure their needs are identified, monitored, and met. We will build on these relationships to quickly identify and monitor new Enrollees with high needs and promote health, healing, and permanency from the earliest point possible.

IDENTIFICATION OF NEW ENROLLEES WITH HIGH PH/BH NEEDS

WellCare will have procedures in place to identify quickly when a high needs Enrollee comes into care and processes to help us identify their needs. Our strategy for Kentucky SKY is to assume that every new Enrollee is complex until the assessment and care planning process indicates differently. Our identification procedures will include the following.

- Obtaining information from DCBS. Our FOC and Care Coordinators will be embedded in DCBS/DJJ offices, which will facilitate quicker notification of a child coming into care. The FOC or Care Coordinator receiving the notice will immediately ask the DCBS/DJJ staff providing the notice if they are aware of any existing PH or BH needs and request any information DCBS has already collected during the removal process, through the initial assessment, results of the CANS if completed, and other prior DCBS/DJJ assessments (Needs-Q, RCNA, and DCBS/DJJ Service Plans/Case Plans) if the child was previously in care. We will use all available information from DCBS to assign a Care Coordinator and begin assembling an appropriate CCT. These staff will immediately begin researching and outreaching to obtain information about the child's needs.
- Leveraging Existing Information in CareCentral. The Enrollee may be, or may previously have been, a WellCare Enrollee. The CCT will identify any information we may already have in our system, such as existing or previous care plans, medications, utilization history, open authorizations, and treating provider information. For any current or former WellCare Enrollee, the CCT will immediately outreach to treating providers to obtain the most up-to-date information on their needs and care.
- Checking Medicaid and Managed Care Eligibility. The CCT will check KY Health Choices to determine whether the child is already Medicaid-enrolled and in an MCO. If the child is in fee for service, such as those receiving home and community-based waiver services, the CCT will outreach to DMS's Member Services to request information as well as to identify

treating providers and outreach to them for information on services and care needs. If the child is in another MCO, the CCT will outreach to the MCO to request the care plan, authorization and provider information, any utilization and claims data, and other information that will give us insight into their needs and ongoing care. We will also identify and request a case conference with any assigned case manager to discuss the child's needs and care.

- Querying the Kentucky HIE. The CCT will query the Kentucky HIE to identify any claims submitted for the child's care. This will help us identify diagnoses that indicate high needs and the treating providers. It will also help us identify recent ED and inpatient utilization, including NICU stays, indicating potentially urgent and unmet needs.
- Meeting Face-to-Face with the Enrollee/Caregiver. The assigned Care Coordinator will outreach to the caregiver within 24 hours of notification that the child is in care to ensure immediate needs are met and schedule an initial face-to-face meeting. The meeting will occur with the Enrollee and caregiver within five to seven days of notification to begin the comprehensive needs assessment process and identify high needs.
- Reviewing Medically Complex Assessment Results. The assigned Care Coordinator, who will be a nurse Case Manager, reviews results of the assessment completed by DCBS Medical Support Section to identify high needs and will coordinate with the DCBS Medical Support Section staff and the Children's Commission's Medically Complex Liaison and nurse (if engaged) with arranging the initial IHP within 30 days of the medically complex designation. The IHP is another key source of information about a child's needs. However, in WellCare's experience with foster care Enrollees, the assessment is typically not complete by the time we are notified that the child is in care. We use the information if it is available, but we do not wait to begin arranging services to address the child's needs immediately.

Ensuring Continuity of Existing Services

Because we know a significant percentage of the Kentucky SKY population has high needs and to make our absolute best efforts to ensure continuity of care and immediately address any unmet needs, **WellCare will assume all children entering care are high needs.** Upon notification, a BH Care Manager will be assigned as the Care Coordinator and will immediately begin the high fidelity wrap around process for a child with indicators of BH needs to ensure continuity and delivery of needed care. For those with complex physical health needs, including but not limited to those with a Medically Complex designation, we will assign a nurse Care Manager as the Care Coordinator to ensure continuity and quickly arrange for needed services. Our highest priority will be to identify and continue existing services and put new services in place quickly to meet ongoing and urgent needs.

Honoring and Coordinating Existing Authorizations. If we identify any existing services or ongoing treatment, the Care Coordinator will be empowered to quickly enter authorization information into our system and reach out to current providers to provide authorization information regardless of network participation status. For non-network providers, the CCT will alert our Provider Relations team, which will quickly contact the provider to offer a contract or if necessary complete a single case agreement.

We will honor existing authorizations for up to 90 days and until we complete the comprehensive needs assessment, develop a care plan, and authorize new services. The Care Coordinator will educate the Enrollee, caregiver, and provider to continue the services with no change until new services are authorized. We will collaborate with PCPs and specialists of prior MCOs to ensure continuity of care for Enrollees with SHCN receiving services authorized in a treatment plan by their prior MCO. Because WellCare already has a broad network, we anticipate that most new Enrollees already receiving services will be engaged with a provider in our network. As a PCP, specialist, or other provider alerts us to an immediate service need, the CCT will develop an initial care plan and initiate the service approval so that the Enrollee can continue current services without any interruption.

Immediately Authorizing Services for Unmet Needs. If the child has urgent needs but no ongoing authorization or current provider, the assigned Care Coordinator will help DCBS/DJJ and the caregiver select and rapidly access a conveniently-located provider with appropriate expertise. Our CCT will coordinate with our UM team to quickly authorize care and provide authorization information to the provider. We will expedite this process for children and youth requiring PRTF services through our Care Coordinators assigned to specific PRTFs who will be able to leverage their relationships with the providers and their presence onsite to facilitate authorizations.

Supporting Placements to Ensure Continuity. Our Care Coordinators and CCT will work with the Children's Review Program and DCBS case worker to identify an appropriate placement to meet the Enrollee's needs. For Enrollees with juvenile justice involvement, our CCT will work with DJJ regional and local staff on placement of the Enrollee. As requested, this will include expediting the scheduling of appointments for assessments and facilitating Providers' timely submittal of assessment results used to determine residential placements as well as compiling and submitting assessment results to the appropriate DCBS or DJJ staff within required timeframes.

Further, our staff will ensure the placement has access to treatment services needed for the Enrollee and their family, as appropriate. We will provide the caregiver with education about the child's condition(s) and needs, including but not limited to information on evidence-based care recommendations, the importance of medication adherence, how to recognize symptoms and exacerbations, and 'red flag' education on when to contact the provider or emergency services. If CRP has difficulty identifying an appropriate placement for a high needs child, we will collaborate on what supports WellCare could offer as a value-added benefit to encourage provider/caregiver willingness and ability to take the child and continue serving the child to preserve a current placement

Supporting Successful Community Placements

Ten year old 'Julie' has been at Our Lady of Peace for three years. She has tubular sclerosis with seizures, is non-verbal, and needs assistance with all activities of daily living (ADLs). Her unique medical issues and history of unsafe behaviors have made it a challenge to find a foster home that can appropriately manage her complex needs and keep her safe. The WellCare Case Manager is working with DCBS, Our Lady of Peace, and community providers to identify an appropriate community placement and determine the education, training, and support potential foster parents will need to provide adequate care. As part of this process, our Case Manager is advocating for a very structured transition process with involvement of the identified foster family prior to the transfer to promote trust and ensure the family is prepared to meet her needs. The Case Manager has already secured specialized DME to ensure Julie is ready with the correct equipment once an appropriate foster home is identified.

MONITORING HIGH NEEDS ENROLLEES TO ENSURE CONTINUITY

The care plan (or Individual Health Plan for medically complex Enrollees) delineates the schedule and methods for monitoring high needs Enrollees to ensure continuity of care. It serves as a roadmap for monitoring and making course corrections quickly when indicated. Once the care plan/IHP is in place, we use a variety of methods for monitoring and ensuring continuity of care. While many of the basic processes and methods for monitoring apply to all Enrollees with high needs, there are some distinctions between monitoring for those with physical health (PH) needs versus those with behavioral health (BH) needs.

Processes that Apply for all Enrollees

Care Planning

As noted above, we will immediately assign new Enrollees a Care Coordinator and CCT within one day of notification. Those with high BH needs will be assigned a BH Care Manager as their Care Coordinator, and those with high PH needs will be assigned a nurse Care Manager as their Care Coordinator. As we learn more about the child's needs, we may modify the CCT to ensure representation of appropriate expertise. The assigned Care Coordinator will identify high needs and determine the intensity of monitoring needed to ensure ongoing continuity of care through the methods described above and our comprehensive needs assessment process, which we will initiate during the face-to-face meeting to occur within 5-7 days of notification. This will include assessing all Enrollees to identify any special health care needs and ongoing special conditions that require a course of treatment or regular care monitoring. (See our response to Question G.8 for a detailed description of the assessment process.)

For all Enrollees with high needs, we engage all stakeholders and complete a care plan/IHP within 30 days of enrollment but sooner if possible. Care plans/IHPs identify Enrollee goals and all identified clinical and non-clinical service needs including treatment for trauma and connection to SDOH resources. The care plan/IHP delineates how all goals and needs will be addressed and documents the monitoring, follow-up, and reassessment and revision schedule and methods to reflect intensity required.

Addressing Barriers

Our Care Coordinators and CCT use strategies specifically designed to address barriers to continuity in this population. These include but are not limited to:

- Using a person-centered approach to ensure the care plan reflects the Enrollee's and family's voice and choice, which improves their adherence.
- Engagement of peer support to further promote their ownership of the care plan and improve adherence.
- Engaging community supports to wrap around the child and family voice to ensure the care plan is their plan and enable them to access services and comply with treatment plans.
- Sensitivity to the role of fear in Enrollee willingness to engage in treatment. For example, we will offer access to 'test run' dental visits to allow the child to become familiar with a dental provider and office prior to treatment.
- Celebrate meeting small milestones when goals are met. A continual focus on the progress the Enrollee has made supports recovery and resiliency and sets the stage for further improvement.

Ensuring Continuity and Stability Requires Active Listening and Trust

Our Care Coordinators and CC Teams recognize the importance of listening carefully to the care provider - to listen to the emotions and thoughts behind the words stated, which helps us detect potential crises or other issues that may disrupt current care and placement. The relationship developed with the caregiver will be key to preserve continuity of services as well as placement stability. The care provider is the expert on what they and the enrollee need and our Care Coordinators and CC Team will yield to their expertise.

Medical Home and Provider Monitoring

We will begin assigning PCPs to our foster care Enrollees at the start of the SKY contract.. We already have processes in place (described in detail in our response to Question G.5 Enrollee Services) to find the right PCP for each Enrollee and will provide trauma training to all medical home providers to support effective treatment. The medical home provider will be responsible to oversee and coordinate all services the Enrollee receives. In addition to the information and data analytics we make available to medical home providers on our provider portal, our Care Coordinators and CCT will support the medical home through facilitating information exchange, involving them in all IHP meetings, assisting them to locate appropriate specialists when needed, and providing scheduling and transportation assistance to ensure Enrollees access recommended care. Our staff will coordinate with the medical home to discuss implementation of the care plan/IHP and the child's progress.
The Care Coordinator and CCT will interact at least bi-monthly (and more frequently as needed) with specialists and other providers to obtain monitoring information about the Enrollee's progress and share information from other treating providers to promote integration of care.

Regular Enrollee/Caregiver Contact

The assigned Care Coordinator will monitor continuity of care and progress through regular face to face and other contact with Enrollees and their caregivers. This will occur at a minimum according to contract requirements but will occur more frequently as needed. For example, a child who is technology-dependent (such as on a ventilator) may require daily monitoring for

some period after moving to a new placement to ensure the caregiver is confident and capable in operating equipment.

Regular Interaction with DCBS/DJJ Staff

Our FOC, Care Coordinator, and CCT will interact as often as daily with DCBS and DJJ staff to discuss Enrollee progress and needs. Co-locating our staff in regional offices will facilitate this communication and promote timely exchange of information that may alert us to a new or changed need or Enrollee/caregiver difficulty in accessing services.

Regular IHP Meetings

The assigned Care Coordinator will convene and facilitate formalized care plan/IHP development and review meetings. At a minimum these meetings will occur per contract frequencies but will be more frequent based on Enrollee needs.

Ongoing Review of Data

Care Coordination staff will review a wide variety of data daily, weekly, and monthly to monitor Enrollee utilization and progress. This will include review of claims and utilization data including daily Admission, Discharge, and Transfer (ADT) data received from our network hospitals, pharmacy fills and adherence data, any gaps in recommended care according to evidence-based guidelines (such as the specialized AAP periodicity schedule or recommended preventive care for chronic conditions such as asthma), data we collect on Enrollee access to SDOH resources (see our response to Question G.10.g below), and information on Enrollee and caregiver calls to our CCHL. Our staff will also review data we obtain from the TWIST and JORI systems and DCBS and DJJ staff such as placement changes.

Medically Complex Enrollees

For our Enrollees who are designated medically complex by the DCBS Medical Support Section, we will assign a nurse Case Manager. The Case Manager will provide nursing consultative services to SSWs, Foster Parents, Fictive Kin, and caregivers for children and youth in Out of Home Placement, both in-state and out-of-state, who are determined by the Medical Support Section to be Medically Complex. The Case Manager coordinates with DCBS Medical Support Section staff to obtain the Medically Complex designation for a child and as indicated, provides information on improvements and changes to the child's needs that may allow withdrawing the designation.

Among those with co-morbid physical and behavioral health (BH) issues, inpatient admissions/1000 decreased by 11%, ER visits/1000 decreased by 13%, and specialist visits/1000 increased by 29% from 2016 to 2019.

We will also assign a nurse Case Manager as the Care Coordinator for other Enrollees who have high PH needs but do not have a medically complex designation, such as those with asthma, diabetes, or other chronic health issue that is not severe enough to meet the Medically Complex designation but still requires consistent care management to ensure access to appropriate care and services.

Immediate Support for Continuity

Upon receipt of the medically complex designation, the Care Coordinator will immediately begin the process of obtaining the child's medical records and identifying services that need to be continued as described above. The SSW will be able to access all records WellCare is able to obtain through our ClearSky solution that will allow timely, HIPAA-compliant, secure access to the most up-to-date information we have on each Enrollee. The Care Coordinator will also outreach to the SSW and coordinate scheduling the initial home visit within 30 days of enrollment (or receipt of medically complex designation, whichever is earlier) with the Enrollee and caregiver to identify medical and behavioral health issues and needs.

IHP Development

The Care Coordinator will ensure the Medically Complex service team members are invited to all IHP sessions, including, but not limited to, the SSW, FSOS, Medically Complex Liaison, Foster Parents, Adoptive Parents, Fictive Kin, Caregivers, and medical and other service Providers. This includes out of state providers for Enrollees in out of state placements. As appropriate, we invite local education agency representatives to participate to ensure integration with and support for the Individual Education Plan (IEP) and help them identify and address health issues in the IEP.

Our Care Coordinator will convene and facilitate the initial IHP session to assess the child's ongoing needs. This will include sharing all available information with the care team prior to the meeting and providing any updates during the meeting to ensure all involved have as complete and current an understanding of the child's history as possible. Another key responsibility of the Care Coordinator will be to promote Enrollee and family voice and choice through the IHP process and advocate for what they feel is important. We use a person-centered process and Motivational Interviewing, along with culturally and linguistically competent education on Enrollee conditions to support active, effective Enrollee and family involvement.

The Care Coordinator facilitates the process with a goal of reaching a consensus across all IHP participants on what the care plan should look like to best meet the Enrollee's/family's goals and needs. We understand that DCBS as the official guardian has final authority over the IHP. Once the IHP is completed, the Care Coordinator signs the plan, distributes the signed copies to all Medically Complex service team members, and coordinates with our UM team to put authorizations in place and initiate services.

Ongoing Monitoring and Support

Ongoing, the Care Coordinator provides training, on-going training and support to caregivers and completes monthly home visits to the child separate from the SSW to monitor needs and care. This includes review of documentation in the medical passport to confirm appointments for medical, BH, vision or dental care, receive of immunizations, and relevant clinical history that may provide insight into new or changed care needs. As needed, the Care Coordinator supports the Enrollee and family to maintain the medical passport and keep it up to date. The Care Coordinator identifies any barriers to continuity and adherence and uses a person-centered process to develop solutions with the Enrollee

and caregiver. For example, if an Enrollee can or will only use a specific brand of nutritional supplement that is not on the approved list, the Care Coordinator will work with the DME supplier to access that brand.

At all times, the Care Coordinator is available to act as a resource to the biological family and SSW in identifying and planning for the Enrollee's health care needs when family reunification or permanent relative or Fictive Kin placement has been addressed as an outcome in the family service plan. The Care Coordinator also assists DCBS personnel as requested regarding the Enrollee's health care needs.

Regular IHP Reviews

At least every three months, the Care Coordinator will convene and facilitate a meeting with the Medically Complex service team to review the IHP, the child's current needs and progress, and re-evaluate the child's continued Medically Complex determination. The IHP will be updated at least every six months to reflect changes to the Enrollee/family goals and needs. The Care Coordinator updates the IHP as determined by the Medically Complex service team and distributes signed copies to each team member. The IHP will also be available via ClearSky.

Monitoring Appropriateness of Ongoing Medically Complex Designation

When indicated by ongoing monitoring or recommendations of the Medically Complex service team, the Care Coordinator will recommend a change in the child's Medically Complex designation based on current and projected needs. The Care Coordinator will outreach to the SSW and Medically Complex Liaison to review changes in the child's needs or services and will follow the final decision of the Medical Support Section on whether to remove the Medically Complex designation.

Enrollees with High BH Needs

A BH clinical Case Manager will serve as the Care Coordinator for Enrollees with high BH needs to ensure a High Fidelity Wraparound approach. Immediately upon notification or enrollment (whichever is earlier), the Care Coordinator will engage the DCBS/DJJ SSW, work to identify current service needs, begin the assessment process, and identify all the stakeholders connected to the Enrollee to participate in the MDT.

Assessment Team Meeting

Within ten days, the Care Coordinator will schedule and facilitate the Assessment Team meeting to identify needs, identify and gather assessments that have already been completed, secure providers and schedule assessments, and initiate care planning. A key focus will be encouraging and advocating for the Enrollee's voice in their behavioral health care, along with the care provider/family involved. Understanding the Enrollee's goals for their care will assist the Assessment Team to develop achievable goals and objectives for the care plan. These goals and objectives

Among those with co-occurring mental health and substance use issues, ER visits/1000 decreased by 14%, inpatient mental health admits/1000 increased by 3%, PCP visits/1000 increased by over 7%, and specialist visits/1000 increased by 84% from 2016 to 2019.

drive the components of the care plan: placement, treatment, and transition.

- Placement. Before treatment and services can be developed, the Enrollee needs a place to live. The living environment is often dictated on issues of safety but for those over 18, preference is also a driver. As part of the assessment process, the Care Coordinator assists in coordinating the completion of the CANS assessment, which is usually completed at commitment to DCBS and every three months. The CANS assessment outcomes will assist the Assessment Team in deciding the most appropriate living environment.
- Treatment. Once placement is decided, treatment services can be identified. The CANS assessment identifies treatment focus, and additional assessments may be needed and incorporated to ensure an accurate picture of the Enrollee's treatment needs. The Assessment Team can decide to refer for psychological testing, further trauma assessment, assessment of human trafficking risk, suicide risks, or other assessment. The Care Coordinator will continue to encourage the Enrollee to verbalize their thoughts around their treatment needs. Often, youth have very good insight into what they need, and meeting the Enrollee where they are is important to treatment success. Additionally, because high behavioral health needs often bring crisis issues, the Care Coordinator will coordinate development of a crisis and safety plan with specific steps for the care provider and Enrollee to take in a crisis situation.

WELLCARE'S MENTAL HEALTH FIRST AID (MHFA) INITIATIVE

Raise awareness of mental health issues within our own organization and position "champions" across the company who can be of assistance to their peers.

Better equip our non-clinical staff who have regular contact with our enrollees to be able to recognize and respond appropriately to those experiencing and demonstrating mental health related symptoms.

Train our partners in the community (such as providers, schools, and non-clinical employees of community-based organizations) in MHFA in order to better serve our enrollees in the community.

- Transition. Once treatment goals and objectives are established, transition is the next primary area of focus. Youth and family voice are again critical. Returning home or into a home environment is often the goal. A realistic discussion of steps necessary to safely live in a home environment must occur, carefully listening to the youth and engaging them in discussion of their hopes and dreams. Careful planning of goals and objectives with specific steps in place to assist the youth toward their identified transition plan is key. Other areas of focus include school supports and services, community supports and services, and natural supports for the overall care plan.

At the end of 30 days, the Care Coordinator facilitates a second Assessment Team meeting and updates the care plan. The CCT will work with BH facilities, including acute and PRTF, for discharge planning as needed. With the assistance of the hospital-based care manager, discharge and clinical planning will occur with DCBS and DJJ and the Enrollee/Enrollee family (see our response to Question 11 for details).

Within the population of Enrollees with high BH needs are several sub-groups of Enrollees with very specialized needs that require additional focused planning and monitoring. These include but are not limited to intellectual and developmental disabilities (IDD), sexual acting-out issues, behavioral dysregulation, suicidal ideation and self-harm behaviors, frequent placement

disruption, and unique medical and behavioral health needs that limit options for placement and care. WellCare's Care Coordinators will leverage special training and experience to work effectively with these Enrollees and develop individualized care plans that are tailored to the Enrollee's unique needs.

Table G.10-2: Specialized Needs That Require Additional Focused Planning and Monitoring

Specialized Need	Key Focus Areas
IDD	Appropriate psychological testing, educational planning and IEP supports within the school, behavioral planning services, transition planning, need for referral to waiver-based programs and supports.
Sexual Acting-Out	JSO risk assessment and treatment identification, ensuring provider expertise and recommendations, risk and safety planning.
Behavioral Dysregulation	Understanding the trauma drivers, understanding the youth voice, understanding evidence-based models to assist, behavioral planning, and psychological testing.
Suicidal Ideation and Self-Harm	Strong safety planning, understanding the trauma drivers, understanding medication and polypharmacy.
Frequent Placement Disruptions	Understanding of placement challenges and supportive services that may be needed to help engage a placement.
Unique Medical and BH Issues	Understanding of how to engage the school system, engage the IEP planning, and access school resources through the Family Resource Centers

Enrollees Engaged with Both DJJ and DCBS

Effective case management for dually-committed Enrollees requires specific expertise with the rules of the court system. For these Enrollees, the court is a key driver of the care planning process. WellCare Care Coordinators for these Enrollees have a history of working within the court system, understand the requirements judges and court officials are looking for, and recognize whether an Enrollee's needs are most appropriately addressed through treatment or community resources. The Care Coordinator will work directly with the court, court-designated worker, and the DJJ team to align the needs of the court system with Kentucky SKY services. When specific assessments are court-ordered, the Care Coordinator will quickly engage our UM staff to determine whether the assessment evaluates for a medical or BH condition. If so, we quickly coordinate the authorization and work with the provider on timely scheduling and reporting results back to the court. If the court order is for an assessment or other service that falls outside of WellCare-covered services, the Care Coordinator and CCT will work with the court system, DJJ, Enrollee, and family/support to identify community or natural resources. Often, behaviors mask clinical needs, and our Care Coordinators will have the expertise and training to make this distinction and support medical necessity determinations for court-ordered services.

c. Describe how the Vendor will stratify Kentucky SKY Enrollees into tiers for Care Management services.

WellCare uses an innovative, multichannel risk stratification methodology to determine risk within our population and identify individual Enrollee risk levels. Our Identification and Stratification (ID/Strat) process leverages multiple data sources integrated through our information systems platform to conduct ongoing identification of Enrollees with high and emerging risk including those with complex and/or multiple medical and behavioral health issues, high service utilization, intensive healthcare needs, or who consistently access services at the highest level of care.

We will build on this process for Kentucky SKY to quickly and accurately identify Enrollee risks and place them into the appropriate case management tier to meet their varied level and intensity of care needs. We will use a combination of advanced predictive analytics and risk scoring along with information from our high-touch comprehensive assessment and monitoring process to pinpoint risks and needs and identify the right interventions and intensity of services to improve outcomes and promote placement stability and permanency. A critical differentiator of our stratification process is that it incorporates the unique factors (such as trauma and placement change history) that impact risk for those in foster care that are not typically encountered among the traditional Medicaid population.

PREDICTIVE ANALYTICS AND RISK SCORING

Our ID/Strat Engine uses an advanced, proprietary algorithm that pulls from a variety of claims, utilization, assessment, and other data housed in our integrated data warehouse to identify the demographic, diagnoses, utilization, and other factors that together provide a picture of an individual's risk for future resource use and condition progression. For Kentucky SKY, our data warehouse will maintain not just data we receive and generate (such as from claims and assessments) but also data pulled from the Kentucky HIE to incorporate any claims generated for the child prior to their entry into the foster care system. Additionally, we will collaborate with DCBS and DJJ to develop processes for accessing data from the TWIST and JORI systems to integrate with information in our MIS to promote a holistic view of each Enrollee.

Included in our ID/STRAT algorithm are rules for co-morbid behavioral health and substance use disorders, co-morbid physical health conditions, co-morbid physical and behavioral health conditions, out-of-home placement, private duty nursing services, and other factors that may necessitate a higher level of case management. The algorithm weights each factor in the context of how all factors combine to affect risk. This contextual weighting enables identification of risks that are not typically picked up through more traditional models. Additionally, our algorithm was specifically designed to identify BH risk, which is often unaccounted for in traditional models but is critical for Medicaid populations and particularly the foster care population. Upon first launching this tool in 14 states, WellCare identified 20% more Enrollees than were identified as high risk by our previous tool, and half of those had a BH diagnosis.

Our ID/Strat Engine generates a variety of risk scores to provide a comprehensive, nuanced picture of individual risks. These include:

- *CDPS Risk Score:* Standard algorithm that identifies the presence of chronic disease and specific impactable conditions, such as pregnancy, behavioral health conditions, asthma and diabetes.
- *Per Member per Month Medical Expense:* The average of total claims expense for each Enrollee for each month over a specified period.
- *Value of Future Adherence:* Medication Adherence Risk Score: A claims-based predictive modeling algorithm that calculates a value of future adherence score based on an Enrollee's current prescribed medications. This data source was developed originally to increase medication adherence based on an Enrollee's historical patterns of compliance and their responsiveness to a variety of interventions. We are expanding this index to include additional medications and supplemental data sets to predict a member's overall medication adherence because the lack of adherence is directly correlated to admissions.
- *Decision Point Predictive Risk Score:* A proprietary algorithm that assigns a future risk score based on admission/readmission risk, ED use, and specific disease progression predictions.
- *Modified LACE+ Index Risk Score:* Updated upon each admission with electronic Admission, Discharge, and Transfer data we receive from hospitals, the LACE+ score helps to identify Enrollees most at-risk for readmission and those who would benefit for enhanced discharge planning and community supports.
- *Social Determinants of Health (SDOH) Risk Score:* We generate an SDOH risk score using data we collect on Enrollee utilization of social service resources.

Our ID/Strat Engine continuously runs against Enrollee data as it is refreshed to enable timely identification of new or changed risk factors. While all Kentucky SKY children and youth will be enrolled in Care Coordination, this continuously refreshed risk scoring will aid us in ensuring stratification to the appropriate tier with changes to a higher or lower tier as the nature, complexity, and intensity of their needs change.

To ensure the ongoing sensitivity and specificity of our risk stratification algorithm, our population health solutions team, along with medical economics, reporting and analytics, and clinical leadership teams, meet every six months to evaluate the performance of our model. Using historical utilization data trends and performance, the team evaluates if factors are appropriate and if they are appropriately weighted. During our most recent evaluation, we identified that members who did not have a PCP visit over a six-month timeframe were at a higher risk for admissions and readmissions. Based on these findings, the team adjusted the algorithm to weight the lack of PCP visits more heavily as a consideration for identification and risk stratification. We anticipate making adjustments as we gain experience with the specific needs, utilization patterns, and other factors among the Kentucky SKY population.

Stratification

An important differentiator of our stratification approach is that **we will we will treat all new Enrollees as if they are in the highest tier (complex)** to ensure rapid response to continuity of care needs as well as any unmet needs. Once services are in place and the child is stable, we will use information from our comprehensive assessment process to build a fuller picture of the child's ongoing risks and needs.

This will include all information we are able to obtain, including recent claims history from DMS, information from DCBS, and information from previous MCOs and providers when the child comes into care, as well as initial provider assessments and input from DCBS and the caregiver about the level of support needed to promote placement stability and progress toward permanency. This involves much more than the child's clinical needs. For example, in our experience a child with a history of multiple placement disruptions is at higher risk for poor outcomes even in the absence of a high or moderate risk clinical condition. We look to information from the CANS as well as other assessment results related to ACEs as one indicator that a child should be stratified into a higher risk level.

For those already enrolled, ongoing stratification combines ID/Strat results along with information such as:

- Results of our comprehensive assessment and reassessment process
- DCBS, DJJ, and provider assessment results including CANS, Needs-Q, RCNA and other evidence-based assessment tools
- Claims and utilization data, including admissions, readmissions, ED visits, and new diagnoses
- Gaps in recommended preventive and chronic care services
- Prior authorization requests for new services
- Medications and adherence data
- Referrals from providers or community organizations (e.g., WIC, Healthy Start, Early Steps)
- Utilization of our 24-Hour Nurse Line and 24-Hour Behavioral Health Crisis Line
- Referrals from our Community Assistance Line liaisons
- Number of placement changes and disruptions, which increases risk for utilization of services
- DCBS, DJJ, caregiver, and provider concerns and recommendations obtained during IHP meetings, family team meetings, and face to face and other interactions with our Care Coordination staff and FOC.
- The Enrollee's voice and thoughts regarding their needs for medical and BH services and interactions with service providers.

Based on all available information, our Assignment Engine generates a risk score from 1 (low) to 3 (high) for each Enrollee, stratifying Enrollees by risk, cost and impactability. The score is reported on our daily census report which our Care Coordination staff reviews to assign the Enrollee to the appropriate case management tier for services tailored to the Enrollee's current level of need for intervention.

As indicated in 41.10.4, our Care Coordination staff will meet no less than quarterly with DCBS/DJJ to identify, discuss, and resolve any health care issues and needs for Enrollees. If the DCBS/DJJ service plan indicates a need for case management, DCBS/DJJ and the CCT will develop a plan for case management. The case management plan will be based on the identified needs as well as information from our stratification process. The Care Coordinator will sign the DCBS/DJJ service plan, indicating agreement and confirming the case management plan has been identified. If an agreement cannot be met for the case management plan, a summary of the issue and resolutions discussed by DCBS/DJJ and WellCare will be forwarded to DMS.

CASE MANAGEMENT TIERS AND SUPPORT PROVIDED AT EACH TIER

WellCare at Home is our field-based, fully integrated Care Coordination program, which includes case management, disease management, and preventive care interventions. We have already adapted this program for our current foster care Enrollees to provide intensive, field-based support for improved outcomes as well as placement stability and permanency. We will further enhance the support we provide under the Kentucky SKY program through a tiered model that aligns with DMS requirements and reflects our lessons learned about the unique needs and intensity of services required to improve health, quality of life, and permanency outcomes for this population in Kentucky.

Figure G.10-2 below shows our tier structure, along with the ratio of staff to Enrollees, criteria, and services provided at each tier as well as the anticipated percentage or number of Enrollees we anticipate serving at each tier based on our experience with Kentucky foster care Enrollees.

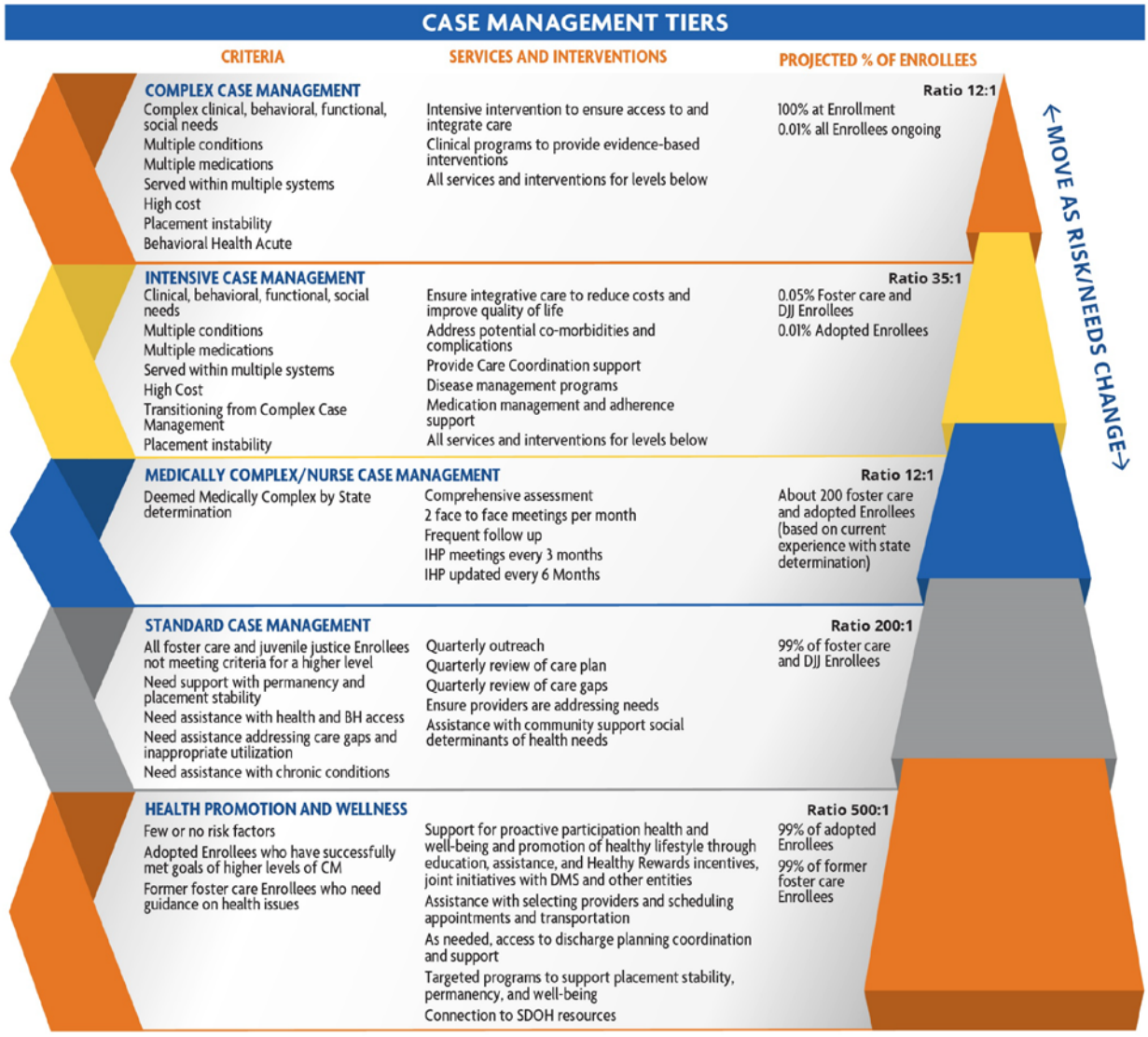

Figure G.10-2: WellCare Case Management Tiers

Through our WellCare at Home program, our Care Coordinators interact with Enrollees in their homes and communities, provider offices, and other appropriate settings. Contact frequency will comply with contractual minimums but will be ***more frequent*** based on each Enrollee's needs and preferences as well as caregiver needs and preferences.

Enrollees will move up or down in tiers as risk level and needs change so that intensity of services is tailored to meet each Enrollee's needs. Regardless of tier, all Enrollees with have access to Care Coordination Services and an interdisciplinary CCT. Each CCT will be led by an appropriate Care Coordinator and include clinical and non-clinical representatives based on each Enrollee's needs. (See our response to Question G.2.c.xii Care Coordinators and Care Coordination Teams for a complete description of how we will staff CCTs.)

Below we described the services and programs available to Enrollees across care management tiers based on their individual needs

CARE COORDINATION SERVICES

CCTs are responsible for coordinating across the continuum of care to integrate physical and behavioral health, pharmacy, dental, and other covered services as well as non-covered services and community resources to meet SDOH needs. All of these services must also be integrated with services in the child's permanence plan in order to support their placement stability and help them achieve permanency goals. Services provided by our Care Coordinators and CCTs are trauma-informed, person-centered, culturally competent, using a strengths-based approach with a focus on resiliency. We also emphasize education and support that caregivers, transition age youth, and former foster care Enrollees need to participate fully in shared decision-making related to care plans, Individual Health Plans, and provider treatment plans.

Comprehensive Needs Assessment

Our comprehensive needs assessment (CNA) process and tools are described in detail in our response to Question 8 Covered Services. Our staff convene Assessment Team meetings as required and needed to support Enrollee needs and continually monitor Enrollee progress and convene ad hoc meetings when conditions and needs change. We have enhanced the CNA tool in our CareCentral system through branching logic to document the number of placements and disruptions for each Enrollee. This will assist us to appropriately identify Enrollee risk and develop interventions designed to promote stability.

We are incorporating ACE scoring into our assessment process. We partnered with Maryhurst to pilot the use of an ACE scoring tool and will use results to identify any needed modifications to the tool or process in order to scale it for the entire Kentucky SKY population. However, all interventions and care planning are trauma-informed since we know all Enrollees have experience some level of trauma.

Support and Coordination for the Enrollee's Multidisciplinary Team

Our Care Coordinators proactively participate in the CRP-led multidisciplinary team (MDT) to help all involved clearly understand the child's clinical, social, and other needs. This includes sharing information we obtain from previous MCOs or providers about the child's needs and

care upon entry into foster care, the care plan, utilization data, and other information; facilitating conferences with network providers as requested; and supporting Enrollee and caregiver voice and choice. For example, our Care Coordinators support the MDT through the court-led Path to Permanency Program to ensure the courts understand the child's clinical needs as well as information such as what their home setting is like and what they need to successfully attend school. We participate face to face as often as possible to build relationships and ensure close coordination with the CRP, DCBS and DJJ caseworkers, DCBS Service Region Administrator for the region, court staff, as well as providers such as Our Lady of Peace or the Ridge Hospital.

Our Care Coordinators as well as Utilization Management staff participate in weekly integrated meetings to assess our high risk Enrollees for proper diagnoses, and review medications and discharge plans. Recommendations for interventions and next steps for the Enrollee are shared with the MDT to support comprehensive, integrated treatment planning. When indicated or requested, our Pharmacy and BH Medical Directors conduct in-depth medication reviews to support MDT recommendations to prescribers. Our staff also make recommendations for network providers that offer trauma-informed treatment.

We propose to **coordinate grand rounds with judges as extensions of the MDT.** Given the significant role of family courts in mandating treatment and services for this population, grand rounds with the family court judiciary will ensure the full MDT, including the presiding judge, has a complete clinical and psychosocial history and that the care plan is in alignment with court ordered treatment.

Care Plan Development

We use predictive modeling information, information from DCBS and providers, and results of all assessments and screenings to develop, within 30 days of enrollment, a child and family-centered care plan that integrates with and fully supports the permanency plan. Based on our experience over the past several years working with foster care Enrollees, we have moved away evolved to a person-centered approach that recognizes the case worker's central role but puts the focus squarely on Enrollee and caregiver goals and expectations of interventions as the foundation of the care plan.

Our Care Coordinators have a primary mission to promote Enrollee and family voice and choice throughout the planning process and advocate for what the Enrollee and family state are important to them. We will promote the **Building Bridges Initiative** (BBI) framework with DCBS, DJJ, providers, and other stakeholders during care planning to advance a youth guided, family driven process that adheres to BBI principles.

Principles of the Building Bridges Initiative

- Youth guided
- Family driven
- Individualized and strengths based
- Collaborative and coordinated
- Culturally and linguistically competent
- Research based
- Comprehensive, integrated, and flexible
- Evidence and practice informed
- Sustained positive outcomes

The Care Coordinator facilitates collaboration among the Enrollee, family/caregiver, and MDT to develop a care plan that addresses the Enrollee's goals and holistic health and social needs as well as caregiver needs to improve health outcomes and support

stability and permanency. This includes educating all stakeholders about benefits available through WellCare, the availability of trauma-informed treatments, and the importance of distinguishing BH conditions from the impact of trauma. Understanding that it is often necessary to address trauma before other interventions will be effective, Care Coordinators work with all stakeholders to create a phased action plan that reflects prioritization of trauma treatment when appropriate rather than concurrently treating trauma and providing other treatment.

Care plans include measurable goals, outcomes, interventions, and covered and non-covered services for the Enrollee's goals, condition(s), and needs, including placement needs. The final care plan and all interactions with the Enrollee, caregiver, and MDT are documented in the Enrollee's record in CareCentral. This includes next steps, interventions, providers, medications, education to be provided to the Enrollee and caregiver, how care gaps will be addressed, and referrals to SDOH resources as well as a schedule for follow up and monitoring. Documentation also includes involvement of the PCP, Dental Provider, Behavioral Health Providers, specialists and other providers in development of the care plan.

The Care Coordinator provides the CCT with all information needed to make timely and appropriate authorizations and referrals, such as information from prior MCOs and Providers needed for current providers to develop treatment plans. The CCT will communicate approved Care Plans and authorizations timely to providers, DMS, DCBS, and DJJ as required, via electronic or direct communications. The Care Coordinator will ensure that SKY Enrollees, providers, Foster Parents, Adoptive Parents, Fictive Kin, Caregivers, DCBS and DJJ have the most current information about community resources to meet the Enrollee's needs and will proactively connect Enrollees to these resources. Care Coordinators will leverage our Community Connections program as described in more detail in response to Question G.10.g below.

The Care Coordinator will spearhead regular MDT review and update of the care plan, following the same person-centered, comprehensive process we use for initial development. Review will consider progress toward care plan goals as well as toward permanency goals, with modifications as needed and agreed by DCBS and the MDT. This will occur on a regular schedule as outlined in the care plan, as well as whenever the Enrollee's needs or placement change.

Ongoing Management and Interventions

The assigned Care Coordinator and CCT provide a point of consistency across the care management process even when caseworkers, caregivers, and providers change. Additionally, CareCentral becomes a comprehensive source of information about the child's care. This allows us to support a consistent approach and 'historical memory' to monitoring and evaluating the child's progress. The Care Coordinator is proactive in collaborating with the MDT to regularly monitor implementation of the care plan, assess effectiveness of interventions, and evaluate progress toward care plan and permanency goals. This includes monitoring and sharing information gleaned from claims and utilization data in our system to provide all stakeholders with a holistic view of the child, including medication adherence, new diagnoses, acute episodes, inappropriate utilization, care gaps, and SDOH resources accessed.

Coordination of Placement Changes

An important service we provide is coordination of care through placement changes to minimize disruption and ensure continuity of care. The process for ensuring timely Enrollees access to PCPs and dental providers during a placement change is described in detail in our response to Question G.5 Enrollee Services. We expect that co-location of our FOCs in DCBS regional offices will minimize the number of auto-assignments necessary after a placement change. Since the FOCs will have a collegial relationship with DCBS staff, we anticipate this will expedite a more tailored selection of a new PCP and/or dentist. We recognize that not all placement changes are emergencies and we expect in some cases for our FOCs to discuss potential providers with DCBS staff in advance of placement to determine what providers would be preferred. The FOC will work with the Care Coordinator to evaluate provider options when a change is necessary.

The Care Coordinator and CCT will facilitate communication between the relinquishing and receiving providers as well as transfer of medical records. The Care Coordinator will also work with the relinquishing and receiving caregivers, if caregivers change, to coordinate exchange of information such as about the Enrollee's needs, preferences, and habits. The Care Coordinator will also help the caregiver as needed with scheduling appointments for the Enrollee with the new providers and arranging transportation, registering the Enrollee in school if applicable, and locating and connecting the Enrollee and caregiver to SDOH resources in the new community. Additionally, the Care Coordinator will provide reminders to the caregiver about the importance of the child taking medications to the new placement and will help ensure the child's clothing and personal possessions move with them.

Addressing Root Causes and Connecting to What Matters Most to the Individual

A 19-year old enrollee was incarcerated following multiple hospitalizations and residential placement disruptions due to self-harm and aggressive behaviors. Our assessment identified that she was a survivor of sexual abuse and human trafficking and lacked positive support from her biological family. Our Case Manager met with the enrollee and her detention center caseworker to discuss treatment and develop a person-centered care plan based on her goals for her future. The care plan included therapy, trauma-informed interventions, and in-person meetings at the detention facility to prepare her to leave the facility, as well as an action plan for her to complete her GED and take a college entrance exam. She was eventually accepted to Western Kentucky University (WKU). Once she started school, our Case Manager helped her create a support system and connected her to WKU resources including on-campus therapy and medical services. She continued her studies at WKU and had no further hospitalization or justice system involvement.

Coordination of Transitions Out of Care

As described in detail in our response to Question G.12 Aging Out Services, WellCare has developed a comprehensive, multifaceted solution to prepare our transition age Enrollees for aging out of the foster care system. The cornerstone of our solution is our Transition Age Youth and Young Adults Program which begins at age 14 and continues throughout the remainder of the Enrollee's tenure in our plan. A central feature of the program is youth-led transition

planning, with intensive education, encouragement, and designated Transition staff to support youth voice and choice. A Transition Coordinator will oversee our efforts, which will include early education and support for development of independent living skills, encouraging the youth to dream about and set goals for their life after foster care, education on how to actively participate in the DCBS/DJJ transition planning process and support during that process, ensuring all stakeholders understand the Enrollee's goals and needs and the benefits available to meet them, and educating the youth about post-secondary and other options and connecting them to the opportunities and community resources they need to build a life they love. The program will also include our Youth Peer Support Specialist to provide the perspective of lived experience. Through this program we will provide a variety of innovative tools and partner with key community organizations such as Kentucky Partnership for Children and Families and the First Lady's Youth Leadership Council to support youth self-advocacy.

The Transition Coordinator, Youth Peer Support Specialist, assigned Care Coordinator, and CCT together will comprise the youth's Transition Team. The Transition Team will be responsible for ensuring continuity of care from pediatric to adult providers, including assisting the Enrollee to choose providers and facilitating case conferences and transfer of information. While a key focus of our Transition Program is educating youth about the benefits of maintaining their Medicaid coverage through age 26, if the youth opts to transition out of Kentucky SKY, the Transition Team will attempt to identify other sources of health coverage and assist as needed to complete applications and transfer records and information to new providers.

Our Transition Coordinator and Family Peer Support Specialist will also support Care Coordinators to work with our adoptive parents to transition Enrollees out of Kentucky SKY when desired by the parent. As with transition age youth, adoptive parents often require education to understand the benefits of maintaining Medicaid coverage. Many adoptive parents assume their employer-based or other coverage provides more benefits or higher quality care than Medicaid. We educate them on differences in benefits, such as the significantly greater BH benefits available under Medicaid as well as EPSDT requirements for Medicaid to cover all medically necessary services. Additionally, we help them determine differences in out of pocket costs between Medicaid and their commercial coverage. If the parents nevertheless opt the child out of Medicaid, our CCT ensures continuity of care by assisting with transfer of records, facilitating case conferences between relinquishing and receiving providers as needed, and being available ongoing to answer questions from new providers.

Coordination of Transitions Across Care Settings

Our formalized Discharge Planning Program uses an integrated, evidence-based approach to coordinating discharge planning and transitions across care settings. This program is described in detail in our response to Question G.11 Utilization Management. For Kentucky SKY, a key focus of our Discharge Planning Program will be on assisting DCBS to ensure availability of appropriate post-discharge placements through securing post-discharge treatment resources and other support the receiving placement needs to fully meet the child's care needs. This will minimize the need for market exception days and quickly move the Enrollee to the least restrictive setting.

Coordinating Transitions Across Care Settings

A 10-year old adopted enrollee with an intellectual disability was not progressing toward her treatment goals despite being in a PRTF for about ten months. Our Care Manager made multiple attempts to work with the provider to adjust the treatment plan and interventions, but it became evident that an alternative treatment environment was necessary to effectively address her attachment disorder. The Care Manager searched for an appropriate alternative but none of the identified providers were able to accept her either due to her age or to her intellectual disability. Leann Magre, our Senior Manager of Foster Care, Adoption, and Guardianship, outreached to Home of the Innocents (HOI) and their Executive Vice President of Clinical Operations to discuss the child's needs, history, and reasons for lack of progress, and to explore treatment options at HOI. Because HOI is a private child care provider, usually a child must be in the state's custody to access their services. However, through collaboration with HOI, the Department, and the child's parents, WellCare was able to secure a bed at HOI and arranged a single case agreement to pay for the service. Our Care Manager coordinated transition of records and medications, as well as the child's clothing and possessions, to the new setting. After about six months, the child made enough progress to transition to Maryhurst PRTF. The Care Manager once again coordinated the transition, including ensuring the new provider had full information about the child's history, needs, reasons for lack of progress at the initial PRTF and changes to treatment approach that facilitated progress. Because of her unique needs, WellCare paid a higher than usual rate for the PRTF service. This child has continued to make treatment progress in the new setting and the parents have expressed that they are very encouraged.

WellCare Programs to Support Enrollee Health, Stability, and Permanency

All Enrollees have access to our full range of wellness, clinical, and condition management programs as needed, tailored to the unique needs of Kentucky SKY Enrollees. We have also developed specialized programs for this population. All programs, shown in **Figure G.10-3**, will feature trauma-informed and evidence-based Enrollee, family and provider interventions. These programs will be delivered by the assigned Care Coordinator to ensure a trauma-informed approach and minimize the number of staff interacting with the Enrollee, caregiver, and DCBS/DJJ caseworker.

PROGRAMS TO SUPPORT HEALTH, STABILITY, AND PERMANENCY

- Wellness
- High Risk OB
- Disease Management
- Comprehensive Psychotropic Drug Oversight
- Pharmacy Toolbox
- Substance Use Diversion
- SKY Smiles (dental)
- Unbundling Pilot
- Discharge Planning
- Frequent BH Readmissions
- Intensive Placement Support
- Transition Age Youth and Young Adults
- Sexual orientation, gender identity, gender expression
- Suicide Prevention
- Ensuring Adoption Success for Enrollees
- Abuse and Neglect Prevention
- Human trafficking

Figure G.10-3: WellCare Programs to Support Health, Stability, and Permanency

Our Discharge Planning Program and Transition Age Youth and Young Adults Program are described above. Below we describe our other programs.

Wellness Program

Wellness, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, is integrated into our care model for children and adolescents. As noted previously we will use AAP/CWLA guidelines for well-child visits for Kentucky SKY, which provide for a higher frequency and intensity of preventive and primary care. The Care Coordinator determines during initial and ongoing assessment and monitoring whether the child is current with recommended services and treatments based on age and needs. We provide assistance scheduling or keeping appointments or arranging for transportation as needed. Care Coordinators monitor via interaction with the Enrollee/caregiver and providers as well as through claims data to verify that appointments have been kept, services delivered, and, if necessary, referrals provided. We also provide a variety of supports and incentives to ensure timely receipt of recommended EPSDT or Child Health Check Up services, including:

- Data Integration and Analytics: To get a complete picture of the health services children receive, we combine the results of EPSDT screenings with other HEDIS measures. Monthly, our quality improvement team monitors use of services across a variety of preventive and chronic care coordination measures to identify potential care gaps. This data is supplied to our case management staff, Member Services staff, quality practice advisors, members and providers.
- Member Outreach and Education: We facilitate the completion of EPSDT services through complementary efforts that include inbound and outbound telephonic outreach, notification and reminder letters, web-based on mobile application alerts and social media.
- Healthy Rewards: We incentivize teen and young adult Enrollees and caregivers of child Enrollees to engage in healthy behaviors like EPSDT visits through our financial incentive program, Healthy Rewards. Enrollees earn cash-value incentives through reloadable debit cards and gift cards when they complete health- related activities like well-child visits and immunizations. Rewards move with the child through placement changes to be available for current caregiver use on the child's behalf.
- Provider Education: Through our provider education program, we train and educate providers about covered services, EPSDT services, and WellCare tools. For the Kentucky SKY program we will add targeted education on the unique needs of this population including the specialized AAP guidelines. We supply provider-specific reports and rosters that identify members due for EPSDT visits. This enables providers to actively monitor compliance, follow-up with Enrollees, and maximize appointments for children and adolescents. We alert providers of important EPSDT milestones. Additionally, as part of our Partnership for Quality (P4Q) program, eligible providers earn quality bonuses for completing EPSDT-related services. For Kentucky SKY, we will provide quality bonuses for providers completing services according to the higher frequency and intensity of the AAP/CWLA standards.

In addition, we will collaborate with DMS and DCBS to establish a Health Home Pilot to provide PCPs serving these Enrollees with an additional case management fee for enhanced behavioral health coordination. Our Care Coordination team will work hand in hand with the provider to

ensure they have access to records for this enhanced coordination responsibility and assist with utilization management approvals. We will expand this concept statewide based on the results of the pilot. We have had exploratory discussions with KPCA IPA about a health home pilot for Kentucky SKY Enrollees assigned to them. Of our current SKY-eligible Enrollees, 27% have a relationship with a PCP associated with the KPCA IPA.

High Risk OB Case Management

WellCare partners with Bluegrass Care Navigators Healthy Start Project to connect enrollees to the project's post-discharge coaching model for infants with neonatal abstinence syndrome and their parents.

Our High Risk OB Program is designed to intervene as early as possible in pregnancy to help the pregnant Enrollee address any and all issues that can affect the pregnancy outcome as well as the her overall health. We consider all pregnant foster care and juvenile justice Enrollees to be high risk due to their age and history of trauma. Our OB nurses have experience in obstetrics, newborn care, substance use disorder and other factors that increase risk for poor outcomes. When we identify a pregnant Enrollee, we will assign an OB nurse to be part of the Enrollee's CCT through seven weeks post-partum. The OB nurse will coordinate with the assigned Care Coordinator to educate, guide and encourage that mom to make the best choices for her and her unborn child.

We also assist with social issues (such as homelessness, sexual assault, domestic violence, and mental illness) and connect the Enrollee to services and resources to support pregnancy loss as well as grief and loss due to the baby being placed in state custody or placed for adoption.

Disease Management Programs

- WellCare has implemented successful disease management programs to address our Kentucky Enrollees' chronic conditions such as asthma, diabetes, mental health and substance use, sickle cell, and cancer. For example, from 2016-2018, ER visits/1000 fell by almost 16%, readmissions/1000 fell almost 4%, and specialist visits/1000 increased by almost 22% for those with an asthma diagnosis.
- All of our existing DM programs will be available to our Kentucky SKY Enrollees. These programs use evidence-based risk assessment tools and self-management practices tailored to the Enrollee's readiness to change which is influenced by their experience of trauma. We identify and address psychosocial issues and barriers to care, caregiver supports, and environmental and functional needs. Our aim is to prevent, reduce, and delay exacerbations and disease progression; integrate condition management with other services received; and prevent potentially preventable events.

Our approach to disease management for Kentucky SKY recognizes the importance of minimizing the number of individuals who contact the Enrollee, caregiver, and DCBS/DJJ. Our WellCare At Home model integrates disease management with Care Coordination, and disease-specific evidence-based guidelines are fully embedded into all aspects of our program. All Care Coordinators are trained to provide evidence-based disease management education, including recognizing and identifying signs and symptoms of exacerbations of chronic conditions, educating around clinical practice guidelines, and using teach-back methods.

Care Coordinators engage Enrollees and caregivers to set goals and gauge knowledge and comfort level in managing their conditions. We provide individualized education, training and support necessary for Enrollees and caregivers to become proficient in self-care as well as confident in their abilities. For example, a Care Coordinator working with a child diagnosed with seizures focuses self-management practices on understanding triggers, warning signs, improved seizure control, safety issues, and lifestyle and behavior modification. In working with the family and caregivers of children with respiratory conditions, a Care Coordinator directs self-management training on equipment use (i.e., peak flow meters, inhalers, and nebulizers) and medication administration (i.e., proper use of inhalers).

Our approach is focused differently based on the age of the Enrollee. For younger children, disease management interventions and education are targeted at the foster caregiver/adoptive parent. As children get older and start planning for transition, interventions and education focus more heavily on the Enrollee and teaching them about their condition and how to effectively manage it. We work directly with our former foster care Enrollees to support them in managing their conditions.

Comprehensive Psychotropic Drug Oversight Program

For prescribing providers and Enrollees prescribed antipsychotics, antidepressants, and medications for the treatment of attention deficit hyperactivity disorder (ADHD), we provide our comprehensive psychotropic drug oversight program. Our program, which is based on nationally recognized guidelines and the U.S. Food and Drug Administration (FDA)-approved indications, is managed and executed by our Pharmacy and Therapeutics Committee, our BH Medical Director, our SKY Medical Director and BH Medical Director, and our Director of Pharmacy. Our program focuses on three critical areas:

- Ensuring appropriate medication use and follow-up for children dispensed medication to treat ADHD
- Promoting optimal medication adherence for those diagnosed with targeted conditions, including depression and schizophrenia
- Ensuring appropriate use of antipsychotics.

Through this program we provide highly targeted Enrollee/caregiver and provider training and education, Enrollee-specific medication profiles, ongoing data collection regarding usage and prescribing patterns, and real-time surveillance through our prior authorization rules and online point-of-service (POS) claim adjudication system edits.

We use our Pharmacy Toolbox to measure and monitor prescribing patterns and usage for a variety of pharmacy-related measures. Toolbox reports display real-time utilization, drug evaluation review, and physician data by month and year-to-date. For example:

- Our “Atypical Antipsychotics for Enrollees Under 10” pharmacy toolbox report provides detailed reporting for those under 10 years of age who are prescribed atypical antipsychotics (excluding those diagnosed with autism).
- Our “Pediatric Prescribing of ADHD Medications” pharmacy toolbox report provides detailed reporting for those under 17 years of age using medications for the treatment of ADHD.

- Our "Polypharmacy of Behavioral Health Medications" pharmacy toolbox report provides detailed reporting of those who have two or more prescriptions for different antipsychotic medications.

Substance Use Disorder Program

This program will provide educational prevention services to at-risk youth to divert them for abusing substances, specifically opioids. We will collaborate with community partners, such as Court Appointed Special Advocate (CASA) and other community advocacy groups who have close relationships with youth in foster care. We have already secured a Memorandum of Understanding from CASA to assist with the program.

The Health Belief Model (HBM) will guide our intervention. This model looks at the participants perceived susceptibility to addiction, severity of addiction, as well as the benefits and barriers to remaining drug free. HBM takes into account a person's perceived self-efficacy in preventing addiction or overcoming addiction. The intervention will have several components based on the HBM. There will be an educational component to discuss the health risks of addiction, including death, and how family history can increase susceptibility to addiction. Mentors, who are previous foster children, will present the benefits of staying drug free, and discuss how they addressed barriers to either avoiding or overcoming addiction. We will have a "cue to action" which may include the recent death of the musician Prince, for example. Finally, we will address issues of self-efficacy by educating participants on drug treatment centers for those suffering with addiction. We will also discuss educational opportunities and job training opportunities to secure employment and avoid drug abuse.

SKY Smiles

In 2018, nearly 12% of our foster care Enrollees had not had a dental visit in the previous two years. WellCare is launching a multi-modal outreach program (mailings, phone calls, text messaging) to increase dental exam utilization for these Enrollees. We recently received approval from the Commonwealth for our proposed messaging to this population, which focuses on improving the health and lives of Enrollees in foster care through regular dental checkups which helps keep their teeth clean, maintains oral health, and helps find problems early. Based on our dental benefits administration subcontractor's success rates with this outreach for other vulnerable populations with lapsed dental utilization, we anticipate increasing annual dental visit rates by as much as 33% among our foster care Enrollees who do not have record of a dental visit in the previous 24 months. Our SKY Smiles Program will also include the following components.

Connection to a Dental Home. Every Kentucky SKY Enrollee will be assigned to a primary care dentist and, if necessary, an orthodontic dental home. These dental assignments will follow the Enrollees through their foster care experience in an attempt to maintain stability in this important caregiver relationships. The dental home will ensure continuous access to comprehensive and coordinated care for all preventive, acute, and ongoing oral health needs. In addition, a dental home provides education, anticipatory guidance, and a trusted referral source for more complex needs. Through our partnership with Avesis and Big Smiles, the

largest mobile dental provider covering the entire Commonwealth, connection to a dental home with continuity of care will be assured. Big Smiles can travel to Enrollee communities to ensure consistent care.

Culturally Competent Outreach and Education. We will provide culturally and linguistically competent education and outreach for Enrollees and their caregiver team on the importance of having a dental home, combined with targeted outreach to help ensure they are taking full advantage of their dental benefits.

Tele-dentistry. We will use tele-dentistry technology to help ensure Kentucky SKY Enrollees and their dental home team can continue to work together, even if the Enrollee needs to move to a foster home outside of the 50 miles/50 minutes access standards. Using synchronous modalities, we will connect Kentucky SKY Enrollees with their dental home provider(s) by scheduling and deploying Public Health Hygienists to the Enrollee's home, school or other community-based location to help facilitate the virtual appointment. Asynchronous modalities for tele-dentistry are not currently DMS approved. However, we understand DMS may consider amending its telehealth regulation to accommodate this modality in the coming months. If so, we will utilize asynchronous modalities (store and forward of photographs) as well.

In the case that treatment in a brick and mortar provider office is required, care coordination will ensure that the best care is received in every instance. Included with care coordination is our ability to assist with scheduling so that our members are provided care at a time and location that is most convenient for them and their care providers. Finally, this set of tools ensures maintained engagement so that continuity of care is preserved, and our members maintain consistent progress in their treatment plans. Our use of tele-dentistry will be aligned with the Commonwealth's new tele-health regulatory requirements.

Continuity of Care for Treatment in Progress. Consistent with the 2017 Medicaid Final Rule on Medicaid Managed Care, we will follow established procedures to ensure continuity of care for dental treatment in progress. In the event we are unable to maintain the Enrollee's relationship with their previous dental provider team, we will facilitate the transfer of care to their new providers and will pay for all treatment in progress. In the case of orthodontic care, if the Enrollee's new orthodontist uses a different type of kit or a different type of braces, we will pay for the new orthodontist provider to remove the existing wires and install new ones so that care may be continued. In any instance where care is being transferred between providers, we will review the prior authorization decision and course of treatment.

In the event the previous provider has been paid for services that will now be rendered by the new orthodontist, we will pro-rate the services and institute a recoupment. If orthodontic treatment began for a Kentucky SKY Enrollee who was previously on a self-pay or commercial plan, we will review orthodontic records to determine if the case qualifies for coverage. If the referring dental insurer has a process that is similar or more generous than ours, we will honor the treatment plan. If the referring plan has a process that is more restrictive, we will adjust the plan to align with our more generous coverage.

Trauma-Informed Dental Care. Our dental benefits administration (DBA) subcontractor has a relationship with the founder of P.A.N.D.A (Prevent Abuse and Neglect through Dental Awareness). P.A.N.D.A is dedicated to engaging dentists and dental professionals in identifying child abuse and neglect, elder abuse, domestic violence and human trafficking. Our DBA subcontractor's Vice President of Dental Quality and former Chief Dental Officer for CMS is a P.A.N.D.A. trainer and can deliver professional development for network dental providers on:

- Understanding the problem of abuse and neglect of persons of any age.
- Understanding the clinical signs and symptoms of possible abuse and neglect.
- Understanding the responsibilities for dental professionals in preventing family violence.

This training covers important topics like precipitating causes and contributing factors to child abuse, the clinical signs of abuse and neglect one might encounter in the dental office, and professional liability. Through their relationship with the professional education site, Dr. BiCuspid, our subcontractor's presentation of P.A.N.D.A. content has been recorded and is available for continuing education administered by IMV, Ltd., an American Dental Association (ADA) CERP Recognized Provider.

Dental Care for Enrollees with Special Health Care Needs (SHCN). For Enrollees with disabilities, medical needs often take priority over their oral health care, despite the fact that many medical conditions may affect oral development or be accompanied by complications such as oral trauma, bruxism, oral infections, and gingival overgrowth. In addition, some dentists are reluctant to treat individuals with disabilities because of a lack of familiarity with, or misperceptions about, the office and clinical practices that are required to meet their needs. While all dental benefits administrators are required to solicit and publish information about whether a dentist serves Enrollees with SHCN, there are currently no required, objective criteria that an office needs to meet to declare their ability to serve these Enrollees. Because there is wide variation in what Enrollees with SHCN may need to have safe and successful dental treatment, this self-declaration by dentists may not provide enough information to help members make the best choice when selecting a dental provider.

To address this, we are working with our DBA subcontractor to offer **Sensi-Dentistry™**, a special needs dentistry program created to address the unmet needs of those with SHCN. Sensi-Dentistry improves access to care, Enrollee experience, and health outcomes through provider training on SHCN, detailed assessment of provider ability to meet the needs of Enrollees with SHCN, a Find-a-Dentist tool to help families find dentists who have completed Sensi-Dentistry training (available July 2020), education for families on how to choose a Sensi-Dentistry trained dentist, a pre-appointment visit for the Enrollee and family to meet the dentist and explore the dental office, and reimbursement to providers for additional time needed to serve those with SHCN.

In addition, we will offer mobile sedation dentistry to allow Enrollees who require anesthetic to complete oral health treatment to receive care in a dental sedation center or even in their dentist's office, rather than in a costlier hospital setting. This additional care delivery mechanism can play a vital role in improving access and health.

Unbundling Pilot Program

The goal of this program is to provide mental and medical health interventions and intensive assessments to help to prepare children to transition to the appropriate placement in the least restrictive setting. We have partnered with Home of the Innocents to implement this program.

For children who meet program criteria, HOI's Children's Assessment and Transitional Service Center will provide four core services: Medical and Mental Health, Emergency Housing, Assessment/Placement Recommendations, and Collaborative discharge planning. Behavioral Health Services will be provided by HOI's Child and Family Services Program and medical services will be provided by Open Arms Children's Health, as clinically indicated. Participants may:

- Step down to an HOI foster care home as part of the treatment continuum, based upon availability and the child's individualized treatment needs
- Step up to an HOI residential unit as part of the treatment continuum, based upon availability and the child's individualized treatment needs.

While outcomes are not yet available, we anticipate outcomes to include reduction in number of placements, prompt and proficient placement, increased utilization of placement best practices, limiting further trauma, and increasing the efficacy of caregiver training for the special needs children/youth being placed in their care.

Frequent BH Readmission Program

For Enrollees with frequent BH readmissions, we propose to conduct weekly rounds with DCBS and DJJ. Our Care Coordination staff including BH clinicians, Pharmacy Director, and BH Medical Director will collaborate with caseworkers to develop step down plans and intensive supports for community maintenance such as crisis planning and intervention, Mental Health First Aid for caregivers, and medication management. Because these Enrollees often have complex clinical needs, it may be necessary to be creative and build what the Enrollee needs for placement. WellCare has already demonstrated the ability to assess needs and collaborate with DCBS, DJJ, and providers to create unique services to meet specific member needs, such as authorizing two providers to both meet with the Enrollee to support a smooth transition to a new provider and single case agreements to help an Enrollee access a specialized service not covered by Medicaid.

Intensive Placement Support Program

This program will provide intensive support for Enrollees who have high and specialized needs preventing DCBS from securing a permanent foster placement. We propose to conduct weekly rounds with DCBS for these Enrollees. Participants would include our nurse and BH Care Coordinators along with the DCBS caseworker. As needed, providers, caregivers and other stakeholders would be invited to participate and provide recommendations. This is where listening to the voice and experience of the caregiver as well as the youth is highly critical. The relationship between the caregiver and the Enrollee must be preserved. Once that relationship is beyond repair, placements disrupt. This program will focus on youth voice and creative solutions to provide what the youth tells us they need.

Sexual Orientation, Gender Identity and Expression (SOGIE) Program

Youth in foster care with diverse sexual orientations, gender identities, and gender expressions (SOGIE) at higher risk for negative outcomes than their heterosexual and cisgender peers in foster care. This includes negatives outcomes relating to health, placement stability, homelessness, and reunification with family of origin. To develop and implement best practice programs aimed at improving outcomes for foster care youth, the University of Maryland School of Social Work's Institute for Innovation and Implementation collaborated with the U.S. Department of Health and Human Services, Administration for Children and Families' Children's Bureau to establish the National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for Lesbian, Gay, Bisexual, Transgender, Questioning, and Two-Spirit Children and Youth in Foster Care (QIC-LGBTQ2S). The QIC-LGBTQ2S. WellCare will develop our SOGIE Program incorporating caregiver interventions and tools, curriculum, and intervention and evaluation approaches such as those recommended by QIC-LGBTQ2S.

Suicide Prevention

The Seven Core Components of the Zero Suicide Framework

LEAD system-wide culture change committed to reducing suicides
TRAIN a competent, confident, and caring workforce up-to-date in suicide care
IDENTIFY patients with suicide risk via comprehensive screenings
ENGAGE all individuals at-risk of suicide in a suicide care management plan
TREAT suicidal thoughts and behaviors using evidence-based treatments
TRANSITION individuals through care with warm hand-offs and supportive contacts
IMPROVE policies and procedures through a continuous quality improvement plan

Source: Zero Suicide, https://zerosuicide.sprc.org/

We will enhance our current suicide prevention education and support through implementation of Zero Suicide, a continuous quality improvement framework for health systems to transform suicide prevention efforts. Zero Suicide offers a toolkit that provides guidance in implementing the seven core components of the framework. Safety planning for both the Enrollee and the care provider is paramount when suicide is a risk. WellCare will work with the care team to ensure adequate safety plans are in place, assist the Enrollee to verbalize when their triggers and concerns begin to grow beyond their current coping skills, assist the care provider to be prepared with the exact steps they need to follow, and ensure the provider network is prepared for an acute admission and crisis need.

Ensuring Adoption Success for Enrollees (EASE) Program

This program will provide intensive education and support to adoptive families to ease the adoption process and promote a successful adoption and family transition. Care Coordinators will educate adoptive parents on what to expect throughout and following the adoption process, including common reasons for disrupted adoptions of children from the foster care system and services and resources available to prevent disruptions. We will connect adoptive parents to peer support, adoptive parent support groups, respite resources, family therapy resources for families with other children, and SDOH resources. WellCare will take our lead from the adoptive parents and youth on the specific supports they need for success. The care plan will address their unique support needs.

Abuse and Neglect Prevention Program

As part of our implementation of the requirements of the Families First Prevention Services Act in October 2019 (ahead of the required 2021 implementation deadline), WellCare will implement an Abuse and Neglect Prevention Program for Kentucky SKY. The aim of the program will be to educate foster caregivers and adoptive parents on abuse and neglect and assess for and address caregiver support needs such as parent peer support and respite as well as SDOH needs to ensure caregiver needs are met and prevent burnout and resentment. We will collaborate with DCBS and DJJ to finalize the program.

Human Trafficking Prevention and Healing Program

Children in foster care are at greater risk than the overall population for being victims of human trafficking and sexual exploitation. We will implement a dual-aim program to:

- Protect Enrollees from victimization through education about risks and how to identify and report potentially dangerous situations
- Help Enrollees who have been victimized to heal through specialized treatment and support resources.

WellCare will collaborate with the Attorney General's Office of Child Abuse and Human Trafficking Prevention and Prosecution (OCAHTPP), the Statewide Human Trafficking Task Force, and other community organizations to develop training and education for our Care Coordination staff, Enrollees, caregivers, and providers. For example, we will work with OCAHTPP to determine how we can leverage their training on how to recognize signs and report human trafficking. We will identify providers in our network with expertise treating victims of sexual abuse and human trafficking and connect Enrollees who have been victimized.

d. Provide a description of the Vendor's targeted evidence based approaches applicable to the Kentucky SKY populations. Provide details on the Vendor's approach for ensuring Network Providers' compliance with evidence based approaches mandated by the Vendor for Kentucky SKY Enrollees.

WellCare of Kentucky offers a comprehensive Quality Management program that leads the Commonwealth in 24 HEDIS® measures for 2019 (including Well-Child Visit measures, Medical Assistance with Smoking and Tobacco Use Cessation, Breast and Cervical Exams and Annual Dental Visits) and has maintained a two year NCQA accreditation status. **Since we became National Committee for Quality Assurance (NCQA) accredited in Kentucky in 2014, we have improved our accreditation scores from 79.0 in 2015 to 85.73 in 2018, and have the highest NCQA quality ranking in the State Medicaid program at 3.5.** In addition to having the highest quality rating, we also have the highest percentage of ratings of a 4 or higher in the 2019 – 2020 report. HEDIS measures reflect compliance with evidence-based guidelines for recommended clinical care and as noted above, we have also achieved HEDIS improvements for our current Kentucky SKY-eligible Enrollees.

In addition, we ensure provider compliance with other evidence-based standards such as through our medical record review audits for BH providers. In 2018 the majority of BH providers

at all three levels of care (inpatient, outpatient, and targeted case management) achieved passing scores and scores for all three levels improved over 2017.

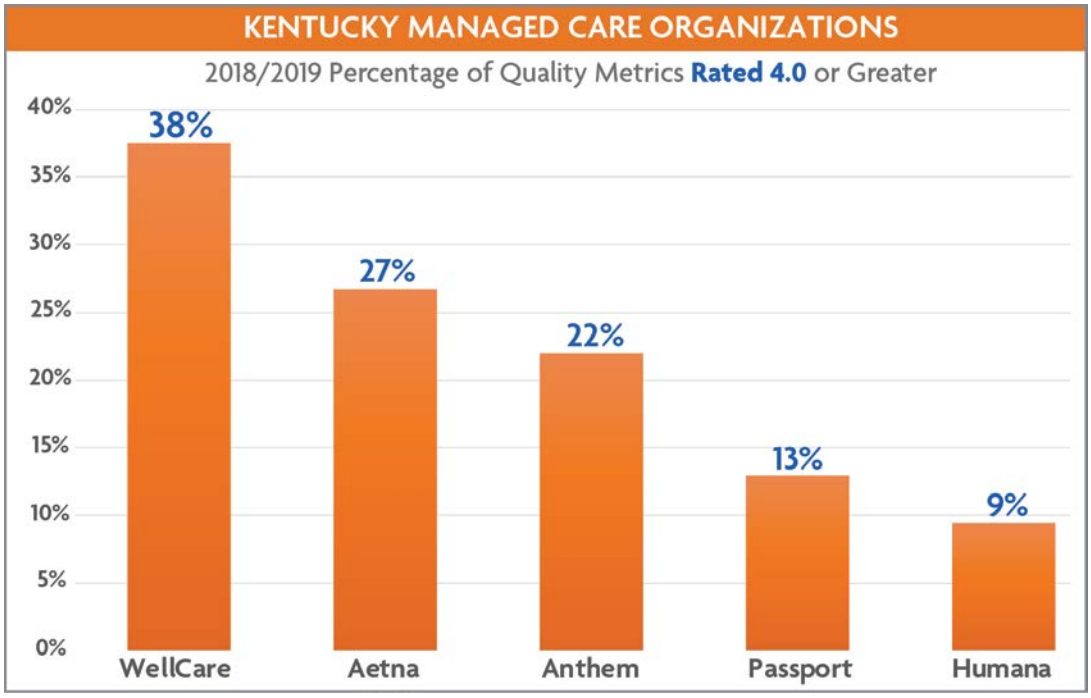

Figure G.10.d-1 WellCare Percentage of Quality Metrics

We know that improving outcomes for this population requires going beyond traditional HEDIS guidelines through adoption of alternative and additional guidelines tailored to the unique needs of children and youth in foster care. This will help us achieve better outcomes for Enrollees, decrease costs, and improve provider accountability. We will build on our successful experience promoting evidence-based approaches and ensuring provider compliance through our intimate knowledge of the Kentucky Medicaid landscape and the unique needs of Kentucky SKY Enrollees as well as our local, hands-on approach and our best-in-class reporting capabilities.

EVIDENCE BASED APPROACHES

Customizing for the Kentucky SKY Population

Evidence-based approaches and clinical practice guidelines are an essential component of our overall quality measurement and improvement program and provide a foundation for effective approaches to the care of our Enrollees. These guidelines are embedded in every aspect of our operations from care planning and utilization management to quality monitoring and reporting. Our physical health, BH, and pharmacy guidelines reflect evidence-based recommendations from leading specialty associations, colleges and societies (e.g., American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Diabetes Association), as well as peer-reviewed literature and studies.

WellCare's extensive evidence-based practice resources are in strong alignment with the top diagnoses among our foster care and juvenile justice Enrollees. We already use a wide range of

evidence-based guidelines relevant to the population, such as for ADHD, antipsychotic drug use, asthma, autism spectrum disorder, depression, epilepsy, lead exposure, and obesity. We provide other examples in **Attachment G.10.d-1 BH Child and Adolescent CPGs**.

We will adopt additional evidence-based guidelines and approaches specific to the Kentucky SKY population to reflect their unique clinical and non-clinical care needs.

Our Utilization Management Advisory Committee (UMAC), comprised of network providers as well as our Medical Director and BH Medical Director, continuously reviews, updates, and as needed adopts new guidelines to reflect the latest evidence on effective care for our enrolled population. To ensure appropriate expertise for Kentucky SKY, we will establish a **SKY Enrollee Outcomes Committee** which will provide recommendations to the UMAC on appropriate evidence-based guidelines. The Enrollee Outcomes Committee will include representation of providers that serve these Enrollees (such as pediatricians and BH providers) as well as foster and adoptive parents and a former foster care youth. The committee will also include our SKY Medical Director and BH Medical Director. See our response to Question 9 Health Outcomes for more detail on the committee.

TOP DIAGNOSES

Diagnosis	% SKY Eligible Enrollees
SED	43%
Depression	19%
Asthma	14%
Obesity	12%
Bipolar	5%
Substance Abuse	4%
Serious Mental Illness	2%
Diabetes	1%
Hypertension	1%

Evidence-Based Approaches We Will Use

Well-Child Guidelines. A foundational evidence-based approach we will adopt, as described previously, will be the standards developed by the American Academy of Pediatrics and Child Welfare League of America. These standards differ from the guidelines for well-child care that apply to the traditional child Medicaid population in both the frequency and the intensity of services that should be provided.

Trauma-Informed Care. Understanding the impact of trauma on children and youth in foster care and how it affects every aspect of their care, we will adopt a range of evidence-based approaches for appropriately addressing trauma, grounded in SAMHSA's six key principles of a trauma-informed approach.

SAMHSA'S SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice
- Cultural, Historical, and Gender Issues

We will draw from sources that include but are not limited to:

- SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) which includes numerous evidence-based guidelines for trauma-informed approaches.
- The National Child Traumatic Stress Network's catalog of evidence-based trauma interventions.

- The Child Welfare Information Gateway (US Department of Health and Human Services, Administration for Children and Families' Children's Bureau).
- The California Evidence-Based Clearinghouse for Child Welfare.
- Building Bridges Initiative.

Care for Juvenile Justice Involved Youth. This subgroup has unique health and mental health care considerations such as traumatic injury, tuberculosis, sexually transmitted infection, reproductive health, high rates of psychiatric disorders, substance use, and suicide risk. In addition to evidence-based approaches we have already adopted, such as

American Academy of Child and Adolescent Psychiatry's (AACAP) *Transgender Youth in Juvenile Justice and other Correctional Systems*, we will leverage sources for evidence-based approaches to their care such as:

- American Academy of Pediatrics Committee on Adolescence. Health Care for Youth in the Juvenile Justice System.
- National Commission on Correctional Health Care. Standards for Health Services in Juvenile Detention and Confinement Facilities.
- US Department of Justice, Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide.

Other Areas of Care. The table below provides some of the other relevant areas of care for which WellCare has already adopted or will adopt evidence-based guidelines and approaches. *This list is not exhaustive* but provides a sample of approaches that reflect the latest and consensus recommendations for effective care in these areas.

Table G.10-3: Examples of Evidence-Based Approaches We Will Use

Area of Care	Examples of Evidence-Based Approaches
Appropriate Utilization of Psychotropics	AACAP: *Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents* HEDIS guidelines on metabolic monitoring SAMHSA: *First and Second Generation Antipsychotics in Children and Young Adults: Systematic Review Update - March 16, 2017* SAMHSA: *Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents*
Evidence-based BH treatment interventions	Child Parent Psychotherapy Trauma-Focused Cognitive Behavioral Therapy Parent Child Interaction Therapy Dialectical Behavior Therapy
Crisis Intervention Services	Mental Health First Aid
Substance Exposed Infants	SAMHSA: *Neonatal Drug Withdrawal*
BH Screening/Identification	Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Area of Care	Examples of Evidence-Based Approaches
Suicide Prevention	Cognitive Behavioral Therapy for Suicide Prevention Dialectical Behavior Therapy Collaborative Assessment and Management of Suicidality
Developmental Disabilities	AACAP: *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder* AACAP: *Comorbidity Treatment in Autism Spectrum Disorders and Intellectual Disabilities*
Substance Use Disorder	SAMHSA. *Principles of Adolescent Substance Use Disorder Treatment*
Smoking Cessation	Public Health Service: *Clinical Practice Guideline on Treating Tobacco Use and Dependence, 2008 Update*

ENSURING PROVIDER COMPLIANCE

We will build on the effective processes we already have in place for ensuring provider compliance with our evidence-based approaches and guidelines, customizing for Kentucky SKY to promote the highest quality care for these Enrollees. Based on experience implementing new programs (including transitions from fee for service to managed care and implementation of value-based purchasing arrangements) in Kentucky and other states, WellCare understands how to educate, monitor, and support providers to adhere to or change practice.
Our compliance approach involves initial and ongoing education and training on our guidelines, incentives to encourage compliance, regular multichannel monitoring to identify providers that are not meeting expectations, intensive technical support and assistance to help providers improve and meet compliance goals, and a corrective action process for repeated non-compliance.

Education and Training

The shift to a sole-source contract emphasizes to providers the importance of differentiating between this population and the traditional Medicaid population and increases their awareness that these Enrollees may require alternative or additional treatment approaches. WellCare will reinforce this emphasis and increase awareness through inclusion of required evidence-based approaches in our comprehensive Kentucky SKY provider education and training program. This program, described in detail in our response to Question 8, will incorporate topics that are included in network-wide training (such as trauma-informed care and suicide prevention) as well as topics targeted to specific provider types (such as evidence-based BH treatment approaches targeted to BH providers).

Incentives

WellCare has achieved positive results ensuring provider compliance with evidence-based guidelines, such as incentivizing providers who meet HEDIS targets. We will provide incentives to PCPs to promote compliance with the AAP well-child guidelines through enhancing reimbursement in recognition of the increased intensity of services as well as configuring our system to accept claims for unlimited well child exams in accordance with AAP guidelines. We are also exploring development of additional incentives such as:

- Qualified Residential Treatment Provider (QTRP) incentive for meeting Building Bridges Initiative (BBI) standards. We will ask providers to complete a baseline self-assessment, collaboratively develop a work plan, and re-assess at established intervals to determine improvement and evaluate compliance.
- BH hospital and PRTF level 2 incentive for reducing seclusion and restraints and increasing alternative methods of addressing behaviors. This incentive will be part of our Performance Improvement Project described in our response to Question G.9 Health Outcomes.
- Placement Stability over six, 12, and 18 months. Longer placement tenure increases a child's feelings of safety and stability. This in turn leads to better progress toward development milestones as well as continuity of care.

Monitoring

WellCare's compliance monitoring for Kentucky SKY will incorporate our monitoring approaches used for our traditional Medicaid population (described in detail in our response to Question C.9 Quality Management and Health Outcomes) but will be enhanced to reflect the higher-touch, more intensive oversight necessary to promote quality for these Enrollees and ultimately support permanency. These more intensive monitoring approaches will include:

- *Care Coordination Monitoring of Enrollee Progress*. Care Coordinators and CCTs interacting face to face with Enrollees, caregivers, providers, DCBS, and DJJ discuss Enrollee progress on the care plan as well as the permanency plan. The frequent, immediate feedback received through our high fidelity wrap around approach will enable our staff to identify early any issues with provider compliance.
- *Review of Provider Self-Assessments.* We will ask providers to complete self-assessments to establish baseline compliance and measure progress toward compliance. For example, as noted above, we will ask QTRPs to complete a baseline BBI standards self-assessment to identify compliance gaps and follow-up self-assessments to monitor progress toward compliance.
- *Provider Audits.* Our Provider Relations Team will select and audit subsets of providers to which guidelines apply. We may select providers randomly, based on high volume, or when we identify low performance in established metrics. We will also audit through our Annual Medical Record Review (AMRR), described in more detail in our response to Question C.9 Quality Management and Health Outcomes.

We will also use other monitoring methods such as:

- *Appointment Accessibility Surveys.* Our Network Integrity Team partners with an external vendor to conduct telephone surveys to assess appointment availability, appointment wait time, and after-hours coverage. We re-audit any Providers who fall short of standards and follow-up with a corrective plan as needed. Findings are shared with the Provider Relations Team to ensure appropriate follow-up and education is provided to Providers failing to meet accessibility standards. For Kentucky SKY, appointment surveys for PCPs will help us monitor compliance with the increased frequency of AAP guidelines.
- *Grievances and Complaints.* Our Member Advocates, Member Services Representatives, and Care Coordination staff review, log and categorize grievances and complaints by cause, disposition, and type for review and follow-up. Feedback generated from our SKY Enrollee Outcomes Committee will also provide us with regional or systemic trends which are

addressed by our Member Advocates before a formal complaint is filed. Grievance and complaint information is reviewed by our Network Integrity and Quality Improvement Teams to monitor access to care, used by our Network Development Team to identify the need and opportunities for expanding access to care, and allows our Provider Relations Team to follow-up and work with Providers. Our Inquiry Coordinator will assist Enrollees, foster and adoptive parents, relatives, Fictive Kin and caregivers with grievances and complaints as needed. The Inquiry Coordinator will make decisions and report to DMS, DCBS, and DJJ any inquiries and complaints made by or on behalf of SKY Enrollees or providers.

For all monitoring, we will identify individual providers in need of follow up as well as track and analyze trends to identify needs for follow up and re-training network-wide or by provider type.

Technical Support

When we identify non-compliance and when a provider requests assistance, our regionally located Quality Practice Advisors (QPAs) will outreach and provide a range of technical supports to assist the provider to come into compliance. Currently, WellCare has three teams of regionally located QPAs responsible for assisting providers in closing care needs and educating them on HEDIS and HPR measures and other required guidelines. We will be expanding our QPA team to provide coverage in every DCBS and DJJ region and providing intensive education and training on our evidence-based guidelines, compliance requirements, and how to support our providers. Support may include gap analysis to determine processes the provider needs to put in place for compliance, re-training on guideline content, training for additional practice staff, and direction to external training and certification resources. QPAs will work face to face with providers at their locations. Care Coordination staff will assist as needed to reinforce QPA efforts including checking in with providers during MDT meetings to confirm the provider is following evidence-based approaches.

We will also deploy our **Members Empowered to Succeed (METS)** program to reinforce use of evidence-based approaches. The program, which started in Kentucky as a pilot and has now been deployed in all of our markets, assists Enrollees in stepping down from intensive services or obtaining more specialized or extended services. The METS team works closely with providers and our Care Coordinators to create an authorization plan that identifies specific goals to demonstrate progress towards recovery. For the Kentucky SKY program, this will include review of provider compliance with evidence-based approaches and technical assistance as needed to improve compliance. METS has delivered meaningful results, including a 6% reduction in ED utilization.

Corrective Action

When necessary, QPAs will develop formal corrective action plans for providers to bring them into compliance. Our process includes timeframes and milestones for demonstrating improvement. Corrective actions may include peer to peer consultation with our Medical Director, BH Medical Director, and Pharmacy Director as needed. Repeated non-compliance and failure to successfully complete corrective action plans will be grounds for termination.

e. Provide a description of the Vendor's approach for ensuring Network Providers are providing Trauma-informed Care to Kentucky SKY Enrollees.

Trauma-informed approaches and care are foundational to WellCare's Kentucky SKY program. While all involved in the child's care must be educated and trained to use trauma-informed approaches – including all our Enrollee-facing staff, DCBS and DJJ staff, foster and adoptive parents, fictive kin, biological parents, and other stakeholders – the providers treating the child or youth carry a uniquely important responsibility for delivering trauma-informed care. Our multifaceted approach to ensuring providers are providing trauma-informed care includes the following components.

CONTRACTING WITH PROVIDERS WITH EXPERTISE IN TRAUMA-INFORMED APPROACHES

Our network already includes providers with experience using evidence-based trauma-informed care approaches as described in detail in our response to Question G.6 Provider Network. As we build out our Kentucky SKY network, we are approaching network adequacy not just in terms of number of providers, but in terms of having the right providers with the right expertise to meet this population's needs.

Our Network Development team is identifying additional providers not currently contracted with us who have trauma expertise through asking about their trauma-informed care experience as part of the credentialing process. We are also asking our community partners such as Kentucky Partnership for Children and Families and the Kentucky Foster and Adoptive Care Association to help us identify trauma-informed providers that are not already in our network. We will outreach to identified providers and attempt to contract with them.

EXPANDING AVAILABILITY OF TRAUMA-INFORMED TREATMENT

WellCare knows from our experience serving the Kentucky foster care population that availability of trauma-informed providers is limited, particularly in more rural areas of the state. We are making efforts to transform and expand evidence-informed treatment throughout Kentucky.

We will model our efforts on our experience expanding availability of mobile crisis response, crisis stabilization, and other services that are not always readily available in every community in order to prevent out of home placements for youth living with caregivers in a community setting. Our most recent example, which we implemented June 1, is our crisis service expansion with LifeCare Family Services, a provider in Tennessee. WellCare has contracted with LifeCare to expand into the border area to increase availability of rapid response services to children and families in their natural environment using a strength-based approach with creative, flexible solutions. Using this experience as a model, we will identify providers in bordering states with trauma-informed expertise and work with them to expand services and service sites into Kentucky.

ASSESSMENT OF TRAUMA INFORMED PRACTICE

Using the National Child Traumatic Stress Network framework for trauma informed health care, we will work in collaboration with DCBS, the Kentucky Partnership for Children and Families, the University of Louisville Kent School of Social Work, and our providers and community

stakeholders, to develop a checklist for trauma-responsive care. This tool will include indicators that the provider understands and is implementing trauma-responsive care, such as:

- Child-friendly waiting areas and exam rooms
- Use of ACE assessments, trauma, PTSD and other behavioral health screens
- Use of seclusion or restraint
- Initial and continuing trauma-informed care education for office staff, nurses, and physicians.
- We will also use our credentialing and recredentialing processes to systematically identify provider resources with formal training in areas of trauma-informed care, the use of behavioral health assessment instruments, and the use evidence-based practices like trauma-focused cognitive behavioral therapy (TF-CBT), dialectical behavioral therapy (DBT), parent-child interactional therapy (PCIT), rapid eye movement desensitization and reprocessing (EMDR), and others. We will identify areas of subspecialty focus include sexual abuse, physical abuse, domestic violence, human trafficking and others. This drill down on expertise available in network will help us direct children and youth to providers that offer key evidence-based approaches for treating trauma.

PROVIDING COMPREHENSIVE PROVIDER EDUCATION AND TRAINING ON TRAUMA-INFORMED CARE

As described in detail in our response to Question G.8 Provider Training, our Healing Futures program is a comprehensive approach to educating and training the system of care about trauma, its effects, and evidence-based approaches for interacting with and providing treatment to children and youth who have had Adverse Childhood Experiences. To increase the trauma expertise of our overall network, we will provide training through our Provider Relations team via in-office meetings and group sessions, and through on-demand webinars and downloadable training materials on our Provider portal.

PROVIDING INCENTIVES FOR COMPLIANCE

To encourage providers to improve their ability to provide trauma informed care, our Delivery System Transformation work will include offering enhanced reimbursement for providers who are or become Trauma Informed Care practices. We will identify our Trauma Informed Care practices and connect Enrollees to them as Preferred Providers. This will include identifying those that have obtained training and/or certification beyond WellCare's Healing Futures trauma training.

REGULARLY MONITORING AND TAKING ACTION TO ENSURE COMPLIANCE

Our monitoring of individual providers as well as network trends in compliance with trauma-informed care guidelines will follow the processes outlined previously in our response to Question G.10.d above. Our QPA and METS teams will provide high-touch technical support when we identify providers that need assistance and when providers request additional support. This will include development of Individualized Provider Quality Plans. Our QPA team will use the checklist tool described above to assess provider progress meeting performance expectations, readiness for change, and capability to implement changes. This analysis

determines a baseline for provider performance and informs development of an individualized approach to improving trauma-informed and responsive care for key providers. We will implement corrective action, up to and including termination, for repeated non-compliance and failure to improve.

f. Describe how the Vendor will use telemedicine and telehealth to improve quality or access to physical and Behavioral Health services.

WellCare of Kentucky will leverage our telemedicine and telehealth capabilities to improve access to quality physical and behavioral health services for our Enrollees through new initiatives that make it possible for children and youth to receive care directly from the foster home, school, or facility that best suits their needs and at the convenience of their family, guardian, or foster parent. To support this approach, we will leverage WellCare Health Plans' model of services, including their national telemedicine/telehealth experience, resources, and suite of progressive mobile health applications that engage Enrollees in self-directed care and computerized cognitive behavioral therapy (cCBT).

With the passing of Senate Bill 112, which expands telemedicine/telehealth capabilities and the payment parity model, we can apply a more progressive strategy that facilitates expanded access to services for children in foster care, adopted children, and those in involved in the justice system through the Department of Justice (DJJ). For example, at WellCare's Florida health, we adapted quickly to the new direct-to-consumer model, engaging providers across the state to rapidly build an enhanced telemedicine/telehealth network for Enrollee access to primary care physicians (PCP), specialists, and behavioral health providers. Since Florida transitioned to a direct-to-consumer state, more than 5,000 Enrollees at our health plan have accessed telemedicine services.

Today, our providers, local Community Mental Health Centers (CMHC), and Federally Qualified Health Centers (FHQC) already use telemedicine/telehealth to connect their Enrollees to specialists and behavioral health providers, such as psychiatrists and mental health counselors, to help address their patients' whole-person needs. **In 2018, we paid claims to providers for over 6,800 telemedicine/telehealth services for over 20 different types of services.** The following section describes our approach for increasing access to services in the Commonwealth.

STRATEGY TO DRIVE NEW PROVIDERS TOWARD NEW TECHNOLOGY AND METHODS

Often, children in foster care experience multiple transitions to new foster homes or facilities in different regions of the Commonwealth, which makes it difficult to provide a consistent healthcare experience supported by a reliable PCP and multidisciplinary team (MDT). We believe that telemedicine/telehealth capabilities will help children in the foster care and justice systems, as well as adopted children, and biological parents working toward reunification have access to a team of physicians capable of providing long-term, consistent support. This continuity allows Enrollees to maintain relationships with physical and behavioral health providers, as well as other specialists critical to their stabilization and well-being.

Understanding the Environment. As an active participant in the Kentucky Health Telemedicine Network (KTHN) board meetings and the SB 112 Task Force, our team has contributed

recommendations regarding telemedicine/telehealth services, as well as methods for promoting its use by both providers and our Enrollees. We understand the local environment and DMS's vision for expanding these capabilities. As the KTHN Board transfers oversight of telemedicine/telehealth policy to the Cabinet of Health and Family Services (CHFS), we will continue to provide recommendations upon request as to how we can better serve the whole-person needs of all Enrollees, regardless of where they live.

Education to Inform Providers of the Direct-to-Consumer Model. Moving forward, our outreach efforts will introduce our providers to the new direct-to-consumer model, which will facilitate medical appointments for our Enrollees' physical and behavioral health needs from anywhere an Enrollee and their foster parent, family member, or guardian has access to an internet connection and video camera capabilities. Our SKY Provider Engagement Team and SKY Provider Liaison will proactively identify and meet face to face with providers, PCPs, and pediatricians to support enabling their facilities for these services. This process includes educating providers on the logistics, payment options, eligibility, technology, implementation, and best practices involved, coverage policies, and the benefits of telemedicine/telehealth for both Enrollees and providers. To facilitate an easy transition, we will educate them on the documentation and billing process to support DMS's new required billing fields and modifiers that identify the originating and recipient sites. We explain potential increased revenue resulting from preventing appointment cancellations and the potential opportunity for increased reimbursement from offering non-traditional appointment times.

Ongoing education includes in-person presentations in a variety of forums such as breakout sessions at our annual Provider Summits; on both our public website and the provider portal; and through our popular bi-weekly Webinar series. We will also coordinate services with the Fee-for-Service (FFS) program for Enrollees who can benefit from telemedicine/telehealth services in the local schools.

Provider Contracting. We are confident that our network of more than 33,500 providers caring for our population of approximately 8,100 children and adolescents in foster care throughout the Commonwealth will increase access to healthcare services for our SKY Enrollee population. To accommodate the needs of the Kentucky SKY program, we will be contracting with private child care providers not currently supporting Medicaid. In addition, we are identifying, partnering, and contracting with specialty providers to expand access to specialty services (e.g., applied behavioral health analysis, neuropsychology, trauma therapies, and mobile crisis). Telemedicine/telehealth technology will ensure access to these services, making them available when and where an Enrollee needs the service.

FACILITATING ACCESS TO TELEMEDICINE/TELEHEALTH FOR SKY ENROLLEES

As the telemedicine/telehealth landscape undergoes a progressive transformation in the Commonwealth, we will educate Enrollees and their foster parents, guardians, or adoptive parents on how that affects the way they receive care. Described below, our approach includes new initiatives developed for the SKY program that will facilitate better access to healthcare services for our Enrollees.

Technology Agnostic Software. We will be implementing a comprehensive education campaign to our providers, as well as families and schools in the Commonwealth to increase the adoption of telemedicine/telehealth services. With the advances in the telemedicine/telehealth industry, providers are securing affordable solutions to extend their reach of care. By encouraging our contracted providers to use a platform of their choosing without limiting their options, we enable them to provide services for all their Enrollees—not only those managed by WellCare of Kentucky. This method helps connect foster children and youth to behavioral health clinicians, PCPs, follow-up care, and specialty providers from the comfort and convenience of their home. As needed, we will work with DMS and DCBS to facilitate a device to foster parents if they do not have a laptop, device, or smartphone in the home.

This will help relieve the burden of transportation and time spent driving children or multiple children, as is often the case in a foster home, to and from medical appointments. Our care coordinators will assist foster parents, parents of adopted children, and families or facilities supporting youth in the justice system throughout the set-up process, which includes downloading the dedicated application based and enabling unique log-in information for each child. If a foster parent supports more than one child in the household, they will be provided with a unique log-in for each of the children in the home. Whenever a child transitions to a new home environment, the account is deactivated, and the foster parent will no longer have access.

Care Coordination. Using technology-enabled solutions such as telemedicine/telehealth improves communication among members of the Enrollee's multidisciplinary team (MDT), which is crucial to the care coordination process. By leveraging the proven, secure web-conferencing software of their choosing, providers can participate in calls, discharge planning, and transitions of care without leaving their office. This process allows family members, guardians, providers, and representatives from DCBS and DJJ to participate in meetings from any location. In addition, many of our providers and CMHC partners currently use this technology to connect Enrollees in the provider's office to specialists such as mental health counselors and psychiatrists. We will help expand this model by coordinating Enrollee care that maximizes the efficiency of their medical appointments and increases convenience for the Enrollee, MDT, and supporting foster parent or family member. For example, a child or youth in the foster care system must visit an LHD in person to receive their immunizations. We envision a model of support where the LHD and our care coordinator schedule additional medical appointments with their pediatrician or mental health counselor to be conducted during their visit using telemedicine/telehealth capabilities. For these collaborations, we will reimburse the presenting site as well as the consulting site. LHDs already provide care to our Enrollees, but we envision using them in this scenario as conduits to specialty care. As LHDs are located statewide (in all 120 counties), this will be especially beneficial for our Enrollees in rural areas.

WellCare Hotline Tele-Visit Routing. Our Nurse Advice Line (NAL) provides 24/7 support for our Enrollees' medical needs with qualified physicians, physician assistants, licensed nurse practitioners, and nurses. Our Behavioral Health Services Line provides crisis support, de-escalation, and guidance to either the Enrollee's care coordinator, PCP, emergency department, or local urgent care center depending on the severity of the issue. Our qualified staff will be trained on specific SKY Enrollee protocols for handling their calls and initiating next steps. For

example, if an Enrollee calls and needs assistance with a non-emergent issue, we will help initiate a real-time tele-visit with their provider to diagnose, treat, manage, and prescribe any necessary medications on the spot. This new initiative will ease the burden of foster parents caring for a sick child or who do not have access to a nearby healthcare facility.

In addition, regardless of whether or not an issue is immediately resolved, our SKY Enrollee guidelines dictate that the service line representative will immediately contact the care coordinator for follow-up care within 24 hours. All services will be outlined as part of the initial care plan, created within 30 days of the Enrollee's enrollment and identified as part of the care coordination plan—both created with DCBS and DJJ permission for all identified services.

Specialized Treatment Therapies. We will help coordinate the care and appointments for Enrollees who require access to specialized treatment therapies that often require several months of waiting to attend a scheduled appointment in the local region due to physician shortages. Enrollees will have access to psychiatrists and talk therapists specializing in CBT, as well as additional specialty providers and treatment therapies typically not readily available, as described in **Table G.10-4.** This may also include psychiatrists, child psychiatrists, child psychologists, pediatric neurologists, neuropsychologists, applied behavioral analysis specialists, speech therapists, as well as second opinions and other specialists required for consultation on medically complex cases.

Table G.10-4 Access to Specialty Providers

Enrollee Access to Specialty Providers through Telemedicine/Telehealth	
Certified Juvenile Sex Offender Treatment Providers	Through meeting with a certified juvenile sex offender treatment provider, an Enrollee receives a full risk assessment that identifies the potential for future acting out and determines the appropriate level of care—taking into consideration the safety of the individual, those around them, and the community. Often, young children act out because they are dealing with trauma and do not know how to process it on their own or correct their behaviors. The treatment provider highlights areas of concern and develops a focused treatment intervention based on a specific model of care for the entire MDT to follow. The intervention addresses the Enrollee's behaviors, pre-behaviors that occur before acting out, situations to avoid, and steps for the child or youth to take to understand the different stages in the thinking and behavior process that lead to acting out. Because these children are often simply living out their trauma, it is not always necessary for them to be admitted to residential treatment, which is why telemedicine/telehealth services can help bridge service gaps for Enrollees who require a lower level of care. This specialized training is a critical need for a child or youth dealing with the emotional difficulties of trauma and requires learning correct behaviors from a trusted professional.
Neuropsychological Testing	A specialized set of psychological examinations, neuropsychological testing identifies whether or not a physiological cause may be responsible for an Enrollee's intellectual or developmental disability or issue. This helps the care team determine if the issue can be addressed through therapy or if it

Enrollee Access to Specialty Providers through Telemedicine/Telehealth	
	requires more extensive treatment from a neurologist or other behavioral health specialist.
Applied Behavioral Health Analysis (ABA) Testing	A specialty model of care, providers certified in ABA provide specialized behavioral health interventions, functional analysis, and identify an individual's behaviors and the associated functions behind those behaviors. Once behavioral triggers have been identified, the ABA provider develops a behavioral intervention plan that is then taught to the foster parents, families, or guardians of the child so they can intervene before a negative behavior occurs. Instead, the child learns a new behavior and a better way of interacting with the world around them. ABA specialists are in high demand, with long wait lists that can prevent children and youth from receiving the high-level of care and attention they require and deserve. It is our goal to bridge this gap through telemedicine/telehealth services
Substance Use Disorder (SUD) Treatment Providers	We will facilitate access to SUD treatment providers for Enrollees, enabling them to receive therapy and counseling from the convenience of their home. We plan to promote (to providers and Enrollees) the option to use telemedicine/telehealth for the counseling and psychotherapy component of SUD treatment when outpatient services have been identified as the most appropriate level of care.

Remote Clinical Monitoring. For Enrollees with diabetes, asthma, or hypertension, remote clinical monitoring provides feedback between Enrollees, foster parents, families, guardians, providers, and care coordination staff. For example, remote clinical monitoring capabilities for diabetes facilitates coaching and support for testing blood glucose levels at home, as directed by the Enrollee's provider team. Using remote clinical monitoring equipment, data continuously transmits to the child's provider and WellCare of Kentucky's care coordination staff. Enrollees, foster parents, guardians, care coordinators, and providers receive early-warning alerts when an increase in symptoms occurs (e.g., blood glucose levels rise), enabling a quick response through Enrollee outreach and follow-up care to address the issue. Care coordinators use this information while working with the child, foster parent, family, guardian, and the treating provider to develop personalized program goals and update the care plan. We provide pre-visit reports, which contain actionable information about their current diabetes self-management, and access to Fit4D, a self-management support tool for youth and adolescents managing Type 1 and Type 2 diabetes. Additionally, we issue provider alerts for urgent issues such as a significant increase in symptoms or blood

Supporting Enrollees in the Home

Remote clinical monitoring results in healthier Enrollees, reduced utilization, and decreased medical costs. Applied nationally throughout WellCare's health plans, the biometric monitoring program shows that Enrollees with diabetes improved Hemoglobin A1c compliance rates from 7.54% to 15.45%.

glucose readings outside of the target range. We provide similar monitoring and alerts for asthma related to medication use and adherence.

Store and Forward Model. WellCare of Kentucky intends to embrace the "store and forward" telemedicine/telehealth option. This option can be used for radiology consultations (CT-scans, MRIs, MRAs, X-rays) in which a clinical expert reviews the given image and provides an assessment to the provider who is treating the Enrollee. The consult can occur while the Enrollee is still present in the treating provider's office or later at a more convenient time for both the treating provider and the clinical/radiology expert.

SUPPLEMENTAL MOBILE HEALTH APPLICATIONS FOR SELF-DIRECTED CARE

WellCare of Kentucky will provide our Enrollees, foster parents, guardians, and families with access to our suite of mobile health applications that engage Enrollees in self-directed care and computerized cognitive behavioral therapy (cCBT).

JOOL Health Coach. Last year, we collaborated on a new program for our foster care youth with JOOL Health Coach, a personal coaching smartphone application that encourages youth to check in with their peers and engage in healthcare services. With tailored tracks specific to different populations, Enrollees have access to a transition-aged youth pathway for those with SUDs. JOOL includes SUD assessments, resources, and referral information to help youth and their families easily learn about their SUD and the local treatment options available in their community. To date, over 100 youth to date are enrolled.

MyStrength. An online, evidence-based behavioral health therapy platform, depicted in **Figure G-10.4**, MyStrength provides our Enrollees with interactive clinical programs empowering them to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges, while also supporting the physical (e.g., smoking cessation, diabetes) and spiritual aspects of whole-person care. MyStrength's integrated model includes computerized cognitive behavioral therapy (cCBT), mindfulness, motivational interviewing and Assertive Community Treatment (ACT) protocols with personalized pathways that facilitate user interaction, mood trackers, and additional tools to measure effectiveness and improvement.

MyStrength has shown the following benefits upon implementation: a 43% rapid symptom reduction within the first two weeks of engagement, 83% as effective as face-to-face therapy at a fraction of the cost, and a 70% cost reduction in total paid claims for Enrollees.

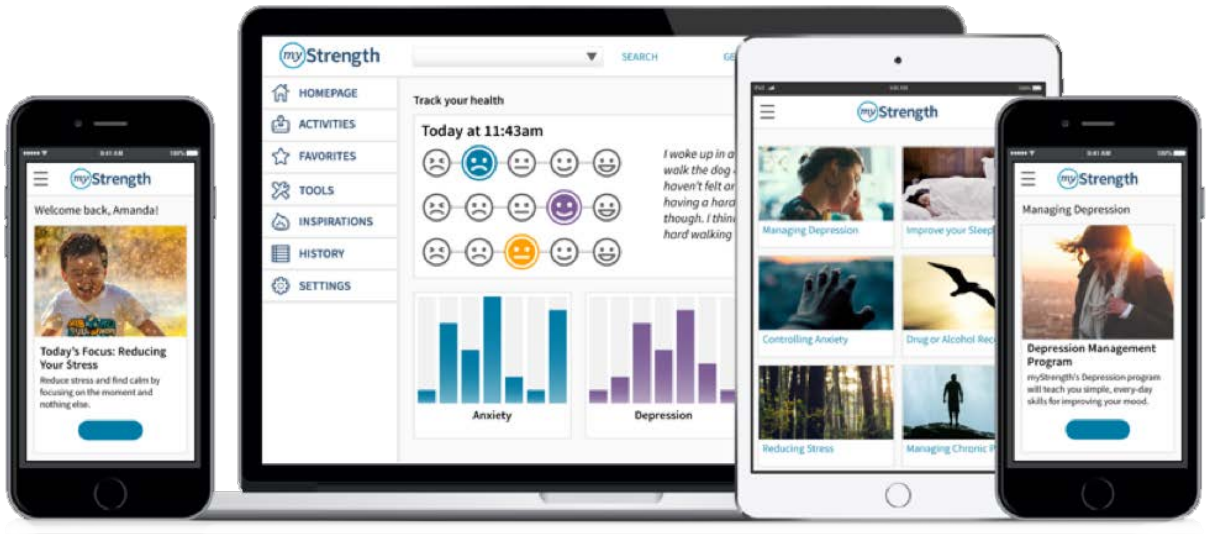

Figure G-10.4 MyStrength Behavioral Health Therapy Platform

AbleTo. The AbleTo program is a virtual CBT solution providing weekly coaching sessions with a coach and professional therapist to handle the behavioral health components of co-morbidities. The team helps the Enrollee set goals and build a program tailored to their personal needs. Coaching sessions occur twice a week at a time convenient to the Enrollee.

Fit4D. Supporting youth and adolescents with Type 1 and Type 2 diabetes, Fit4D is a support tool that includes chat messaging and push notifications. Through personalized education and coaching services, Fit4D supports Enrollees by teaching self-management behaviors and guidance for following treatment and care plan recommendations, as well as participating in preventive services. Health coaches speak to both the guardian and the Enrollee, or for older participants, help supplement diabetes treatment and education as Enrollees learn to manage treatment on their own.

MAP Health Management. This tool provides mobile peer support for SUD. MAP is a national vendor that matches Enrollees with a peer with the same lived experience as they go through detox and need support for their triggers. Addiction is a chronic disease – MAP's peer recovery support services extend the care continuum to match the chronic nature of the disease.

- Improve long-term engagement across SUD Enrollee populations to facilitate early intervention, motivate Enrollees to seek treatment when appropriate, reduce the impacts of relapse, and direct care needs such as readmission when appropriate
- Reduce out of network utilization for SUD treatment
- Capture and report on longitudinal outcomes data, including social determinants of health, on SUD populations and treatment programs.

This 24/7 recovery support solution matches a peer with the same 'lived experience' to an Enrollee in need. We understand that Enrollee engagement is key to recovery success, which is why providing this real-time, 24/7 access to support and ability to triage for additional services is critical. This connectedness helps Enrollees feel less alone and isolated.

g. Describe how the Vendor will capture data related to Social Determinants of Health and incorporate this information into its Care Management approach.

Social determinants of health are a well-known factor in health outcomes for Medicaid Enrollees. Enrollees in the Kentucky SKY population share the social determinants needs of other Medicaid populations. For example, Enrollees over 18 may need assistance with housing, job skills training, secondary education, and connection to food pantries and completing SNAP applications.

However, there are important nuances to SDOH needs among Enrollees in the foster care and juvenile justice systems, listed in **Figure G.10-5**, that require differences in approach.

UNIQUE CONSIDERATIONS FOR SOCIAL DETERMINANTS OF HEALTH WITHIN THE KENTUCKY SKY POPULATION

Foster family SDOH needs must be considered and addressed in order to meet the child's needs, which may change when their placement changes. For example, a foster family with only one foster child may easily be able to afford clothing and shoes, school uniforms and supplies, and activity fees, while the subsequent foster family with lower income and multiple foster children in their care may need assistance with these needs. Foster families may also need assistance securing needed items for a child placed in the home late in the evening when stores are closed.

This population has distinct SDOH needs related to the risk factors arising from Adverse Childhood Experiences, which may result in delinquency and violent behavior. Engaging SDOH resources can promote "protective factors" that mitigate those risks such as through supporting relationship development and strengthening a child's sense of belonging. Examples include providing transportation to school sporting events and fees for clubs and teams to encourage peer relationships and community involvement. Other protective factors can be supported through facilitating a child's sense of mastery. For example, assisting a child to continue with art lessons when her placement changes may foster her perception of her own self-efficacy as her drawing skills improve, as well as provide continuity through other changes in her life.

Trauma can impact a child's ability to connect with new people and adapt to new situations, and repeated placement changes that require the child to start over with foster family, school, and friends can result in secondary trauma. The ability to "be a normal kid" is vital to their well-being and striving to maintain continuity through placement changes is a key social determinant. For a child whose placement change moves them out of their previous neighborhood school boundaries, paying for additional transportation can enable the child to continue at that school with current friends and sports or other extracurriculars.

Figure G.10-5: Unique SDOH Considerations for Kentucky SKY Population

As described below, we assess and capture data about Enrollee SDOH needs and incorporate that data into the case management process using an approach that recognizes these and other important distinctions.

CAPTURING DATA

We capture data on Enrollee SDOH needs through the assessment process, coordination of care, and ongoing monitoring of Enrollee utilization. We also capture data on Enrollee referral to and use of external resources to meet SDOH needs. In addition, we collect z-codes to help us further pinpoint and track SDOH needs among our membership. All data is captured in CareCentral. Data generated through the case management process is captured in the Enrollee's record, while z-codes are captured in the claims system. CareCentral integrates both types of data so that we have a full picture of each Enrollee's needs, use of SDOH resources, and outcomes, and are able to trend to evaluate population needs and the effectiveness of our SDOH approach.

Data Captured Through the Case Management Process

WellCare's assessment process includes a comprehensive SDOH assessment which helps us identify underlying barriers to an individual's progress towards positive health outcomes. We have adopted the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation's Accountable Health Communities Health-Related Social Needs (HRSN) Screening Tool. This tool provides ten simple questions that ask about living situation, food, transportation, utilities, and safety. For foster and adoptive parents and for Enrollees age 17 and older, we use the additional supplemental questions that ask about financial strain, employment, family and community support, education, physical activity, substance use, and mental health. The tool gives us an overall view of an individual's needs and allows us to identify areas which require further assessment to identify types and intensity of needed support.

For our traditional Medicaid Enrollees, the assessment is performed by our Community Connections Help Line (CCHL) team when an Enrollee calls the Help Line. However, to facilitate relationship-building with our Kentucky SKY Enrollees and ensure that our staff who are responsible for quickly pulling together a care plan and ensuring continuity when a child comes into care, the assigned Care Coordinator and CCT will complete the SDOH tool during initial assessment, at every placement change, and during transition planning for Enrollees aging out of care and/or the Kentucky SKY program. In addition, we screen for new or changed SDOH needs at every Enrollee/caregiver contact and through regular communication with the child's DCBS and DJJ caseworkers. Care Coordinators complete the tool electronically via tablets which connect securely to CareCentral and populate the information into the Enrollee's CareCentral record.

We use a 'close the loop' process that ensures services are being received and that they are having the desired impact on clinical and permanency goals.

We also capture data through care coordination and monitoring. Care Coordinators are alerted to potential SDOH needs during interdisciplinary rounds, discharge planning, and coordination with DCBS and DJJ. Staff document these needs in the CareCentral record and address them as described below. In addition, ongoing monitoring of service utilization can identify gaps or inappropriate utilization that suggests the presence of an unmet SDOH need, such as missed appointments that may indicate the foster parent lacks transportation or child care for other children in the home.

We identify service needs and interventions for the Enrollee's care plan based on all information and data captured through claims, ongoing assessments, patient rounds, discharge planning, and case monitoring. The Care Coordinator ensures the care plan is communicated with the Assessment and Care Teams for implementation. The Care Coordinators document the resources provided in the Enrollee's CareCentral record, which tracks and analyzes services utilized all the way through disposition. This facilitates our 'close the loop' referral and connection process. We recognize that if one Enrollee is experiencing a SDOH need, other Enrollees may also be experiencing the same SDOH need. This process allows us to maintain a living data set of information around community resources and needs that is continually analyzed and trended to evaluate overall efficacy.

SDOH Data Generated by Providers

WellCare currently receives ICD-10 Z-codes on provider claims. We will educate providers on their use to identify social barriers for the Kentucky SKY population. Monthly, we will generate a report for the CCT to review with summary information and Enrollee detail that allows drill-down by assigned Care Coordinator and by Enrollee. Care Coordinators will work with our trauma-trained Community Action Team to outreach to the Enrollee/family to address the unmet social resource need, documenting all additional identified needs and the resources provided in the Enrollee's CareCentral record. Additionally, our Community Action Team will review the report, which will identify SDOH "hotspots" where specific types of needs appear particularly prevalent. The Community Action Team will engage our local partners in the area to develop solutions to address any gaps in available resources.

Our CommUnity Connections program works locally to meet family resource needs at any time of the day or night. Kentucky SKY Enrollees and families can call our toll-free CommUnity Connections Help Line 24/7 for help from a trauma-trained Peer Support Specialist who will connect them to social services in their communities.

WellCare has established strong partnerships with Providers across the state to promote the Community Connections Help Line within their practices for SDOH data collection. The Community Connections program uses data collected through CCHL calls to invest back in the community where gaps are located and support high referral agencies to ensure continued services are accessible in the community. The support the CCHL offers to Providers across the state allows them to focus on identified medical or behavioral health needs while Enrollees are in their office for appointments, instead of social resource needs.

Enrollee-Generated SDOH Data

WellCare has collaborated with JOOL Health to offer a one of a kind smartphone-based application that promotes health engagement and personal well-being. The application captures Enrollee-entered data for factors (such as health and life engagement, willpower/self-control, and resilience) that are impacted by ACEs and protective factors as described above, providing insight into SDOH needs.

The JOOL Life Coach (described in more detail in response to Question G.12 Aging Out Services) is aimed at engaging and improving purpose in life of transition aged youth. Among other features, the app provides a Purpose Composer, which asks the youth to identify four purposes: a personal purpose, a family purpose, a work/school purpose and a community purpose. An example of a school purpose could be "I want to be on time to school every day and exceed the expectations of my teachers".

It also has a charting feature that allows the youth to track daily alignment with their purpose; sleep, presence, activity, creativity and eating (SPACE); and personal outcomes. After ten days of charting, the application begins to give interactive visuals of what factors impact S.P.A.C.E., willpower and the Enrollee's outcomes the most. After fifteen days of charting, the application begins to forecast S.P.A.C.E, willpower and personal outcomes and then provides tips to improve the outcome.

The app stores the Enrollee inputs and charting data, which can then be used by the youth and the Care Coordinator to identify SDOH needs and evaluate efficacy of accessed resources. These identified needs and outcomes are captured by the Care Coordinator in the EHMR.

INCORPORATING SDOH DATA INTO CARE MANAGEMENT APPROACH

In 2008, WellCare was among the first Medicaid Managed Care plans to fully integrate social service needs into our care model and operations. Through our Community Connections, depicted in **Figure G.10-6**, we proactively identify Enrollees with unmet social service needs, remove barriers to appropriate access and healthy lifestyles, and build strong community partnerships we can leverage to benefit Enrollees and families. Since launching our Community Connections Program in Kentucky, we have connected 31,000 people to 165,000 services across the Commonwealth. A **Robert Wood Johnson Foundation study documented a 53% reduction in inpatient spending among individuals who accessed a social service through our Community Connections.** We continue to invest in new technology, training, and operations to enhance our model and our ability to identify and address social barriers to health. We will apply this model to the unique needs and barriers of the Kentucky SKY population, integrating the SDOH data we capture into the case management process to improve health outcomes and support the child's permanency goals.

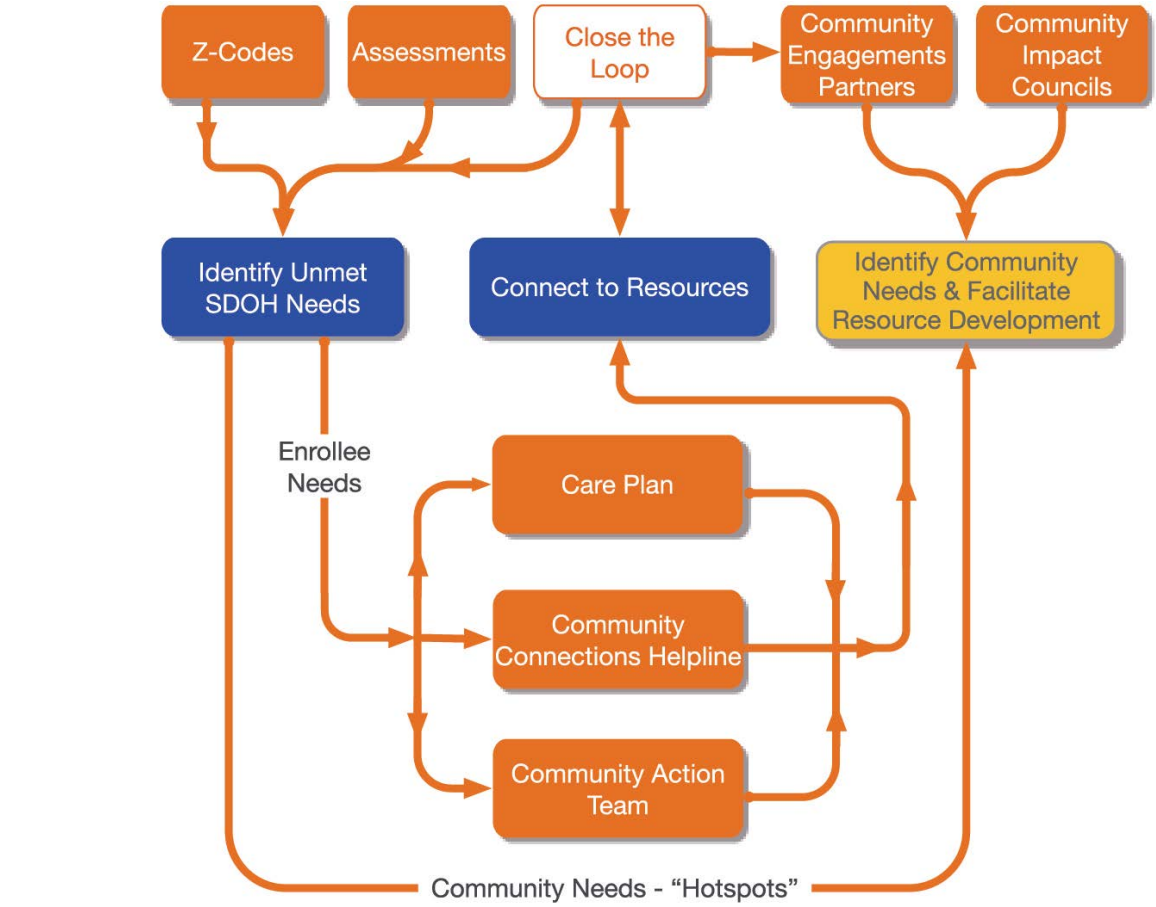

Figure G.10-6: Community Connections

Assessment and Care Planning

SDOH data is a fundamental part of the care planning process and supporting the permanency plan. All information we capture about SDOH needs is incorporated into care plan development and revision to ensure a holistic approach. Using Motivational Interviewing, the Care Coordinator helps the Enrollee and caregiver set goals for each identified need and develop an action plan that supports goal implementation and permanency goals. The Care Coordinator works with the MDT to review identified SDOH needs in the context of other information gleaned from the comprehensive assessment (including medical, behavioral, oral, and other health needs), Enrollee and caregiver goals, as well as the child's permanency goals. We are currently in discussions with DCBS to participate in meetings with their Independent Living Specialists to assist in identification of and addressing SDOH for transition age youth.

> **Exposure to ACEs increases risk for delinquent behavior and future adult offending but engaging SDOH resources can help promote many "protective factors" that can mitigate this risk.**

All care plans address SDOH needs including but not limited to needs such as:

- Housing
- Financial assistance such as for utilities
- Social, such as after school activities, academic and school clubs, sports participation
- Educational, such as academic support, GED, support for secondary education
- Job skills/job search support
- Food insecurity
- Clothing
- Interpersonal safety
- Social transportation
- Cultural and spiritual needs

The care plan describes the Enrollee's psychosocial needs and how such needs will be addressed to ensure the Enrollee's ability to live safely in the community and to support the permanency plan. The focus of the care plan is on what the Enrollee and family believe are important and the goals they set. We have found that Enrollee and family goals are often tied to a social determinant of health. Addressing SDOH needs is key to being successful at overall goal obtainment and progress toward good health.

Once SDOH are identified and incorporated into the care plan, the Care Coordinator and CCT uses our proprietary Navigator database to identify local resources and actively connect the Enrollee and caregiver to the SDOH resources identified as needed. Navigator catalogues local social services provided by community and faith-based organizations across Kentucky. In addition to support provided by the CCT to identify and connect to SDOH resources, Enrollees, caregivers, foster and adoptive parents, and DCBS and DJJ may access our CCHL via toll-free number or website at any time for assistance accessing the nearly 330,000 Kentucky resources listed to mitigate the Enrollee's and family's social barriers to health. All CCHL staff will be trained on trauma and the Kentucky SKY program.

If services were not able to be accessed for any reason or if different or additional resources are required to meet goals, the Care Coordinator refers the Enrollee to a new resource or coordinates with our Community Connections field engagement team to locate or create the needed resource. Currently, our Community Connections team is leading all WellCare markets with over 30,000 Enrollee referrals through our database. Our Community Connections teams work closely with our local **Community Engagement Partners** to help Enrollees quickly access local resources as well as to identify gaps in local resources that WellCare can help address.

WellCare's Community Connections Community Engagement Partners are individuals across the Commonwealth who are active on local boards of directors, county coalitions, and interagency workgroups. Our Care Coordinators regularly connect with them on new resources available and to troubleshoot barriers our enrollees face. Care Coordinators can often reach out immediately through these personal connections to facilitate rapid enrollee access to a needed community service.

Developing and Supporting Resources to Meet Enrollee Needs

As part of our population health management approach, we continually track and trend data to identify the needs of our enrolled population. This includes using SDOH data to identify our Enrollees' needs for social services that support their health and well-being outcomes. For the Kentucky SKY population, we also use SDOH data to evaluate population needs to support stability and permanency. We combine our SDOH data with public health surveillance data to create a complete picture of the Kentucky social service landscape, target our efforts to support local resources, and identify gaps.

Table G.10-5: Examples of Partnering with the Community to Deliver SDOH Resources

Roo's Wish	Roo's Wish provides clothing and other items needed by hospitalized foster and adopted children due to weight changes during their treatment. This support will allow these children to feel a sense of autonomy and empowerment as they are able to make decisions in selecting the items that they need. This will in turn work towards improving their self-esteem. We provided funding for items for our Enrollees.
Hotel Inc	In Warren County, we leveraged nontraditional partnerships to increase access to healthcare for homeless and housing insecure individuals. We supported Hotel, Inc. in their partnerships with EMS of the Medical Center of Bowling, the Bowling Green Police Department, and the Warren County Sheriff's Department to locate and provide services to through Hotel, Inc.'s four homeless street teams. Volunteers included RNs, nurse practitioners, paramedics, and trained core volunteers who conducted wellbeing checks and health assessments in the field. When they identify our Enrollees, they alert us so we can engage the Enrollee in Care Coordination. This effort resulted in connections with over 2,200 homeless individuals (almost 13% were WellCare Enrollees). Of our identified Enrollees, 43% were referred to Care Coordination with 62% of them moving into safe and stable housing arrangements.

KY Coalition Against Domestic Violence	The Coalition's Purple Purse fund offers emergency assistance for domestic violence survivors who have an immediate financial barrier to a basic need. We have provided $20,000 in grant funding from 2016-2018 to support the fund in helping individuals deal with unforeseen expenses they cannot address on their own, such as a car breaking down or difficulty paying rent due to missing work when a child is hospitalized.

Our **Community Impact Councils** (CIC) are collaborative assemblies of community and civic leaders representing a broad spectrum of stakeholders including local social service agencies, faith-based organizations, public representatives, and service providers. The CIC is facilitated by a WellCare Community Engagement Partner. The CIC has been designed to identify health issues at a community level using key health data in order to identify ways to improve. Local CICs are strongly rooted in local communities and CIC membership typically includes individuals who have strong connections in their community, with social and financial capital connected to their community. One particular area of attention is the availability and sustainability of social resource organizations (also called the social safety net) that remove social barriers to accessing health care, with examples provided in **Table G.10-5**, above. Our goal is to understand the community's existing services, pinpoint the most urgent gaps, and collaboratively identify action steps and partnering opportunities to address those priorities while seeking creative ways to proactively sustain social resource organizations and their services in local communities. Please see **Figure G.10-7** for additional information.

Our SDOH data supports our work with these partners to:

- Identify gaps in local resources.
- Evaluate the efficacy of the local social safety network.
- Enhance and sustain the social safety net by sharing data with community partners to increase the available services through grants, advocacy, and the WellCare Community Foundation.

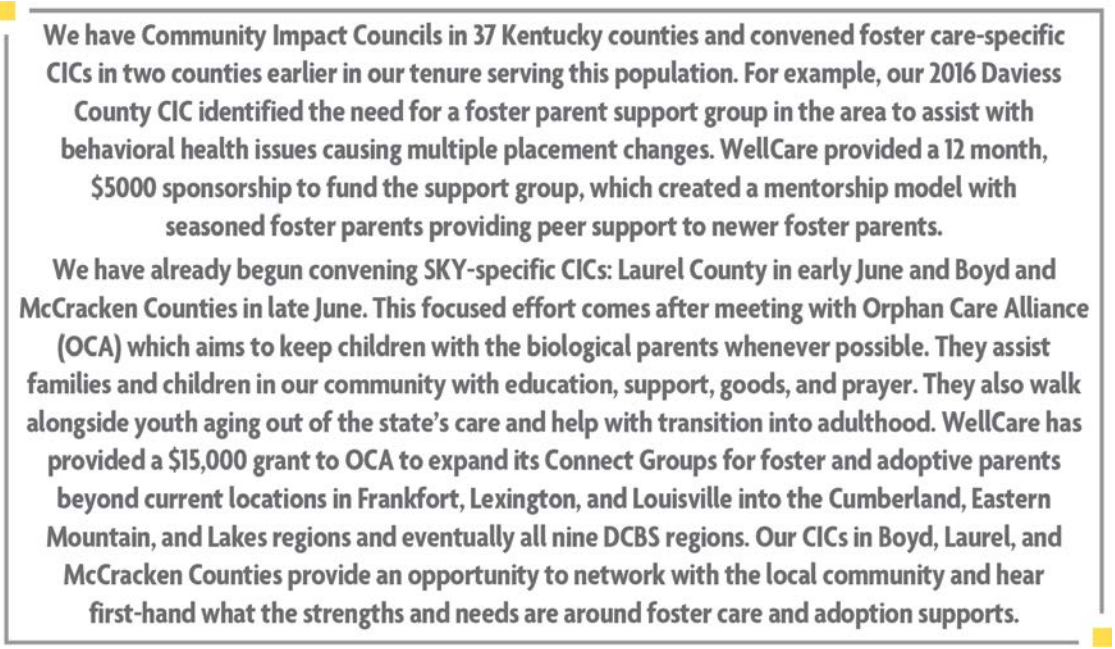

Figure G.10-7: WellCare Community Impact Councils

WellCare Works

A key example of an SDOH need for many Enrollees in the Kentucky SKY population is employment. This is a critical SDOH need for transition age youth and those who remain in the system until age 26. We have used SDOH data for our current foster care Enrollees to adapt and implement our WellCare Works program in areas where our foster care Enrollees with employment needs are located.

Building on research that indicates a strong link between improved health and social connectivity (including consistent employment), WellCare created WellCare Works to connect Enrollees to tools, training and other resources that promote social engagement and empowerment including:

- Preparing to test for a General Education Diploma (including reading, test prep, and more)
- Resume building and interview preparation
- Peer-based networking opportunities
- Training programs in multiple formats on several different topics including financial literacy, and more
- Facilitated access to:
  - On-the-job training opportunities
  - Community-based education and supported employment resources
  - Volunteer opportunities that can be used for networking or gaining applicable work experience
  - Community supports that help address social barriers to working like housing, transportation, affordable child care, and more.

Helping Enrollees Find Jobs and Create Housing Stability

Angela became homeless due to not getting enough hours at her housecleaning job. She reached out for help from Clean Start, a mission of Ashland Area Presbyterian Ministries which provides a one-stop shop for people in need. Through Clean Start, Angela was introduced to WellCare Works for job preparedness and placement support. WellCare Works provided her assistance in creating a resume and locating available jobs in her community. Today, Angela works with Kentucky Fried Chicken and has an apartment at Shelter of Hope while she seeks long-term housing. She has meaningful and sustainable employment, which is essential to creating and maintaining housing stability.

Because everyone connects differently, WellCare created these programs and tools to be accessed online, face to face (through our Welcome rooms for example) or telephonically. In addition, we have assembled a robust network of more than 190,000 resources (virtual, national, and local community based) to support our Enrollees and their families take charge of their personal health including social connectivity and employment.

We integrate WellCare Works with local employment resources targeted to areas where our job-age Enrollees are located. For example, we provided grants to Come-Unity Cooperative Care in Laurel County and The Gentry House Inc. in Calloway County for administrative support

and staff training on our WellCare Works platform. Their front line staff provided one on one support to our local Enrollees, including employment assistance and training on use of the WellCare Works platform. Through the platform, Enrollees can access multiple tools to learn, train, prepare, and secure employment and/or volunteer opportunities.

h. Describe how the Vendor will coordinate with DMS, DCBS, DJJ, and physical and Behavioral Health Providers to ensure each Provider has access to the most up-to-date medical records for Kentucky SKY Enrollees

Critical Enrollee Information To Support Providers

- Physical and behavioral health (BH) conditions and diagnoses
- Historical utilization of preventive, primary, and specialty care
- Prescribed medications
- Any ongoing course of treatment and treatment plans
- DME and medical supplies needed

Efficient provider access to up-to-date medical records is important for ensuring continuity of care for any population but is of critical importance for children in the foster care system, in which Enrollees frequently change placements, caregivers, and providers. To ensure continuity, avoid duplication, prevent gaps, and effectively address current needs, providers need as much information about the child's health and history as possible.

Once a child is enrolled with WellCare, our CareCentral health management system maintains a holistic record of the child's care and needs based on provider claims data, care plans, and other information we routinely collect as described in more detail in Question C.6 Management Information System. Providers will easily access this comprehensive data via the Medical Passport that will be available on the **WellCare Provider Portal** (Provider Portal).

The provider portal is our HIPAA compliant, web-based information sharing solution for providers, enabling authorized users to perform administrative functions (eligibility and benefits inquiry, claim and authorization submission, etc.) and communicate securely with WellCare staff via messaging and/or secure live chat. The Provider Portal offers access to the electronic health record for each WellCare Enrollee, comprised of a longitudinal view of medical, BH, and pharmacy utilization data, as well as Enrollee care plans, care gaps, and related care quality information.

The provider portal has proven to be an important offering for medical data sharing with our providers. However, a key lesson learned during our eight years serving Kentucky foster care Enrollees is that this solution is not sufficient for ensuring continuity through two critical transitions: 1) the child's entry into foster care, and 2) provider changes that result from placement changes or other factors.

To ensure continuity through both types of transitions, WellCare worked with DCBS and DJJ to develop an intensive approach as described below to coordinate with DMS, DCBS, DJJ, and physical and BH providers to ensure each provider has access to the most up-to-date medical records during each transition. We will work with all stakeholders to further enhance our approach and take Kentucky's foster care program to the next level in ensuring quality care for this vulnerable population.

COORDINATING UPON ENTRY INTO FOSTER CARE

Providers are often challenged to provide quality care when a child enters the foster care system because services must be delivered within a short timeframe and in many instances historical medical records are not available. Children and youth in foster care often have limited access to healthcare prior to entering the system and even children who have received care in the past often do not have a regular provider. This situation can severely limit availability of medical records, and even when records are available, they are often not up to date.
Below we describe our current process for coordinating with DMS, DCBS, DJJ, and providers upon a child's entry into care, along with enhancements we plan to make for Kentucky SKY.

Facilitation of Medicaid and WellCare Enrollment

Upon notification of a new child entering foster care from DCBS staff or via receipt of records in the enrollment file, our Care Coordinators work with DCBS to ensure that the child's application for Medicaid is completed and submitted to the DJJ Child Benefit Worker as quickly as possible. Our staff contacts the DJJ Child Benefit Worker to confirm the child has been entered into DMS' Medicaid Management Information System (MMIS) and is officially enrolled in Medicaid. Once the child's enrollment is confirmed, our Member Enrollment Team expedites the child's enrollment into WellCare.

Enhancements: WellCare plans to work with DMS and DCBS to create a mechanism that alerts us within 24 hours of a judge signing the court order for the child to enter foster care. This will allow us to begin the next steps of the process earlier (e.g. contacting prior MCOs and/or providers for current/historic treatment information). For example, our interoperable MIS can support secure receipt and processing of both HIPAA and non-HIPAA standard file formats, and we will explore with DMS, DCBS and DJJ the potential to receive automated notifications that can drive immediate workflows with our staff to ensure timely transitions for new Enrollees.

We will obtain medical records from the Kentucky HIE which we will leverage for early needs identification. Additionally, we plan to co-locate Care Coordination staff in each DCBS region to support close collaboration, including but not limited to accelerating our timely receipt of notification that a child is entering care.

Initial Care Coordinator Engagement to Obtain Records and Information

Our Care Coordinator initiates engagement within 24 hours of the child's enrollment into WellCare. The Care Coordinator contacts the DCBS case worker to obtain any information DCBS has for the child, including but not limited to CANS results and the medically complex designation and information (as applicable) from the Children's Commission. The information our Care Coordinator collects also includes any known providers and their contact information, as well as information that DCBS may have about ongoing care, services, and medications and urgent unmet needs of the Enrollee.

Enhancement: WellCare will co-locate FOCs and Care Coordinators at DCBS offices in all nine DCBS regions to facilitate quick exchange of information about the child's needs and care.

Outreach to Previous MCO and Providers to Obtain Records and Information

While the Care Coordinator engages with DCBS, our CCT determines whether the child was previously enrolled in Medicaid fee for service or another MCO. If the child was in FFS, our staff outreaches to DMS to request any information related to treating providers and ongoing services. We then outreach to any identified providers to request records. If the child was in another MCO, we outreach to the MCO and request the child's records and identification of any PCP and treating providers. We outreach directly to these providers to request records. Additionally, our staff reviews any records available through the Kentucky HIE to identify providers that have submitted data for the Enrollee, and outreaches to request records.

Enhancements: We will implement several enhancements to our current process.

- Using Provider Facing Staff to Support Record Gathering. We will leverage our Provider Relations Representatives (PRRs) and Quality Practice Advisors (QPAs) to enhance the medical and BH record gathering process. Our PRRs and QPAs have regular and frequent face to face and telephonic contacts with our providers and work with our CCT daily. Once our CCT identifies historic/current providers for new Enrollees, the CCT will notify the PRR and QPA assigned to that provider (if an existing WellCare network provider) to accelerate the receipt of key clinical data for the new Enrollee.
- Electronic Exchange of Prior MCO Historic Medical/BH Information. Our MIS can receive and process HIPAA standard encounter data (or other state-specific historic processed claims data formats). We will work with DMS and other Medicaid MCOs to receive this historic data for new Enrollees. We will load this data into our interoperable MIS (EIM – see Question C.6), where our clinical staff and data analysts can use the historic information to identify providers and specialists who served the child, along with additional information on services utilized to inform care planning.
- Historic Pharmacy Information. Our MIS can receive and process NCPDP pharmacy utilization data and we propose to receive from DMS and/or MCO Pharmacy Benefit Managers (PBMs) prior prescription drug utilization history and load into EIM. Once that data is available in our MIS, our Pharmacy Director and Pharmacy Technicians can use our analytics utilities to identify any polypharmacy issues and other medication needs and patterns.

Integration of Received Records and Information

All records and information we receive for the child are integrated within our CareCentral platform (see Question C.6 Management Information System) and populate the child's record in our MIS which is then available to treating providers via the Provider Portal. This will form the basis for the Medical Passport. Our Provider Portal is designed for HIPAA compliance, and we employ Role Based Access Controls (RBAC) to implement specific job profiles that allow access and privileges to users commensurate with their job responsibilities, in full adherence to the HIPAA Minimum Necessary Rule.

Ensuring DCBS and DJJ Have Up to Date Records

The WellCare Care Coordinator alerts the DCBS or DJJ case worker face-to-face or via phone that we have been able to obtain records. The Care Coordinator describes information and

provides hard copies as requested. We also provide records as requested to the Children's Commission to support determination of whether the child is medically complex.

Enhancement: Our HIPAA-compliant ClearSKY solution will allow the assigned DCBS/DJJ case worker to securely access information about the child. Information via ClearSky will include the Medical Passport, medical records we are able to obtain, ongoing utilization data once the child begins receiving services, and the care plan/IHP. This will facilitate timely DCBS and DJJ access to comprehensive information about the child's needs and care.

Ensuring Physical and Behavioral Health Providers Have Up To Date Records

The Care Coordinator works with DCBS and DJJ to coordinate with the provider performing the initial assessment within 24-72 hours of the child coming into care, including participation in case conferences with the provider to discuss the records and information we have available. The assessment provider may access this information via our Provider Portal and when needed the Care Coordinator arranges for case conferences with previous providers to discuss the child's needs and care. The CCT outreaches to the new network PCP and physical and BH specialists to discuss the child's needs and availability of records via the portal. For all children and youth with special health care needs receiving services authorized by the prior MCO, the Care Coordinator and CCT collaborate with these providers to ensure continuity of care and a smooth transition into WellCare, including but not limited to facilitating case conferences with new providers. In addition, the Care Coordinator will authorize services identified on the initial care plan, incorporating any services authorized by the previous MCO, allowing all service providers to immediately receive approval from WellCare so that services can begin quickly.

COORDINATING WHEN PROVIDERS CHANGE

Coordination when providers change goes beyond our robust standard process that we use for all Enrollees, which is described in detail in our response to Question C.13 Enrollee Selection of PCP. While Enrollee records are available on the portal and we contractually require current providers to forward medical records to new providers, the need for timely services and the importance of ensuring new providers are fully aware of the child's care and needs requires a more intensive process.

For Enrollees in intensive or complex case management, the Care Coordinator and CCT are typically aware that a placement change is upcoming through their ongoing involvement in family team meetings and close monitoring of the Enrollee's progress. For Enrollees in the lowest level of case management, DCBS notifies us when a placement change is imminent.

In both cases, our staff work with DCBS and the Enrollee and caregiver as needed to identify appropriate providers and arrange appointments. During this process, our staff discuss the child's needs and care with the new providers and educate them about availability of records on the portal. We outreach to the relinquishing provider to request records be sent to the new provider and check in to confirm that records are sent timely. As needed, the CCT facilitates case conferences between previous and new providers to ensure a smooth transition of care.

- Attachment G.10.d-1 BH Child and Adolescent CPGs (Provided Electronically)

11. Utilization Management

G.11. UTILIZATION MANAGEMENT

a. **Describe how the Vendor will collaborate with Network Providers, the Department, DCBS, and DJJ to provide coordinated care for those Kentucky SKY Enrollees accessing psychotropic medications.**

b. **Describe how the Vendor will collaborate with the Department, DCBS, DJJ, hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, physical and Behavioral Health Providers and others on Discharge Planning needs of Kentucky SKY Enrollees across all levels of care.**

G.11. UTILIZATION MANAGEMENT

WellCare of Kentucky will comply with the Department of Medicaid Services' (DMS) expectations and requirements as specified in Section 20 Utilization Management and Section 41.10 Utilization Management of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix,** provided electronically.

Our Utilization Management (UM) program ensures our Enrollees receive the most appropriate, integrated, and effective treatment to achieve the best clinical outcomes. We accomplish this through the prospective, retrospective, and concurrent assessment of medical necessity and appropriateness of the allocation of medical and behavioral healthcare resources and services given, or proposed services, to meet a SKY Enrollee's needs. Our UM and care coordination staff collaborate and base decisions about care and services based on medical necessity, evidence-based clinical practice guidelines, and consideration of a Kentucky SKY Enrollee's holistic needs and their ability to achieve safety, permanency, and social and emotional well-being. **Our focus on shared decision-making means physical and behavioral health providers, pharmacists, Kentucky SKY Enrollees, foster parents, adoptive parents, fictive kin, caregivers, and Department, DCBS, and DJJ staff work together to make decisions and select treatments and care plan interventions based on clinical evidence that balances risks and expected outcomes with Enrollee and family preferences and values.** During shared decision-making, stakeholders openly discuss problems and strategies and rely on consensus to arrive at a decision. We acknowledge that DCBS serves as guardian for Kentucky SKY Enrollees and has the authority to approve whether a Kentucky SKY Enrollee can take psychotropic medications and when.

a. Describe how the Vendor will collaborate with Network Providers, the Department, DCBS, and DJJ to provide coordinated care for those Kentucky SKY Enrollees accessing psychotropic medications.

Our UM and care coordination programs use a data-driven approach to understand the needs of the populations we serve in Kentucky. We pay attention to the appropriate use of psychotropic medication use of our Kentucky Medicaid foster care and adoption assistance population. Our pharmacy director has certification and experience in behavioral health medications and participates in interdisciplinary care team meetings, shown in **Figure G.11-1**.

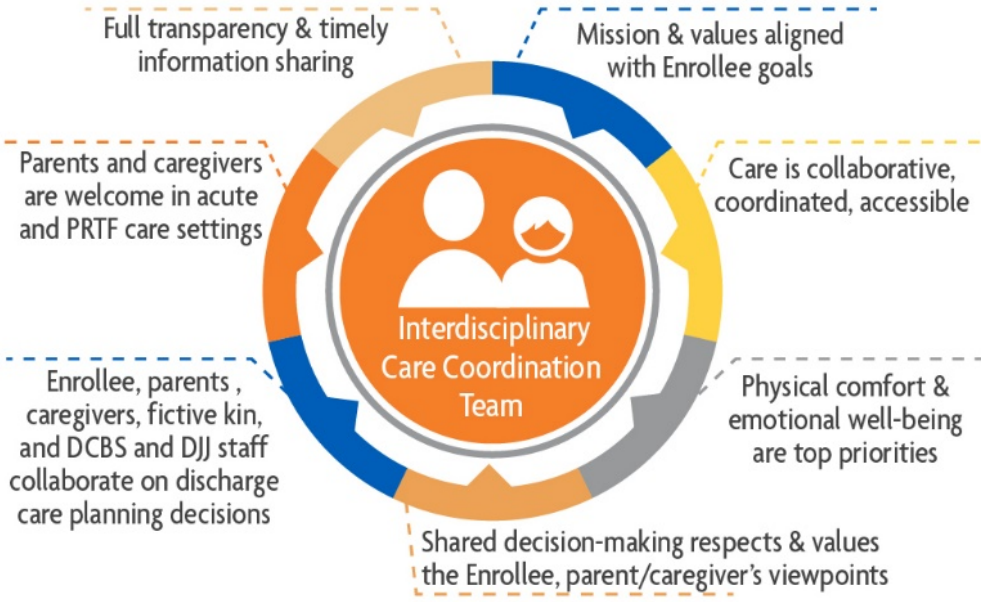

Figure G.11-1: Interdisciplinary Care Coordination Team

Kentucky Medicaid data shows that some Kentucky providers prescribe children in the foster care and adoption assistance population a combination of two, three, or even four psychotropic drugs. While some providers write psychotropic medication prescriptions without listing a specific mental health diagnosis in the Enrollee's record. Other providers report writing prescriptions for psychotropic medications for youth without clarity of who is authorized to provide consent. Not unlike youth in other Medicaid programs, our Kentucky Medicaid foster care and adoption assistance population:

- Is more likely to experience trauma
- Has an increased likelihood of social-emotional issues early in life
- Experience higher prescribing rates of atypical antipsychotics
- Is more likely to receive multiple medications

WellCare of Kentucky currently has approximately 8,100 Enrollees in our foster care and adoption assistance population. We collect and analyze pharmacy data specific to this population, including psychotropic medication utilization using criteria, including but not limited to:

- #/% overall and by age range with 1+ psychotropic prescription (denominator – all FC Enrollees)
- #/% overall and by age range with 1+ psychotropic prescription (denominator – FC Enrollees prescribed psychotropics)
- Average # of psychotropics prescribed (denominator - #FC Enrollees prescribed any psychotropic)
- #/% Enrollees by age ranges with 4+ psychotropic prescriptions (by overall FC pop and by FC Enrollees with a prescription)
- % Enrollees with psychotropic prescription and no therapy

Data for the foster care and adoption assistance population indicates (as of April 2019):

- Psychotropic use is increasing in the Kentucky Medicaid foster care and adoption assistance population--in some age groups it has more than doubled during the last year. Data for our Enrollees shows:
  - 14 children (0-6 years old) had prescription fills for one or more psychotropic medications in April 2019 compared to 2 children in April 2018
  - 241 children (7-12 years old) had prescription fills for one or more psychotropic medications in April 2019 compared to 158 children in April 2018
  - 436 children (13-18 years old) had prescription fills for one or more psychotropic medications in April 2019 compared to 368 children in April 2018
  - 15 children (children 13-18 years old had 9 of those prescriptions) have prescription fills for 4+ psychotropic medications compared to 9 children in April 2018
  - A total of 766 children and youth (0-18+ years old) had prescription fills for one or more psychotropic medications in April 2019 compared to 630 children in January 2018

- Today, our Kentucky Medicaid foster care and adoption assistance children have an average of 1.21 psychotropic medication fills each.
- Our Kentucky Medicaid foster and adoption assistance children 13-18 years old consistently had the highest volume of psychotropic medication fills during the last 18 months.
- Our Kentucky Medicaid foster and adoption assistance children 13-18 years old consistently had the highest volume of 4+ psychotropic medication fills during the last 18 months.
- During the last 18 months, one Kentucky foster/adoption assistance child 0-6 years old had prescription fills for 4+ psychotropic medications during a one-month time period in Q2 2018.

Our goals are to ensure the safety and quality of care for Kentucky SKY Enrollees, assure appropriate use of psychotropic medications, and promote other services and supports in addition to or as an alternative to psychotropic medications to achieve positive health outcomes. A critical component in improving appropriate use of psychotropic medications among children and youth in foster care is engaging, educating, and collaborating with providers, DMS, DCBS, and DJJ staff, and other key stakeholders. Currently, our care coordination team, using our monthly reporting algorithm, identifies children on multiple psychotropic medications and outreaches to engage in our field-based care coordination program. For children who take psychotropic medications and are engaged in our care coordination program, the integrated care team seeks input from our pharmacist. We also reach out to and consult with the DCBS Medical Director on specific children. We have made it a priority to increase our focus on monitoring of provider prescribing patterns for psychotropic medications, encourage providers to recommend alternatives to psychotropic medication, and intensify education and consultation with prescribers and facilitate additional collaboration with DMS, DCBS, and DJJ.

Polypharmacy Interventions: We have two programs within our drug utilization review (DUR) activities focused on polypharmacy or therapeutic duplication. Our point of sale (POS) program,

which the PBM manages, has an alert that checks for two or more medications from the same therapeutic class. When this occurs, the system generates a message to the pharmacist filling the claim. We review these alerts quarterly to identify any global trends.

In addition, we have a behavioral health polypharmacy program. Monthly, we review data to identify any Enrollees who may have more than one antipsychotic medication. Once identified, we send a letter alerting the provider and request a formal review of the Enrollee's medication profile. We perform a follow-up review of the Enrollee's medication profile during the next three months to determine whether a positive change has occurred. **We consider the letter a success if the Enrollee no longer meets criteria for the same measure at the time of the three-month follow-up. In 2018, we targeted over 400 Enrollees with a success rate of 60% -- meaning approximately 250 Enrollees no longer meet the criteria.**

Managing Antipsychotic Medications for Children: Our Pediatric Antipsychotic Utilization program identifies potential drug therapy issues, including excessive dose and multiple medication therapies for children 10 and under in the Medicaid population. When we identify drug therapy issues, we suggest recommendations to the provider via outreach. The program goal is to identify antipsychotic use in Enrollees less than 10 years old and identify potential drug therapy problems. We direct communication at the provider level to inform a prescriber about Enrollees with potential therapeutic opportunities. **In 2019, we performed targeted medication reviews for 860 Medicaid Enrollees under the age of ten.**

HOW WE COLLABORATE WITH NETWORK PROVIDERS, DMS, DCBS, AND DJJ TO PROVIDE COORDINATED CARE FOR KENTUCKY SKY ENROLLEES ACCESSING PSYCHOTROPIC MEDICATIONS

WellCare of Kentucky has a fully integrated, person-centered model of care with all services managed within our one entity, using one comprehensive approach, leveraging one integrated team, supported by one single system, CareCentral. This integration helps us better manage Enrollee whole-person care based on individual needs and collaborate with those involved in an Enrollee's care. Our Kentucky SKY care coordination framework facilitates collaboration with network providers, DMS, DCBS, and DJJ to provide coordinated care for all Kentucky SKY Enrollees. Care coordinators provide information to and assist providers, pharmacies, Kentucky SKY Enrollees, foster parents, adoptive parents, fictive kin, caregivers, as well as DCBS and DJJ staff with care coordination of psychotropic medications.

We tailor person-centered care to reflect the choice and voice of each Enrollee and their foster parent, adoptive parent, fictive kin and caregiver, as applicable, with input and collaboration from providers and DMS, DCBS, and DJJ staff. We focus on addressing a Kentucky SKY Enrollee's defined goals. On the Kentucky SKY contract, our care coordinators have the capability to make baseline UM decisions when they develop a Kentucky SKY Enrollee's initial care plan and initiate service authorizations. This is a change from our current Kentucky Medicaid contract. We anticipate this change will accelerate Kentucky SKY Enrollee access to needed care and services.

WellCare recognizes that children in DCBS custody frequently have complex physical and behavioral health conditions that require team-based care and treatment. DCBS, acting as the child's guardian, is tasked with making critical medical and behavioral health decisions. For example, a child's attending physician may advise the use of powerful mood stabilizing or antipsychotic medications that can have potentially serious side effects. Our care coordination framework supports shared decision-making activities and collaboration among our staff and network providers, DMS, DCBS, and DJJ throughout the UM and care coordination process--from screening and intervention to follow up and measuring program effectiveness to promote positive Enrollee outcomes:

Timely Screening and Early Intervention Help to Identify Enrollees using Psychotropic Medications

- Connect Kentucky SKY Enrollees with a care coordinator to quickly assess children entering the Kentucky SKY program to identify physical and behavioral health, pharmacy and social needs and gaps in care and then link them to providers to intervene as early as possible.
- Help providers seek or document consent from DCBS in the Enrollee's record for those taking psychotropic medications.

Wraparound Approach Supports Individualized Care and Service Planning

- Convene an interdisciplinary care coordination team led by a care coordinator as part of a wraparound approach to support individualized care planning to assure we facilitate collaboration from all stakeholders, including clinical and non-clinical representatives to meet the individual needs of Kentucky SKY Enrollees, including appropriate medication regimens.
- Collaborate with Kentucky SKY Enrollee, foster parents, adoptive parents, fictive kin, caregivers, care coordinator, providers, pharmacist, and DMS, DCBS, and DJJ staff; discuss coordination of and appropriate Kentucky SKY Enrollee use of psychotropic medications and alternative treatments; document the involvement of interdisciplinary care coordination team members and submit this information to DMS, DCBS, and DJJ.
- Encourage facilitated shared decision-making principles, a key component of person-centered healthcare, to empower and increase Kentucky SKY Enrollee and family and caregiver engagement and to encourage families to maintain a key and active role in the Enrollee's healthcare, including their understanding of the risks and benefits of psychotropic medications and their decision about whether or not to use psychotropic medications. Given the complexity of these decisions, WellCare believes that facilitated, shared decision-making can be a powerful process that brings together a team to meet and discuss care and treatment options. The primary DCBS guardian is always identified as a key constituent of this team. Other members of such teams are decided on a case-by-case basis depending on the needs of the child and may include the treating physical and behavioral health physicians, our care coordinators, the DCBS medical director, and WellCare's physical and behavioral health medical directors. We already have experience facilitating such shared decision-making teams. For example, we have identified many children on multiple psychiatric medications, often referred to as polypharmacy, with serious potential for side

effects. We have facilitated meetings between DCBS guardians, DCBS medical director Dr. David Lohr, our WellCare of Kentucky foster care director, a WellCare of Kentucky pharmacist, and our behavioral health medical director and child psychiatrist.

- Develop an individualized, customized care plan for services based on the youth's and family's strengths and needs; coordinate and provide needed physical and behavioral health care, pharmacy, and social services, monitor progress, and regularly revise the care plan as needed.
- Strengthen monitoring activities for Kentucky SKY Enrollees administered psychotropic medications and adherence to clinical practice guidelines to reduce inappropriate use of psychotropic medications.
- Increase education and engagement among Kentucky SKY Enrollee, foster parents, adoptive parents, fictive kin, caregivers, providers, and DMS, DCBS, and DJJ so they understand what psychotropic medications are for, how they are used, what side effects they may have and how to properly dispose of unused medications.
- Consult and share data with Primary Care Providers; educate them on how to secure consent for prescriptions for psychotropic medications in the Kentucky SKY population, the appropriate use of psychotropic medications, including use of psychotropic medication-related clinical practice guidelines, protocols, best practices, and the availability of telehealth for consultations with a child psychiatrist.
- Promote cross-agency data sharing to promote collaboration among physical and behavioral health providers, DMS, DCBS, and DJJ staff, and other system partners; and communicate and monitor progress and impact across the system of care to improve service delivery for Kentucky SKY Enrollees.
- Conduct ongoing training to ensure providers serving the Kentucky SKY population have the necessary knowledge and skills, e.g., know how to find and use evidenced-based clinical practice guidelines for prescribing psychotropic medications; delivering trauma-focused cognitive behavioral therapy; training about sexual abuse, attachment disorders, and adverse childhood events (ACES); and provide trauma-informed care.

Collaboration between UM and care coordination

- Monitor clinical coverage decisions specific to psychotropic medications.
- Monitor consistency of pharmacy utilization with Enrollee benefit plans.

Performance and outcome measurement to curb over prescribing and improve Enrollee outcomes

- Analyze Kentucky SKY pharmacy data to identify providers with outlier prescribing patterns for psychotropic medications and provide follow-up by our Medical Director and/or local pharmacy director for situations warranting intervention.
- Track and trend service utilization, outcomes, and expenditures for the Kentucky SKY population, including use of psychotropic medications.
- Collect data related to how many children receive mental health assessments for those with suspected mental health needs and the extent to which they receive timely and appropriate follow-up and treatment, including psychotropic medications and/or alternative treatments.

ADDITIONAL APPROACHES TO ENHANCE COLLABORATION

The following approaches enhance collaboration with and engage stakeholders is valuable to improving Kentucky SKY Enrollee health outcomes inclusive of oversight of and appropriate utilization of psychotropic medications:

Co-location of local, field-based care coordinators in DCBS offices heightens collaboration and timely interventions for KY SKY Enrollees: Collaboration and partnerships between WellCare of Kentucky staff and DMS, DCBS, and DJJ staff are essential to meeting DMS's goals for improved health outcomes. Today, our Kentucky field-based care coordinators serving the foster care and adoption services population are local and often work physically in DCBS and DJJ offices statewide. On the Kentucky SKY program, we will build upon existing relationships with DMS, DCBS, and DJJ staff and continue in-person outreach in local DCBS and DJJ offices.

Co-location enhances collaboration and coordination, problem solving, and information sharing with DCBS and DJJ staff. Today our regional teams of associates live and work in the regions and districts where DCBS and DJJ offices are located. We assign a local WellCare of Kentucky care coordinator to each DCBS Service Region. This care coordinator meets with his or her assigned Service Region and county level offices to establish and maintain internal relationships with DCBS and DJJ staff.

On our current Kentucky Medicaid contract, we conducted monthly meetings in each DCBS Service Region at contract go-live, with meetings occurring quarterly today. Care coordination staff conducts similar meetings with DJJ East and West Service Districts. Care coordinators conduct frequent Enrollee-specific treatment planning meetings with Service Region, county level, and Community District staff, collaborating to ensure each Enrollee in the foster care and adoption services population can access physical, behavioral health, pharmacy, and social services and is receiving the care he or she needs across the care continuum. We leverage established relationships during these meetings as we gain insight into Enrollees with existing care coordination and access needs. We collaborate with DCBS and DJJ staff to connect the Enrollee with needed services without duplicating them. We seek recommendations from DCBS and DJJ staff regarding provider and state agency educational and targeted-training needs.

As part of the Kentucky SKY program implementation and ongoing, we will expand upon existing relationships with regional staff in the Service Regions and Community Districts to address concerns, problem resolution, provider and state agency educational needs, and risk management for the Kentucky SKY program.

Monthly meetings enhance our partnership with the Commonwealth: The partnership between WellCare of Kentucky and DCBS and DJJ staff is critical to implementing reforms to address evolving needs and to learn about DCBS and DJJ recommendations for new provider training modules. We recognize the importance of leveraging the expertise of DCBS and DJJ staff when strategizing and problem solving about physical and behavioral health services for the Kentucky SKY population. WellCare of Kentucky will conduct formal meetings to ensure SKY Enrollees' needs are being met. **Monthly:** We will conduct Service Region and Community District program-level monthly meetings, which will focus on concerns, problem resolution, educational

needs and risk management. These meetings will occur in service regions at convenient locations for DCBS and DJJ staff. Our regionally based team members will attend these meetings in-person. We will offer WebEx and dial-in capabilities those who cannot attend in person. We will discuss with DCBS and DJJ staff a process for our staff to learn about and join already scheduled meetings and training to facilitate productive engagement, without adding to the already heavy workload of regional staff. **Quarterly:** We will conduct quarterly meetings, or more frequent if needed, Enrollee-focused meetings with DCBS staff to identify, discuss, and resolve identified healthcare issues, e.g., increase in psychotropic medication fills, and specific needs of Kentucky SKY Enrollees. This might include specialized Medicaid covered services, community services, and whether the child's current primary and specialty care providers are part of our network. Meetings will focus on identifying barriers to accessing care, specific treatment needs, or specific subpopulations or age groups that need stronger service options.

Our new Quality Team Provider Outreach Initiative will expand provider education about psychotropic medications: WellCare of Kentucky plans to work with our Quality team to expand engagement of network providers across the Commonwealth to provide targeted education about psychotropic medications. We will educate Kentucky providers to prescribe psychotropic medications only when it is in the foster youth's best interest because taking unnecessarily prescribed multiple psychotropic medications has the potential to damage a youth's health.

MCO Training at Pharmacies

In 2018, our pharmacy director and pharmacy manager conducted 547 provider meetings, engaging over 1,300 providers in the Commonwealth to provide education and one-on-one pharmacy-related training.

Our provider interventions currently include in-person provider visits from a Provider Representative (PR rep) and a quality practice advisor (QPA) on our quality team, sharing of best practices, and continuing education. Today in Kentucky, we have 16 QPAs who are nurses trained in quality education. They visit provider offices to review HEDIS measures and clinical practice guides and to address any issues the practice may have that is adversely contributing to quality scores or health outcomes. They provide detailed clinical profiles, open care needs, and chronic condition reports sorted by Enrollee, physician, or practice compared to state benchmarks. Our programs include provider incentives driven by related HEDIS measures to encourage participation and quality outcomes. **In 2019, WellCare of Kentucky QPAs made more than 6,000 visits to provider offices to educate providers and advance the Commonwealth's quality measures.**

Our QPAs have established relationships with providers. As part of this quality outreach initiative, QPAs will educate providers about use and over-utilization of psychotropic medication by children and youth in foster care and discuss the side effects and risks associated with psychotropic medication use. They will review claims data and educate providers who over prescribe psychotropic medications about appropriate prescribing. QPAs will present provider-specific data comparing provider practices to other practices and defined benchmarks.

In addition, WellCare of Kentucky conducts weekly educational webinars with PowerPoint presentations for providers every Friday, a sample agenda is provided in **Figure G.11-2.** Training focuses on specialized topics based on need or suggestion. We dedicated one webinar provider meeting to a pharmacy.

Figure G.11-2. Targeted educational webinar agenda for our pharmacy program training

Stronger focus needed on complex care case conferences with DCBS staff on the most challenging Enrollees: In Kentucky, our staff has made progress on sharing particularly challenging complex care cases for foster care and adoptive care Enrollees through collaboration among DCBS, care coordinators, other stakeholders, and our behavioral health Medical Director to enhance UM decision-making based on an Enrollee's whole-person needs. Our behavioral health Medical Director identifies specific Enrollees with challenging complex care needs and brings them to the attention of DCBS. WellCare of Kentucky recommends a stronger focus on a similar shared decision-making process with more frequent input from DCBS staff. WellCare of Kentucky is interested in pursuing more frequent collaboration with DCBS and an efficient process whereby we can convene timely complex case conferences for our most challenging cases.

b. Describe how the Vendor will collaborate with the Department, DCBS, DJJ, hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, physical and Behavioral Health Providers and others on Discharge Planning needs of Kentucky SKY Enrollees across all levels of care.

Enrollee outcomes data shows us that specific, timely interventions are effective in successfully supporting individuals as they discharge from hospitals or facilities and move between settings. Care transitions are widely recognized as periods of heightened health risk, which can result in health complications and costly readmissions. Our Kentucky SKY formal discharge-planning program includes a comprehensive evaluation of a Kentucky SKY Enrollee's physical and behavioral health and social service needs. This is in addition to the identification of services and supports needed to transition into the most clinically appropriate, least restrictive setting possible following a Kentucky SKY Enrollee's discharge from an institutional clinical setting or residential placement, or a transition between levels of care. WellCare of Kentucky uses transparent UM processes and takes steps to quickly approve services needed post discharge to maintain a Kentucky SKY Enrollee in the least restrictive setting possible. **Our care coordinator outreach efforts continue to have a positive impact on reducing hospital readmissions in Kentucky. In 2018, WellCare of Kentucky's readmission rate for the number of Enrollees readmitted to an acute hospital or facility within 30 days of a discharge was down 3% from 2016.**

WellCare of Kentucky has experience with discharge management at the Commonwealth's four hospitals, including Western State Hospital (WSH), Eastern State Hospital (ESH), Central State Hospital (CSH), and Appalachian Regional Hospital (ARH). Through the first two quarters of 2019, 271 of our Medicaid Enrollees were discharged from these four hospitals. Approximately 40% of these Enrollees agreed to engage with our care coordinator in discharge planning and care coordination activities.

Our current experience serving the foster care and adoption population in the Kentucky Medicaid program informs our approach to meeting the Commonwealth's expectations and requirements for discharge management and transitional care management for Kentucky SKY Enrollees and their families. On the current contract, WellCare of Kentucky leadership staff meet with providers and with hospital and facility staff serving large groups of the foster care and adoption assistance population, e.g., Our Lady of Peace; Children's Alliance and PRTFs, to enhance discharge-planning processes, improve information sharing, and expand educational opportunities, such as pharmacy utilization of psychotropic medications and telehealth.

Behavioral Health P4Q: We introduced the Behavioral Health P4Q program in 2019 to address the prevalence of behavioral health conditions in Kentucky. Unique to WellCare of Kentucky, this program offers bonus payments to all 14 Kentucky CMHCs and behavioral health hospitals--including Bourbon Community, Sun Behavioral Kentucky, The Ridge, Lourdes and Baptist Corbin--for improving behavioral health-related measures. Measure include antidepressant medication management; medication adherence to antipsychotics; follow-up after behavioral health inpatient hospitalization; cardiovascular monitoring for Enrollees with schizophrenia; diabetes monitoring for Enrollees with schizophrenia and diabetes; diabetes screening for bipolar, schizophrenia, and antipsychotics; and metabolic monitoring for children on antipsychotics.

DISCHARGE PLANNING NEEDS OF KENTUCKY SKY ENROLLEES

We will collaborate with DMS, DCBS, DJJ, hospitals and other acute care facilities, PRTFs, residential providers, physical and behavioral health providers, the Children's Review Program, the DJJ Placement Services Division, and others on discharge planning needs of Kentucky SKY Enrollees across all levels of care. Today, we coordinate care for our Kentucky Medicaid and foster care and adoption service Enrollees across a full continuum of care. Our current Care Coordination team work hand in hand with our Utilization Management team to make sure we share and incorporate into the discharge planning process all clinical information and social determinants for health information. We encourage care coordination team planning with DCBS, DJJ, and AA parents, along with providers, to assure discharge planning consistency and ensure referrals for the next level of care are in process. To plan for discharge, clinical services need to be identified and appropriate placement and levels of supervision needed must be identified. Often, the hold up to identifying an appropriate discharge plan is due to the Enrollee's level of supervision need. Once the appropriate placement is identified, finding the correct level of clinical intervention can then be planned. Discharge planning also involves ensuring that social determinants of health and community resources are identified and planned. WellCare of Kentucky maintains written policies and procedures in place for discharge

planning focused on strengths-based, culturally competent, and medically appropriate treatment designed to meet Enrollee needs, including those identified with emotional and behavioral issues.

Notification of admission or discharge facilitates timely Enrollee engagement: WellCare of Kentucky uses predictive analytic ID/Strat results, admission, discharge, and transfer (ADT) feeds, direct facility EMR access, electronic prior authorization requests in 278 format, faxes, and HIE to identify Kentucky SKY Enrollees with an inpatient admission and who are experiencing a care transition. In addition to having hospital-based staff onsite in larger Kentucky hospitals and facilities, we require WellCare network hospitals to alert us when Kentucky SKY Enrollees have an inpatient stay or come to the Emergency Department with behavioral health issues.

In-person staff in large hospitals and enhances our engagement with Enrollees: To engage Enrollees quickly, we embed onsite inpatient care managers in high-volume hospitals and facilities and telephonic concurrent review nurses at low-volume hospitals and facilities to identify Kentucky SKY Enrollees experiencing an inpatient stay. Onsite inpatient care managers, concurrent review nurses, and our integrated care management system, CareCentral, enhance a care coordinator's ability to quickly engage Kentucky SKY Enrollees. Our approach to care management ensures each Kentucky SKY Enrollee needing discharge management and transitional care management has a single point of contact who follows-up with the Kentucky SKY Enrollee, family, network providers, and DMS, DCBS, and DJJ staff. Embedded onsite inpatient care managers and concurrent review nurses review inpatient hospital and facility stays for medical necessity. They review a Kentucky SKY Enrollees' status to assure the severity of presenting symptoms and the intensity of services provided support the ongoing need for an inpatient level of service.

Advanced analytics identify Enrollees at high risk of readmission: WellCare conducts predictive modeling and risk stratification to identify Kentucky SKY Enrollees at moderate or high risk of readmission, including the LACE+ index, at admission when discharge planning begins. Our LACE Index Scoring Tool for Risk Assessment of Hospital Readmission system alerts our care management staff about a Kentucky SKY Enrollee's condition. Activated at the time of ADT or other notification, this proprietary algorithm helps care coordinators prioritize care needs. It assigns a daily readmission risk score using length of stay, acuity, comorbidities, and ED use to predict the likelihood of readmission. **Use of the LACE tool, combined with WellCare's added analytics, increased the accuracy of the tool's predictive power by more than 60%.** The LACE+ score guides the level of transitional care management and the type (in-home or telephonic) and duration of support and interventions. In Kentucky, we stratify Kentucky SKY Enrollees into risk levels. The care coordinator completes medication reconciliation telephonically with the WellCare of Kentucky pharmacist.

The following information informs ID/STRAT risk stratification includes:

- A weekly assessment risk score using weighted questions to stratify Enrollees and identify those with statistically significant predictors for multiple readmissions.

- A monthly claims-based risk score using claims related to chronic conditions and enrollment data, e.g., considers aid category separately, a diagnostic classification algorithm, PMPM dollar thresholds, utilization requests, and impactable condition flags.
- A monthly pharmacy adherence score using claims, clinical, and intervention data to show Enrollee compliance with medication regimens based on claims history. It predicts an Enrollee's risk of specific medication outcomes, quantifies the financial value of better medication use, and assesses an Enrollee's receptivity to intervention.
- A monthly predictive risk score using admission, readmission, Emergency Department, and disease progression predictions to create a holistic risk profile.

DISCHARGE PLANNING FROM HOSPITALS AND OTHER ACUTE CARE FACILITIES

Effective discharge planning requires a team approach. Our Kentucky SKY discharge planning activities prioritize collaboration with hospital or facility staff, network providers, DMS, DCBS, and DJJ staff, the Children's Review Program, the DJJ Placement Services Division, community advocates and others to create a person-centered discharge plan and facilitate a Kentucky SKY Enrollee's proactive and successful transition to a lower level of care. Rapid responses often require same-day or next-day outreach for high-need Enrollees who are admitted to a hospital or facility. Onsite inpatient care managers, concurrent review nurses, and care coordinators add new Kentucky SKY information related to the hospital or facility admission in CareCentral.

Our care coordinator makes sure Kentucky SKY Enrollees have voice and choice during the discharge planning process and that a Kentucky SKY Enrollee's family has the training and support they need to keep a Kentucky SKY Enrollee safe and well. A Kentucky SKY Enrollee's discharge plan and transition care plan align with the DCBS case plan and our Kentucky SKY Enrollee's care plan in CareCentral. The transition care plan includes safe discharge into the most appropriate, least restrictive setting possible, access to the full range of services needed including behavioral health services, and possibly a plan for eventual reunification with the Kentucky SKY Enrollee's biological family.

Our Kentucky SKY care coordinator oversees discharge planning and care transitions, including:

- Provide timely, in-person and/or telephonic follow-up post discharge, scheduling Primary Care Provider post-discharge appointments (48 hours to 7 days), and referrals to specialists, appointment scheduling assistance, transportation, and social needs, follow up to confirm completed appointments, and referral management
- Conduct and update needed assessments
- Coordinate comprehensive medication management, medication reconciliation, and medication self-management, engaging a pharmacist
- Conduct Kentucky SKY Enrollee and parent or caregiver condition-specific education; how to recognize the red flags the youth's condition is worsening; self-management support; use of a personal health record; alternatives to using the Emergency Department; and wellness/prevention education
- Provide specialized training and education for parents and caregivers when a Kentucky Sky Enrollee has a medically fragile condition that requires special procedures or use of special equipment post discharge

- Create an individualized care plan with interventions, including Primary Care Provider, specialist, and behavioral health visit follow-up appointments, durable medical equipment (DME), in-home supports, and connection to peer support, as appropriate
- Connect Kentucky SKY Enrollees to community resources for health-related social needs using the resources of our Community Connections program. WellCare has extensive engagement and strong partnerships with community-based organizations that support Kentuckians with their social needs, including the Community Farm Alliance, Orphan Care Alliance, SOAR, Kentucky Home Place, Operation UNITE, and more
- Connect Kentucky SKY Enrollees to value-added benefits. Many of our value-added services are particularly valuable for Kentucky Sky Enrollees post hospital or facility discharge. For example, home-delivered meals for Enrollees discharged from an inpatient stay hospital, rehabilitation or skilled nursing facility; meal program for Enrollees discharged from a behavioral health facility; respite services for caregivers; and over-the-counter items - $10/month per Kentucky SKY Enrollee.
- Convene interdisciplinary care coordination team meetings of clinical and non-clinical representatives and strengthen collaboration with hospital and facility discharge planning staff, providers, pharmacies, Kentucky SKY Enrollees, foster parents, adoptive parents, fictive kin, caregivers, and DMS, DCBS, and DJJ staff to coordinate a broad spectrum community-based physical, behavioral, pharmacy, and social services post discharge across all levels of care.
- Facilitate collaboration and oversees information sharing between interdisciplinary care team members and DMS, DCBS, and DJJ staff
- Coordinate linkage to community services through our Community Connections program and follow up on referrals to community-based services to see if a Kentucky Sky Enrollee's and foster family's needs have been met
- Conduct timely in-home, high-touch engagement and follow-up with Kentucky SKY Enrollees with complex care needs. A high-touch, high-intensity home visit from a care coordinator after hospital discharge substantially reduces 30-day readmission rates for individuals with multiple chronic conditions. For individuals with complex chronic conditions, home visits reduce the likelihood of a 30-day readmission by almost 50 percent compared to less intensive forms of transitional care.

Our goal for discharge planning is to provide a proactive and well-coordinated plan for transitioning an Enrollee from an inpatient facility or PRTF to the most appropriate level of care while focusing on quality, safety, and Kentucky SKY Enrollee and family satisfaction. Another important goal is to engage Enrollees in person-centered services, supports, and resources that wrap around the Kentucky SKY Enrollee to minimize his or her risk for readmission. Assuring timely post-discharge follow-up physician and behavioral health specialist appointments is a key strategy to reducing readmissions.

CARE COORDINATION FOR KENTUCKY SKY ENROLLEES DISCHARGED FROM RESIDENTIAL CARE

We coordinate inpatient behavioral health discharges, e.g., from Our Lady of Peace or The Ridge, and work with the hospital clinical team to assist the Children's Review Program or DJJ Placement Services Division to engage with PRTF staff for admission to the program. Our clinical leadership team meets with PRTF leaders to establish and maintain relationships, points of contact, etc. to facilitate smooth behavioral health discharges. Discharge planning is often the first step to a Kentucky SKY Enrollee's recovery. Therefore, we begin planning as close to the point of a behavioral health admission as possible. Within the first 30 days, our care coordinator outreaches the DCBS/DJJ guardian and the PRTF to discuss initial thoughts of discharge placement and needs. The Children's Review program or DJJ Placement Services Division must be involved in the discussion to assist with placement identification and referral.

Well-Coordinated Discharge Plan

When our Kentucky foster care Enrollee, Ethan, age 8, was hospitalized during a crisis precipitated by his medical and behavioral health needs, his care coordinator facilitated a consultation call between our Medical Director, Ethan's providers, and his adoptive mother to decide next steps to stabilize him. When psychological testing recommended Applied Behavior Analysis, a service typically only provided to Enrollees with an autism diagnosis, the care coordinator worked with our UM staff to obtain authorization. Today, Ethan is stable, out of the hospital, and living at Home of the Innocents. The family's long-term goal plan is for Ethan to return to a less restrictive setting at home with his adoptive mother.

Prior to discharge, our care coordinator works with the PRTF discharge planner to get copies of documents related to our Kentucky SKY Enrollees care in their facility so we can coordinate getting this information into the Enrollee's record and share this Kentucky SKY Enrollee-specific information with the mental health provider who will be providing the Enrollee's aftercare. Essential information includes:

- Medical needs including allergies
- Medication; dosage; clinical rationale; prescriber
- Discharge diagnosis
- Prevention plan to address symptoms of harm to self or others
- Any other essential recommendations
- Appointments with after discharge service providers-date, time, place
- Contact information for internal providers
- Contact information for PRTF discharge planners or liaisons

For any Kentucky SKY Enrollee in a PRTF who is receiving or who has received psychotropic medication during their stay, we expect the clinical rational for each medication to be clearly documented on their psychiatric discharge summary or final evaluation. The reason for discharge should also appear on the PRTF's discharge summary.

Providing an appropriate continuum of behavioral health services and social supports is crucial to achieving a successful transition to home or a community setting and the best possible

outcomes for children and youth discharged from residential care. Many Kentucky SKY Enrollees are adolescents who have diagnoses of co-occurring mental health and substance youth disorders. In addition, family courts or the juvenile justice system may have had a key role in the placement of the youth in residential care, mandating a residential care placement as part of the disposition process. Our experience shows this population benefits from integrated care coordination, family-driven care, community-based support, collaboration between residential and community-based providers and government entities, and provider adoption of evidence-based and effective practices.

We use a high-fidelity model and strengths-based, culturally and linguistically competent approach that recognizes the importance of the family, school, and community and addresses a Kentucky SKY Enrollee's whole person needs. Youth discharged from residential care have a care coordinator who works collaboratively with residential and community-based providers and others involved in a Kentucky SKY Enrollee's care. The care coordinator facilitates shared decision-making with physical and behavioral health providers, pharmacists, Kentucky SKY Enrollees, families, and DMS, DCBS, and DJJ staff so they work together to make decisions and select treatments and care plans based on clinical evidence that balances risks and expected outcomes with Enrollee and family preferences and values. Collaboration with the DCBS caseworker is vital to successful discharge planning. We have multiple methods to collaborate with DCBS and DJJ staff regarding specific Kentucky SKY Enrollees.

The care coordinator seeks active engagement of the Enrollee and his or her family or support system to plan for and coordinate follow-up community-based care and services that become part of the Kentucky SKY Enrollee's care plan. This plan lists traditional steps toward recovery and management of co-occurring physical health conditions as well as a crisis and safety plan. Service planning, service delivery, and post discharge care coordination may include but is not limited to:

- An in-home evaluation of the family or living situation
- Coordinating with government entities for youth transitioning to an adult system of care or youth engaged with the courts and DJJ
- Coordinating with educational institutions
- Connecting Enrollees to peer support groups
- Arranging housing or alternative placement
- Engaging a peer support specialist to accompany the Kentucky SKY Enrollee to outpatient or other community services
- Connecting a Kentucky SKY Enrollee to educational or vocational opportunities

WellCare employs a peer support specialist who is a young adult with lived experience in the mental health system and who is a former foster care youth. The peer specialist serves as a mentor, navigator, and recovery support for youth in crisis. This peer support specialist can help a Kentucky SKY Enrollee understand treatment options, understand what groups, social and recreational activities are available in the community, and serve as someone to talk to when the Kentucky SKY Enrollee is confused or feeling unsure about where to go for help.

OTHER KEY COMPONENTS OF DISCHARGE MANAGEMENT AND CARE TRANSITIONS

In addition, the following discharge management and transitional care management includes the following key components:

Advanced technology helps us address an Enrollee's whole person needs: We maintain a single and centralized Enrollee record in CareCentral, our claims-fed care management system. CareCentral houses all behavioral health and medical UM and authorizations into a single Kentucky SKY Enrollee view. Fully integrated with our claims systems, CareCentral shows users a Kentucky SKY Enrollee's integrated health record, health history, diagnosis and treatment, outreach efforts, information received from providers, assistance with scheduling appointments, assessment data, medication history, health-related social resource needs, claims history, authorizations, and care plans. Authorized WellCare staff and providers have access to a complete picture of a Kentucky SKY Enrollee's needs across the entire spectrum of care when considering authorization decisions and utilization trends.

CareCentral offers automated notifications and workflows related to care transitions. It supports transitional care management activities by generating alerts based on ADT feeds, electronic and faxed prior authorization requests, predictive modeling, and other sources. It helps the care coordinator bring together a Kentucky SKY's Enrollee's entire interdisciplinary care coordination team (e.g., providers, behavioral health specialists, pharmacists, Enrollee, family, and DMS, DCBS, and DJJ staff). CareCentral's intuitive transitional care management workflows and alerts automate a care coordinator's activities like appointment scheduling, which improves care coordinator efficiency in directing the right transitional care to the right Kentucky SKY Enrollees at the right time.

Integrated leadership and staff and joint rounds improve health outcomes: Local leadership represents physical, behavior health, pharmacy, and social services expertise. This is integral to implementing cohesive population health strategies and programs to improve health outcomes and enhance care coordination and Enrollee satisfaction. Our Kentucky physical and behavioral health Medical Directors conduct joint rounds and consult on cases with comorbidity. We conduct interdisciplinary rounds on a weekly basis to collaborate on the coordination of care for inpatient Kentucky SKY Enrollees. This approach provides an opportunity for a team review of the clinical reasons for a Kentucky Sky Enrollee's admission to determine the appropriate path to discharge and remove any barriers that exist to an effective care transition. Through this approach, we review outpatient service requests and consider the Kentucky SKY Enrollee's entire history in the context of a requested service. We devote significant attention to investigating the nuances of integrated service delivery, soliciting perspectives from an array of providers, DMS, DCBS, and DJJ staff, and community advocates. We align our staffing infrastructure to Kentucky SKY program needs and Draft Contract requirements. Our staff operates under a single set of fully integrated policies aimed at whole-person care, operational integration across internal departments, and collaboration with external entities.

Compliance assessments and ongoing audits assure consistency: Throughout the year, an independent internal clinical service compliance unit performs compliance assessments and ongoing audits to ensure that application of criteria is accurate and consistent. WellCare

conducts online inter-rater reliability (IRR) testing using a commercially available IRR product for all clinical review staff involved in assessments, care and service plan development, and utilization decisions. This audit process assures a consistent Enrollee outcome and experience by evaluating all important elements of the record, including the comprehensive care needs assessment, discharge planning, Enrollee and foster family engagement, biological family engagement as appropriate, care coordination, and monitoring and follow-up for goal achievement. UM teams responsible for identifying opportunities for improvement and taking action receive summary reports, including staff training and coaching. Clinical leadership reviews daily management reports displaying patterns of decisions by health plan and by team to look for over and underutilization (e.g., the percentage of reviews that an RN sends to a physician).

We mirror these quality oversight practices with our pharmacy team. Our quality audit specialists conduct a daily review of prior authorizations to assure all processes, (e.g., turnaround times, process steps, and notice of decision) meet or exceed Commonwealth Contract expectations and statutory requirements. Each month, quality auditors randomly sample ten cases per UM associate, reviewing the chart for adherence to our rigorous review steps, clinical standards and program expectations, and for consistency in clinical decision-making.

Joint Operating Committee (JOC) meetings facilitate process improvement: We will continue to hold JOC meetings where we jointly meet with providers to review performance monitoring results; chart audit results (1:40 or more charts); IRR scores; health outcome and operating metrics; monthly, quarterly, and annual reporting; and agree to implement process improvements. As an example of a process improvement in Kentucky, one of our network providers, The Ridge, said they wanted access to concurrent reviews beyond normal business hours. Our staff brought his issue to the JOC meeting for discussion. The JOC-recommended solution was to extend the concurrent review process to 24 hours a day, 7 days a week for The Ridge. After implementing this solution, we expanded it to include Baptist Hospital.

12. Aging Out Services

G.12. AGING OUT SERVICES

Provide the Vendor's recommendations for enhancing the services and outcomes for FC Enrollees, Former Foster Care Enrollees, and JJ Enrollees aging out of Care and the Kentucky SKY program. Provide examples of services or tools the Vendor has used for other similar programs and detail how these tools have contributed to the Vendor achieving program goals.

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WellCare of Kentucky will comply with the Department of Medicaid Services' expectations and requirements as specified in Section 41.22 FC and JJ Enrollees Aging Out of Kentucky SKY of the Draft Medicaid Managed Care Contract and Appendices and confirmed by each requirement in **Attachment X Contract Compliance Matrix**, provided electronically. Additionally, we have shaded specific citations from the Draft Contract in our narrative to confirm our compliance.

Our experience serving Kentucky's foster care youth since 2011, described throughout this response, positions us strongly to enhance services and outcomes for foster care Enrollees, former foster care Enrollees, and JJ Enrollees aging out of Care and the Kentucky SKY program. We have significant experience working with DCBS and DJJ to support Enrollees as they transition out of care and Medicaid managed care. We also have processes already in place to maintain them in care to keep their health coverage as long as possible, and assist with transition out of care and Medicaid to ensure continuity of care.

WellCare Enrollees Maintaining Medicaid Coverage Beyond Their 18th Birthday		
Length of enrollment beyond 18th birthday	% Foster Care Enrollees	% Adoption Subsidy Enrollees
Less than 1 year	45.8	56.6
1-2 years	21.4	19.9
2-3 years	13.5	13.3
3-4 years	11.9	7.3
4-5 years	6.5	2.7
5+ years	1	.3

Figure G.12-1 Enrollees Maintaining Medicaid Coverage

Currently we serve about 1,000 Enrollees who are age 17 and older. Of these, 54% are 17, 36% are age 18, and 10% are 19 and older. Since 2014, WellCare of Kentucky has had 1,387 foster care Enrollees who were enrolled in our plan on the date of their 18th birthday. **Figure G.12-1** shows that of those, 92% (1,274) maintained Medicaid coverage and WellCare of Kentucky enrollment for some period of time following their 18th birthday. On average, our foster care Enrollees remained on Medicaid for an average of 1.5 years following their 18th birthday, and adoption subsidy Enrollees for an average of 1.2 years.

Our current process is to begin preparing for transition well before an Enrollee turns 17. Discussion with the Enrollee of their goals and needed preparation for adulthood begins as early as age 14. We currently serve 1,588 youth who are 14, 15, or 16. These discussions are a

standard part of our current care planning and monitoring approach for all youth as they enter the high school years. As the youth moves closer to aging out and gains more insight into what adult, post-foster care life may be like, we continually work with them to update their transition planning goals as those goals evolve.

Supporting Youth To Reach For Their Dreams

An enrollee in DJJ custody was transitioning from a structured DJJ placement and moving into college. While the Commonwealth paid for her room, board, tuition, and books, she had no resources available for dorm room needs, such as bedding. WellCare assisted by securing items needed for her dorm room and the Care Manager helped her move into the dorm and get settled. The Care Manager also ensured the enrollee had access needed health and behavioral health services and SDOH resources and followed up with her over a several week period to provide support. In May 2019, our enrollee graduated from college.

During the month of the Enrollee's 17th year, WellCare of Kentucky's field-based Care Coordination staff proactively outreaches and assists with the transition planning meeting in collaboration with the DCBS Independent Living Specialists and DJJ to build the official transition plan. During that first meeting, our Care Coordinator provides state staff, the Enrollee, caregiver, and other involved stakeholders (with necessary consent) an overview of the Enrollee's health conditions, historical utilization, and ongoing service needs (such as prescriptions, ongoing therapy needs, DME, and specialty care) as well as the transition activities that we have already completed with the Enrollee. The Care Coordinator also educates all involved on all health care benefits available through Medicaid, the process for maintaining Medicaid eligibility, and the importance of continuity of care.

Care Coordinators actively participate in all aspects of transition planning and ensure the WellCare of Kentucky care plan continues to align with and support the permanency plan and the transition plan. We also continually assess Enrollee needs for post-transition services as well as SDOH resources, knowing that these needs and the Enrollee's preferences for meeting them may evolve as the Enrollee approaches age 18.

In addition to our Kentucky experience, we are able to leverage WellCare Health Plan Inc.'s (WellCare's) experience serving transition age and former foster care Enrollees in other states, shown in **Figure G.12-2**.

We will build on our current process through our recommendations, services, and tools as described below to enhance services and outcomes for these Enrollees, such as engaging peer support to bring lived experience to assist the Enrollee through the transition process.

WellCare Transition Age (17+) Enrollees In Other States	
State	# Foster Care Enrollees age 17+
FL	585
HI	44
MI	575
MO	687
NE	242
NJ	47
SC	21
Total	2201

Figure G.12-2 Transitioning Enrollees in Other States

RECOMMENDATIONS FOR ENHANCING SERVICES AND OUTCOMES

Support Meaningful Youth Engagement in Improving Services and Outcomes

Through our ongoing work with our transition age, former foster care, and juvenile justice Enrollees, we have learned directly about the importance of supporting engagement of individuals who are impacted by our services. Individuals with lived experience bring a singular insight into the system and transition services and how we can best improve our approach and processes. They know what worked for them, and their input is necessary to craft programs and services that actually meet the needs of our youth.

Collaborate to Obtain Youth Engagement

WellCare of Kentucky will collaborate with DCBS, DJJ, Voices of the Commonwealth, Kentucky Partnership for Families and Children, and the First Lady's Youth Leadership Council to convene workgroups that are essential to continuous assessment of need and problem solving. We will partner with the identified stakeholders to develop a workgroup with foster care Enrollees, former foster care Enrollees and peer support specialists to identify opportunities for improving the aging out services and encouraging Enrollees to remain in foster care.

We demonstrate our ability to bring together partners and facilitate collective improvements for this group of Enrollees by our experience over the current contract implementing focus groups, work groups, and conference activities. For example, we facilitated transition-age youth focus groups focused on building our JOOL health coach tool (described below) and to identify what was most important to these Enrollees. They told us that they want to be heard, that they want support but not to be told what to do, and they want to know what their options are and how they can access what they decide they need as they move forward. During these focus groups, we provided education on their benefits and how to maintain eligibility once they aged out. In addition, during a meeting with Voices of the Commonwealth, the entire group verbalized that they did not know they could access the benefits and opportunities available to them. Our staff provided detailed information on how to access their current benefits, where to go and the process to ensure continued Medicaid coverage once they left the custody of the state, and how to self-advocate for their future needs.

Remove Barriers to and Incentivize Youth Engagement

Our experience also shows that many Enrollees require encouragement and incentives to assume a meaningful role in the identification of opportunities for service enhancements. To ensure ability to participate, Care Coordinators will outreach to Enrollees who desire or are invited to be part of these workgroups and identify obstacles to their engagement (e.g., limited time and transportation). Our Care Coordination Team and Community Connections staff will coordinate with our community partners to provide payment for time, travel assistance, and other support to enable their participation. In addition to providing vouchers for transportation to attend meetings and food during meetings, we encourage participation by providing incentives that recognize their valuable time, such as gift cards that Enrollees can use at local retailers.

Expand Training for Youth Self-Advocacy

We will partner with Kentucky Partnership for Children and Families (KPCF) to offer our transition age and former foster care Enrollees (including youth with a documented history of behavioral health needs and youth that live in group homes and independent living settings) the training and mentoring they need to become leaders in their own lives and communities. KPCF's leadership academy for youth in foster care supports youth to gain the knowledge and skills necessary to not only access health care, but also establish life skills that improve self-sufficiency over time and support successful youth transition to adulthood.

Leann Magre, Provider Relations Liaison, is a previous Board member of the Kentucky Partnership and will spearhead development of this initiative to expand their leadership academy to our Enrollees. We will offer scholarships to encourage their participation in the leadership academy. We also will work with the Kentucky Partnership to design and implement unique training methods to meet youth where they are, such as offering on-demand, visually appealing webinars that can be accessed on smartphones and laptops, as well as in-person sessions in locations these youth frequent such as local community colleges and university campuses.

"WellCare maintains a focus on lived experience always identifying transition age youth with, or at risk of, behavioral health challenges and their family members to share their voices and perspectives! On behalf of Kentucky Partnership for Families and Children, Inc., I am happy to encourage, and support, WellCare on their endeavor to secure the Kentucky SKY contract!"

– CAROL W. CECIL
EXECUTIVE DIRECTOR, KENTUCKY PARTNERSHIP FOR FAMILIES AND CHILDREN, INC.

Transition Age Youth and Young Adults Program

Based on our experience serving transition age youth and former foster care Enrollees in Kentucky, we have developed a comprehensive program to maintain Enrollees in care so they can continue to access Medicaid to age 26 and ensure successful transitions out of foster care and Kentucky SKY. The program provides multi-faceted services and support to enhance current services and improve health, well-being, and quality of life outcomes. Components of the program include the following.

Youth-Led Transition Planning Model

We will support enhancement of services and outcomes for foster care Enrollees, former foster care Enrollees, and juvenile justice Enrollees aging out of Care and the Kentucky SKY program by establishing our **Youth-Led Transition Planning Model**. This new model (depicted in the graphic below) will enhance our current successful approach to supporting smooth transitions and the lessons learned over the past eight years participating in transition planning with DCBS, DJ, our Enrollees, and other stakeholders. The model will support transitioning youth to build the skills required to assume meaningful leadership roles on two fronts: their own

personal planning and system-wide improvements, leading to youth truly having a voice and a choice.

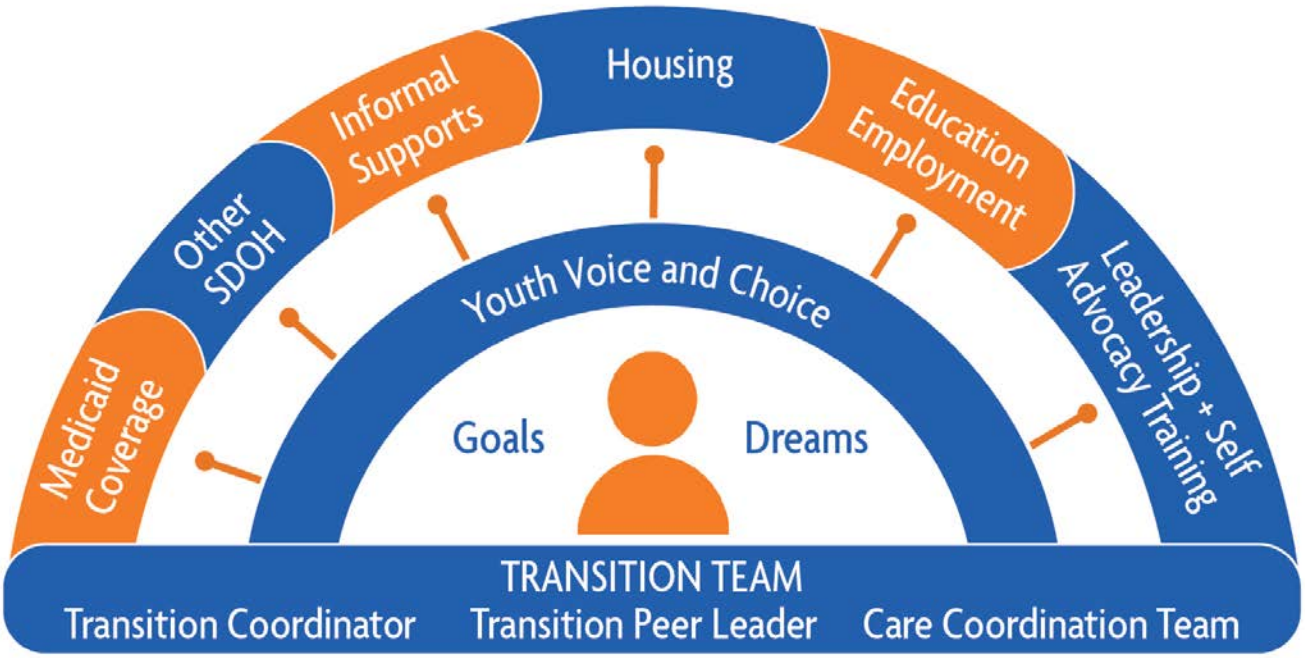

Figure G.12-3 WellCare of Kentucky's Transition Team

Dedicated Transition Team

Our designated Foster Care Transition Coordinator and Youth Peer Support Specialist will support the youth, DCBS/DJJ staff, and the assigned Care Coordinator through the process. The Transition Coordinator will be a Care Coordinator with extensive experience with the Kentucky foster care and juvenile justice systems and with transition age youth. Our Youth Peer Support Specialist will be a non-clinical individual recruited from among former foster care youth to provide the benefit of lived experience in supporting our Enrollees through this critical time.

Proactive Transition Planning. The Transition Coordinator will take the lead for our efforts to support DCBS, DJJ, Enrollees, and stakeholders in transition planning. This will include tracking our population to identify Enrollees age 14 and older and working with the assigned Care Coordinator to develop a plan for and begin implementing the pre-transition education and planning efforts described above. Together with the assigned Care Coordinator, our Transition Coordinator and Youth Peer Support Specialist will promote Enrollee voice and choice throughout the planning and transition process.

Preparing Youth for DCBS/DJJ Transition Planning. In addition to the ongoing work we already do with Enrollees starting at age 14, we will convene a Transition Team, depicted in **Figure G.12-3**, meeting with the youth and caregiver (in person or via phone, based on their preference) within three months prior to the initial transition planning meeting with DCBS or DJJ. The purpose of the Transition Team meeting, which will include a Youth Peer Support

Specialist as desired by the youth, will be to educate them about the DCBS or DJJ transition planning process (as applicable), their role, and how they can drive the process. Ongoing, the Transition Team will provide the education, support, and advocacy necessary to facilitate the Enrollee to drive the process.

Person-Centered Approach to Meet Youth Where They Are. Throughout transition planning, our Transition Team will deploy effective, person-centered strategies to support the Enrollee to engage in identifying transition needs and the right services, strategies, and action plans to address them. These staff will take the time during each Enrollee interaction to truly meet the youth where they are to ensure engagement and buy-in. They will use multi-channel education strategies and evidence-based approaches to ensure the Enrollee has a clear understanding of their health care conditions and needs, the importance of continuing access to health care services, and how developing and adhering to a plan to meet health, independent living, and social support needs will contribute to the Enrollee's goals for their life.

Supporting Youth Voice and Choice. The Youth Peer Support Specialist will provide intensive support for youth voice throughout the process. This will include how to assume an active role in identifying and addressing health care needs to prepare them to effectively participate in shared decision making with health care providers. It will also include educating them on what to expect following transition out of care so they can effectively participate in planning. We plan to engage with the Foster Club to provide their Transition Tool Kit to all transition age Enrollees. This Toolkit is another resource for supporting youth voice and choice and equipping them to self-advocate and achieve their wishes and dreams for their futures.

Identifying and Tracking Health and Social Service Needs. The Transition Team will meet at least every other month to identify and track the Enrollee's needs for health and social services. This will include working with DCBS, DJJ, Enrollees, and their support networks to assess home and community support needs to successfully transition to or remain in the community and to maintain ongoing stability and long term success, as well as SDOH needs that must be met to address their risks. We will work with Enrollees and their informal support network to identify immediate risks that put their success in jeopardy and develop feasible and thoughtful strategies to address these risks, including risks associated with communication obstacles, medical equipment malfunction, medication adherence, housing, education, mental health, and isolation.

We will use Transition Team meetings in addition to formal transition meetings with DCBS/DJJ to continuously assess Enrollee health status and other appropriate factors to determine if an Enrollee meets service criteria, including criteria for HCBS waiver services and initiating the waiver application process and supporting their placement on waiting lists, as needed.

Consideration of Post-Transition Goals and Options. A key area of focus for DCBS, DJJ, and Enrollee/informal support network education will be options for services and supports that are available once they transition, including post-secondary options and how to access disability services from educational institutions and employers. As described in more detail below, we will emphasize the importance of maintaining Medicaid coverage and the process for doing so.

If the youth chooses to remain in care and in Kentucky SKY, the Transition Team will provide support for the transition to adult services. This will include helping the youth identify and select a PCP and necessary specialists who serve adult patients, educating them about coverage differences and evidence-based recommendations for any ongoing care needs.

Coordination Out of Kentucky SKY. If the youth chooses not to continue in care and the Kentucky SKY program, the Transition Team will work with the youth to identify alternative sources of health care coverage, including other publicly funded coverage and resources such as public health departments. For example, we will connect youth in the Kentucky Homeplace coverage area (30 counties in Appalachia) to the organization for assistance from their Community Health Workers, who help more than 200 uninsured individuals each quarter to access health care coverage and would be able to assist. We will coordinate with any new providers to share medical records, the transition plan, and other information as authorized by the Enrollee to support continuity of care through disenrollment from Kentucky SKY.

We will connect youth to the Kentucky Cabinet for Health and Family Services' new website for transition age youth, Kentucky RISE (Resources for Independence, Success, and Empowerment) and help them apply to access vital records such as birth certificates.

Securing Important Documentation. The Transition Team will assist the Enrollee to collect and track important documentation essential for successful adult life, including the Enrollee's birth certificate and social security card. We will also educate the Enrollee on how to access their identification cards.

Maintain My Medicaid Initiative

WellCare of Kentucky will partner with DCBS/DJJ to encourage Enrollees to remain in care to access Medicaid services through age 26 and to locate Enrollees under age 26 who have left care and encourage them to re-enroll.

Supporting Youth to Maintain Medicaid. A key area of education during the Transition Team process will be educating the Enrollee about the services available through Medicaid and the importance of those services to the Enrollee's goals that they set for themselves. This will include ensuring the Enrollee understands their preventive, primary, and chronic care needs; mental health and substance use related needs; medications and the importance of consistent adherence; and the corresponding Medicaid coverage. It will also include educating them on requirements for maintaining Medicaid coverage including the re-certification process. The Transition Team will assist Enrollees, in-person or virtually, to reapply for Medicaid, including ensuring accurate Enrollee information, such as updated Enrollee address and phone number, to minimize future challenges accessing care.

Outreaching to Enrollees Who Have Left Care. We propose to take a proactive role in outreaching to Enrollees who leave care that DCBS and DJJ are unable to locate and providing education on the benefits of accessing Medicaid coverage. Monthly, our Transition staff would generate a list of Enrollees between ages 18-26 who are no longer on the 834 file and

determine whether they are enrolled in another Medicaid MCO. If not, we would partner with DMS and/or DCBS and DJJ to send an outreach message approved by DMS.

We recommend prioritizing electronic communication based on the feedback we receive from our youth regarding preferred contact methods. However, we would add phone, mailed, and in person outreach based on DMS direction. The outreach would include connecting the former Enrollee with the Medicaid benefits worker in their local area. It could also include sharing information with DCBS/DJJ such as former Enrollee contact information and any potentially urgent care needs such as continuation of medications, need for insulin, or a history of high BH needs or BH crisis.

If our contact information is no longer current, we can identify current phone number and email address for former Enrollees who participated in our JOOL program, which provides a smartphone and specialized mobile application to support Enrollee achievement of their own desired outcomes (see below for more detail). We will also request that providers that served the former Enrollee's providers conduct outreach based on the contact information they have and educate the former Enrollee on the benefits of reapplying for Medicaid and how to do so. If permitted, our staff can physically go to the provider location or other location and do direct education and outreach to the former Enrollee, or we may use telehealth methods to engage them. Our provider education for Kentucky SKY will include how they can assist us in identifying former foster care Enrollees accessing care and encouraging them to reapply for Medicaid or, if permitted by DMS, to contact WellCare of Kentucky for assistance.

Strengthen Independent Living Skills Training

DCBS requires foster care providers to create an independent living training plan as the child enters the teen years (age 14) and provide training to help them develop needed skills for adult life. This may include grocery shopping, ironing, how to establish a bank account, and other life skills. We will provide enhanced support to these providers to improve the timeliness and quality of these training plans. Our Provider Relations team will assist the provider to complete a gap analysis, comparing DCBS and WellCare of Kentucky-established requirements and benchmarks to the provider's current practice. One the analysis is complete, we will collaborate with the provider to develop a gap mitigation plan and offer technical support to ensure each child receives high quality, timely independent living training.

Ongoing Support to Meet SDOH Needs

Our experience demonstrates that youth aging out of foster care and the juvenile justice system as well as former foster care Enrollees have significant SDOH needs that can be obstacles to health, well-being, and positive outcomes if unaddressed. Key ways we will address this include the following.

Lifetime Access to Community Connections

All former foster youth will have lifetime access to assistance through WellCare's Community Connections program. As described in detail in response to Question G.10.f, our Community Connections program offers multifaceted support for SDOH needs. We will educate transitioning Enrollees about the support available through Community Connections, the

process for accessing it, and that they may continue to access this assistance indefinitely post-transition as needs arise with which they need help.

Post-Secondary Education and Training Support

As noted above, we will educate youth and all involved in their transition planning about post-secondary options including college, community college, and certification and other training programs available to support the youth's goals. About 600-700 Kentucky former foster care youth are enrolled in college at any given time. We will provide Welcome Home kits to Enrollees to help them settle into dorm rooms and apartments, such as bedding and towels, and connect them to community resources such as for assistance outfitting kitchens. We will also collaborate with DMS, DCBS, DJJ, and partners such as the Kentucky Community Technical College system and the University of Kentucky system to develop a plan to co-locate our staff on campuses where former foster youth are enrolled. We know from experience that some of these youth are homeless. Our plan would include Youth Peer Support Specialist outreach to connect homeless youth to housing supports, encourage them as applicable to reapply for Medicaid coverage, and educate them about the support our Community Connections program can provide.

COMMUNITY RESOURCE ASSESSMENT AND GAP PLANNING

We will work with our local community partners across the Commonwealth to crosswalk the needs of transition age and former foster care Enrollees with available resources in each region. We will identify gaps and work with the partners to identify ways to fill them.

Examples of Services or Tools

Below we provide examples of services and tools we have implemented in Kentucky to enhance services and outcomes for our transition age, former foster care, and juvenile justice Enrollees. Cookie cutter programs that may be used elsewhere are no substitute for approaches and tools that are tailored to the specific needs of youth in Kentucky, based on their input and the input of stakeholders in the Commonwealth. Solutions must be grounded in the voice of our youth here at home and must reflect Kentucky's foster care and juvenile justice infrastructure. The examples below demonstrate our understanding of the unique needs of the Kentucky SKY population and the Commonwealth's system of care and stakeholders.

VALUE ADDED BENEFIT TO PROMOTE TRANSITION SUCCESS

We pilot tested an innovative value added benefit to promote a successful transition between settings. Through the Key Assets program, we collaborated with Our Lady of Peace Hospital, Key Assets in Lexington, and Bluegrass Community Mental Health Center for Enrollees moving from the hospital to a family home. Ideally, a transition of care from one provider to the other for a high needs foster care Enrollee involves a face-to-face case conference to discuss the case and avoid the child having to tell the story all over again to the new therapist. However, Medicaid rules do not permit two providers to bill for providing the same service at the same time.

We paid the relinquishing provider as a value added benefit while the receiving provider billed for the Medicaid service. This approach helped achieve the program goal of avoiding re-traumatization of the child and promoting stability in the new placement through equipping the new therapist to begin meeting the child's needs immediately upon placement in the community.

In addition, we paid a foster parent to come to the group home to visit the child prior to the child switching placements to begin establishing a relationship, which helped us achieve our goals of a smooth transition for a high needs child and stability in the new placement. This overlapping approach can serve as a model for transitioning those who choose to leave care and will have a non-Medicaid source of care post-transition.

JOOL LIFE COACH

Our JOOL Life Coach mobile application (which will soon be rebranded as Kumanu) is aimed at engaging and improving purpose in life of transition aged and former foster care youth to improve health and life engagement, energy (vitality), willpower (self-control), resilience, lifestyle change, and health care costs. JOOL has helped us achieve program goals related to supporting appropriate access to care, overall well-being, and maintenance of Medicaid eligibility.

Those enrolled in the program are provided an overview of the program by the WellCare of Kentucky Care Coordinator along with their caseworker and current care provider, as depicted in **Figure G.12-4**. If the youth has a personal smart phone, we encourage them to use it, if possible. If they do not have access to a smartphone, WellCare issues one with limited capabilities. The Care Coordinator works with the Enrollee to download and set up the JOOL application on the phone.

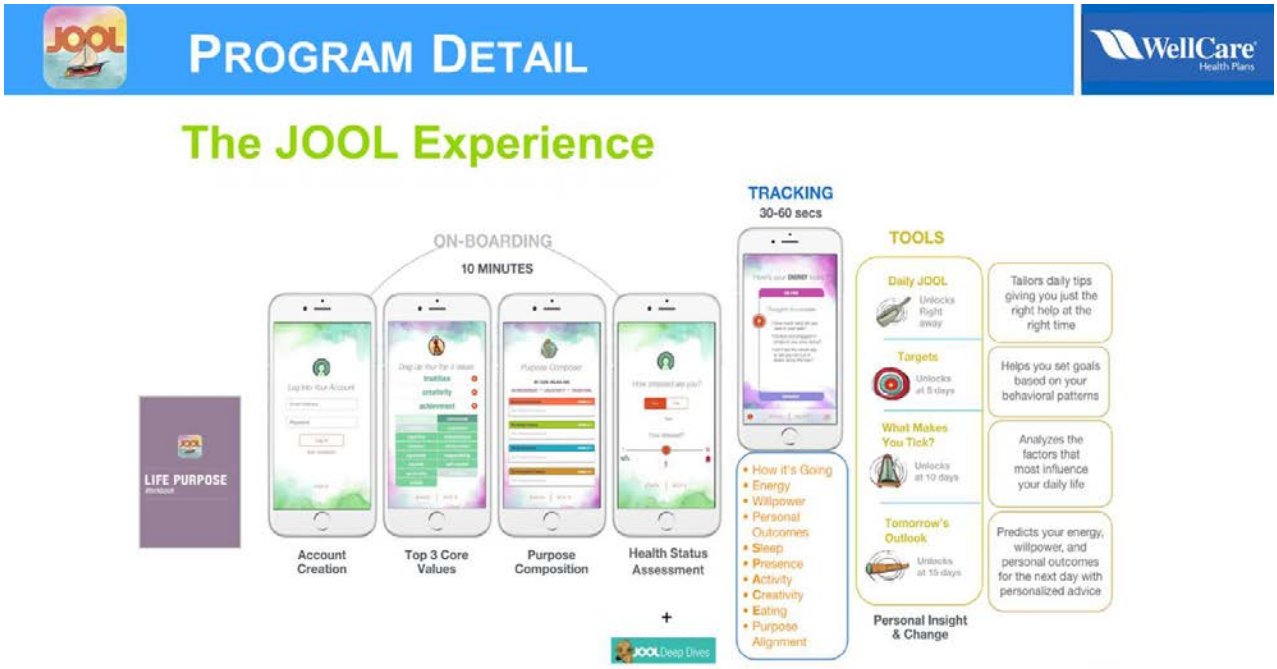

Figure G.12-4 The JOOL Experience

Onboarding. The JOOL application introduces the Enrollee to the program, walking them through the following onboarding steps:

- Core Values. The Enrollee chooses their top core values, such as tradition, responsibility, expertise, kindness, and independence.
- Purpose Composer. This step asks the Enrollee to identify four purposes, a personal purpose, a family purpose, a work/school purpose and a community purpose. An example of a school purpose could be "I want to be on time to school every day and exceed the expectations of my teachers".
- Health Risk Assessment (HRA). The Enrollee answers short questions about information such as age, gender, height, weight, stress level, diabetes, and feeling depressed.

Daily Charting. Once the onboarding is complete, the Enrollee begins daily charting in three areas:

- How aligned are they with their purposes for that day. For example, the Enrollee may be less aligned with the work/school purpose if they were late to school or reprimanded by a teacher.
- S.P.A.C.E. – Sleep, presence, activity, creativity and eating.
- Changes to the Enrollee's personal outcomes.

Personalized Support. The JOOL application "learns" about the Enrollee through charting. After five days of charting, the application establishes a baseline so that it can track how often the Enrollee's targets are met. After ten days of charting, the application begins to give interactive visuals of what factors impact S.P.A.C.E., willpower and the Enrollee's outcomes the most. After fifteen days of charting, the application begins to forecast S.P.A.C.E, willpower and personal outcomes and then provides tips to improve the outcome. Please see **Figure C.12-5** for an example of JOOL's tools.

Daily JOOLS. The application provides "Daily JOOLS", machine learning intelligent tips that get smarter over time. The tips are targeted messages that address executive functioning, S.P.A.C.E., outcomes, and other factors that encourage a healthier lifestyle and taking responsibility for health. For example, a key Daily JOOL discusses the importance of the need to re-certify Medicaid status.

Implementation. Currently, there are 250 WellCare of Kentucky Enrollees who meet the target population criteria. Virtually every Kentucky County has at least one potential program participant. WellCare and leadership from the Division of Protection and Permanency are collaborating to identify the Enrollees to target to pilot this application. The pilot will run for 12 months, followed by a full evaluation to determine outcomes and the best approach to implement it statewide.

Customizing Based on Youth Input. We held a focus group on November 30 with young adults who recently aged out of the Kentucky Foster Care program. One of the more vocal outcomes of the research was that an incentive may be needed to help Enrollees to reach certain milestones of the program, such as the fifteen days of continuous journaling mentioned above.

JOOL SCREENSHOTS

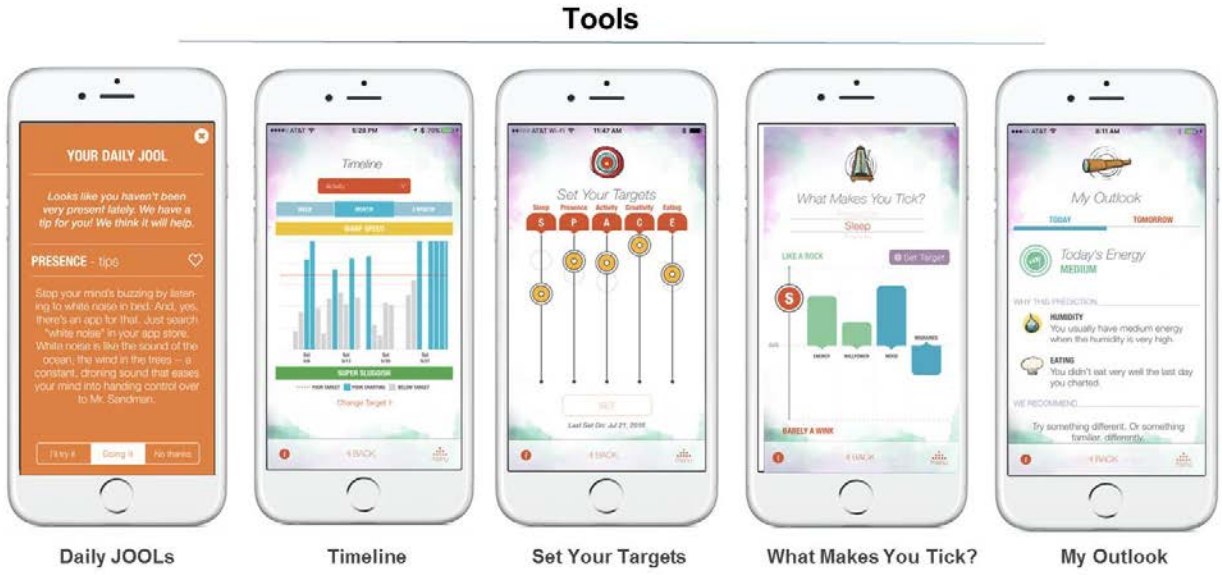

Figure G.12-5 JOOL's Tools

As a result, the program will include some small incentives to help ensure as many Enrollees as possible reach the important milestones of the application. The following incentives will be used in the program:

- Age appropriate, no cost, mobile phone games. Popular games such as Candy Crush, Sims, Farmville, Angry Birds or many other family friendly titles.
- Gift card incentives for Enrollees who reach certain milestones in the program. The following incentives will be available:
  - $25 gift card for program Enrollees who use their own phone.
  - $25 gift card for finishing the program (12 months).
  - $10 gift card each at 3 months, 6 months and 9 months

We will not require the Enrollee to turn the phone back in to us at the end of the 12 month program, however, the cellular service will be discontinued. The Care Coordinator will assist the Enrollee with contact information on the LifeLine phone program.

WELLCARE WORKS

As described previously in subsection G above, our WellCare Works program connects Enrollees to tools, training and other resources that promote social engagement and empowerment. Since launching the Community Connections Program in Kentucky, **we have connected 31,000 people to 165,000 services across the Commonwealth**. We have provided grant funding to local community organizations to train Enrollees to use the WellCare Works platform which provides multiple tools to learn, train, prepare, and secure employment and/or

volunteer opportunities. WellCare Works helps us achieve program goals for meeting employment and financial needs, which are key social determinants of health that, in turn, impact ability to access care and health outcomes. For this population, employment and financial independence also help build resiliency.

COMMUNITY COLLABORATION AND REINVESTMENT

Through our Community Connections Program, we promote collaboration among WellCare of Kentucky, Enrollees, and stakeholders to identify and address obstacles to successful transition and provide community investment funds to support initiatives that address these obstacles. This helps us achieve program goals related to meeting social determinant of health needs (which impacts health outcomes as well as resiliency) as well as to improving integration of effort across the health and social services systems. Our community reinvestment funds support community partner trainings, mentoring programs, internships, and transition assistance tools, e.g. computers and one time financial awards to support transitions (e.g., scholarships to pursue a post-secondary degree or trade-school certificate). Examples of collaboration with the community and reinvestments we have made to support the aging out population include the following.

Supporting the Transition Age Foster Care Conference

WellCare of Kentucky participated in and supported the work of the Commonwealth Transition Age Foster Care Conference. For the June 2018 conference, which focused on preparing for employment, WellCare of Kentucky was a primary sponsor. Leann Magre and some of our dedicated foster care Care Coordinators hosted a workshop on preparing for the job interview process. One topic was conveying a professional appearance. To further support the youth in this area, we set up a Professional Clothes Closet to show participants the types of clothing items and outfits that would help them dress appropriately for interviews and work, and to allow the youth to “shop” for appropriate clothing that they could wear to interviews. Participants left the conference more prepared to apply for, interview for, and secure a job.

Fostering Goodwill

Fostering Goodwill in Fayette County works with youth age 18-24 who age out of the child welfare system to assist them in developing skills and obtaining resources to promote a successful transition to adulthood. They assist youth in obtaining a permanent, safe, and secure environment that promotes independent living and self-sufficiency. The group also provides financial, housing, counseling, employment, education and other appropriate support and services such as collecting necessity household items.

We provided funding to cover food and travel vouchers for youth to participate in Fostering Goodwill’s monthly Fostering Success group meetings that promote basic life skills such as the importance of maintaining their health, legal advice, the need to have health insurance, encouraging them to get needed services within the community, mental health, credit education, employment training, sex education, parenting skills, career preparation, and more. The funding also supported ongoing provision of mentoring for these youth.

Pathways Inc. - Transition Age Youth Launching Realized Dreams

Transition Age Youth Launching Realized Dreams (TAYLRD) aims to positively impact the lives of 16-25 year olds who have, or are at-risk of developing, behavioral health challenges by improving access to high-quality, culturally and developmentally appropriate supports and services across the state. TAYLRD also provides supported employment and supported education services to those aged 16 - 25 years old, who are diagnosed with a behavioral health condition. Appropriate employment in this population is a known factor in recovery and lifelong health improvements. We provided funding to support provision of basic needs and clothing help to youth with employment and educational goals who are homeless and experiencing mental health and/or substance use disorders.

True Up Louisville

True Up Louisville in Jefferson County assists foster children aging out of the system to create educational and/or vocational paths and provides system navigation and application assistance to help them meet their goals. We provided grant funding to support the organization's Awareness Fairs and Experiential Education Series. This included:

- Collateral material to promote the fairs and participation (i.e. poster, pamphlets, etc.).
- True Up website landing page specifically promoting Fall experiential fairs
- Professional Services fees for paid and earned media to promote events throughout the community
- Resource Center/Peer-to-Peer Support
- Rewards/Incentives for participants of True Up's Peer-to-Peer pilot program
- Support for the organization's Resource Center.

13. Use Cases for Kentucky SKY

G.13. USE CASE 1 - VENDOR

Based on feedback from experienced DCBS Social Service Workers, certain providers in the Eastern Mountain Service Region have limited knowledge of trauma-informed evidence based practices. The DCBS caseworkers have documented numerous examples where Emergency Department (ED) staff and physicians/office staff neglected to conduct and document trauma assessments on children and youth, exacerbated trauma when physical assessments were performed on pre-teen girls, and failed to seek medical records before ordering duplicate testing/services.

Describe how the Vendor would address and ensure the delivery of trauma informed care by the contracted provider network for the Kentucky SKY membership. In particular, address how it assesses providers' knowledge of trauma informed care, the approach for targeted provider education at regional and state levels, as needed, and plans for collaborating with DCBS staff. At minimum, address the following in its response:

a. Evidenced based practices and trauma-informed care for the Kentucky SKY membership;
b. Unique needs of children and youth in Foster Care;
c. Access to and sharing of medical records
d. Provider contracting;
e. Provider education and ongoing support;
f. Performance monitoring;
g. Cultural competency; and
h. Community engagement.

G.13. USE CASE 1 - VENDOR

Our approach to improve the quality of trauma-informed care (TIC) delivered through our network is rooted in our local field-based structure and long-standing relationships with providers in Kentucky. Our Quality Improvement team works collaboratively with their counterparts from other functional areas, such as Care Coordinators, Community Connections staff, Operations Account Managers, and Provider Relations Representatives (PR Reps). In addition, we routinely meet in-person with our providers, DCBS, DJJ, law enforcement, community non-profit, and faith-based partners to discuss barriers and gaps in care delivery. We collaborate to identify opportunities to strengthen the delivery system and social safety net. Our strategy to address the lack of trauma screenings, TIC and duplication of medical testing brought to our attention by DCBS in Eastern Kentucky involves multiple mechanisms including: locally-based provider engagement model, with initial and ongoing training and performance monitoring; onsite ED and hospital-based staff; provider summits; joint operating structure agreements; preferred provider incentives.

WellCare is the only MCO serving Region 8 continuously since 2011.

Locally based Provider Engagement Model (PEM): In responding to DCBS concerns in Eastern Kentucky our PR Reps will hold a joint meeting with DCBS, SKY Care Coordinators, Quality Practice Advisors and Patient Care Advocates to identify trends and understand DCBS concerns. A data-driven plan will be developed using use our Quality Performance Metric Engine which incorporates data (e.g., clinical and medical records documentation, CAHPS, claims, complaints,

appeals, grievances, encounters, authorizations, quality of care incidents, care management documentation, pharmacy data, social determinants of health data, etc.) from a multitude of administrative, hybrid, and supplemental sources. We identify SKY members in Eastern Kentucky and assure Providers have a list of youth who require trauma screens, and TIC. In addition, we work directly with providers, ED and office staff on:

Assessment of Trauma Informed Practice. Using the National Child Traumatic Stress Network framework for TIC, we will work in collaboration with DCBS, the Kentucky Partnership for Children and Families, the University of Louisville Kent School of Social Work, our providers and community stakeholders, to develop a checklist for TIC. This tool will include indicators that providers understands and are implementing TIC. For example, child-friendly waiting areas and exam rooms, performance of ACE assessments, trauma, PTSD and other behavioral health screens, limiting seclusion or restraints, and staff education.

Individualized Provider Quality Plans. The PEM team reviews baseline quality results on their trauma assessment and other quality measures (e.g., well-child visits, adolescent well care) and develops a comprehensive plan for each provider in the delivery of TIC. Key input to the plan comes from the provider and their office staff as well as**: Patient Care Advocates (PCA)** WellCare quality experts responsible for supporting rural health providers and who are co-located in our larger practices on a rotating basis to help close care gaps for patients. PCAs have firsthand knowledge of provider practice patterns, barriers to high quality care and population needs. **Quality Practice Advisors (QPA)** who monitor data analytics using P360, our Quality Provider Profiling Program. These reports assess provider progress meeting performance expectations, readiness for change, and capacity to implement changes. **DCBS, Members and Community Stakeholders** who offer feedback through satisfaction surveys, grievances and as part of our SKY Collaboration and Optimization Committee.

Local and Regional Training: Our integrated team hosts regional training forums in partnership with the DCBS and DJJ, augmented with online training, available 24/7.

Appointment Agendas: Appointment agendas are child and youth-specific guides including a comprehensive record of their health status for our most complex enrollees including care needs and missed diagnosis data that can be used as a tool for visits.

Electronic Medical Records (EMR) Exchange: To minimize duplicative procedures, we work directly with providers to connect and use electronic health information in their care planning. We help providers overcome technical challenges and create solutions to fit their needs. For example, we have provided grants to assist small practices and rural providers in connecting to EMR; and we train providers on how to use the Kentucky Health Information Exchange. CareCentral, our electronic care management platform is configured to be interoperable with Health Information Exchanges, EMR platforms, and state-specific electronic Admission, Discharge, and Transfer feeds. This inter-operability results in our network providers having up-to-date and real time information via our Online Provider Portal.

Onsite Hospital Staff. Our contract agreements require hospitals to notify us when a KY SKY is admitted to a hospital (ED or inpatient). We offer a dedicated discharge team that includes onsite Care Managers, who are RNs, in our highest volume hospitals for care planning and

service authorizations. We employ telephonic RNs for smaller hospitals, skilled nursing facilities, and other rehabilitation facilities or settings. Our dedicated team is trained in TIC. By asking key questions such as whether trauma screens have been conducted and if pediatric care staff have completed trauma training, they help to teach and model best practices for our providers.

Provider Summits. To ensure our Eastern Kentucky partners provide TIC we actively solicit input on barriers and work to address them. WellCare hosts provider summits that bring together physicians and practitioners from across disciplines and provider types. Often when WellCare hosts these types of summits they are the first time practitioners from medical, behavioral and social services have sat in the same room to brainstorm barriers and opportunities for promoting high quality care delivery. These meetings:

- Provide evidence-based information and training on TIC
- Understand TIC models that are working in the region
- Understand the challenges that providers face in developing and sustaining TIC
- Determine what WellCare can do to help providers develop TIC

During these summits we engage state and national presenters to share best practices and challenges in implementing TIC. For example we engage peer leaders such as Ramey Estep to present on TIC and the needs of youth in foster care. We invite individual practitioners such as Mark Hamm with Phoenix Preferred Care to host peer-to-peer panels and facilitated discussions on barriers and best practices. In response to the barriers and recommendations identified by providers, WellCare schedules follow-up sessions and assigns work groups (with internal and external membership) to develop actionable recommendations to reduce barriers. Steps we have already taken include:

- Creating an expanded benefit that that allows providers to be reimbursed for consultation and coordination between PCP and behavioral health practitioners;
- Allowing claim payments for two types of services from a provider on the same day (e.g., ACE screening or BH consult and Well-child visit);
- Utilizing Care Coordinators to improve provider communication and collaboration.
- Providing BH and PCP practices a list of providers that jointly serve patients

We continuously promote professional collaboration and dialogue through our advisory committees, quality infrastructure and stakeholder feedback process. For example, in 2016, when WellCare's quality team identified issues with discharges from the Appalachian Regional Hospital (ARH), we met regularly with ARH and our Community Mental Health (CMHC) partners to identify strategies for collaboration and improve the process.

Joint Operating Committees. We establish agreements that include routine meetings (monthly or quarterly) with large health systems and practices (CMHC's, Hospital and physicians) to review operational challenges and expand successes. Our Joint Operating Structure includes provider training, discussions of quality concerns and delivery system challenges. We jointly develop policies and procedures, workflows, position descriptions and other documentation to support TIC and evidence-based practice. We review care gap data, utilization trends and provider relations information to discuss performance issues and challenges. Our joint

agreements also include co-location of staff; clinical rounds for complex Members; quality chart audits; metric monitoring; and process improvement planning.

Preferred Provider Incentives. Enhanced reimbursement is offered to PCPs managing Kentucky SKY Enrollees in the form of a care management fee. This fee compensates the PCP for their additional roles and responsibilities as a medical home. We also offer a Partnership for Quality (P4Q) incentive program that incents reductions in emergency room use, timeliness of initial outreach by the PCP and the completion of trauma informed health assessments in a timely manner. As the KY SKY program matures, we will identify high-quality providers as "SKY Preferred Providers". For example, year-one we will identify PCPs serving large numbers of foster care children, conduct an assessment to identify best practices and adherence to quality standards. Practices identified as delivering high-quality services will be designated as a SKY Preferred Provider for DCBS. We will engage these providers for input on training materials and participation on quality committees. In future years we will expand the SKY Preferred Provider designation to specialty providers.

a. Evidenced based practices and trauma-informed care for the Kentucky SKY membership

WellCare understands that Adverse Childhood Experiences (ACEs) correlate with poorer overall health, increased treatment needs, asthma, ADHD, autism, obesity, mental health issues, and violent behavior. Our **Healing Futures Program** is designed to improve the wellbeing and resiliency of our pediatric population through early ACE identification, timely and appropriate interventions by TIC-trained professionals, and engagement with relevant community resources. As part of our enterprise-wide implementation we are identifying providers with TIC-training to expand our network. We ensure that SKY enrollees receive holistic, integrated care from a trauma-informed perspective across the Commonwealth through trainings held in the providers' offices during monthly on-site visits, a bi-weekly webinar and annual Provider Summit. We are partnering with the University of Louisville, Kent School of Social Work, to implement a TIC training program. Our partnership includes curriculum development, building capacity, launch and evaluation. Training via Webinar and in-person using modules identified elsewhere in our response (see Section G.06 and G.07) such as: Trauma-Informed Care and Adverse Childhood Events using materials and trainings from Kentucky DCBS, DJJ University of Louisville, and The National Child Traumatic Stress Network.

b. Unique needs of children and youth in Foster Care

During initial and ongoing training our PEM, toolkits and online training modules offer information on the unique needs of children in foster care. We will also leverage our partnership with the Kentucky Partnership for Families and Children, Inc. to provide trainings and educate the public regarding children's behavioral health needs including our Community Connections helpline and tools available to expedite social safety net services and family caregiver support. In addition to trauma awareness our formal provider trainings described in our response (see Section G.06 and G.07) include information on the importance of:

- Coordinating Services
- Child Adolescents Needs and Strengths
- Crisis Intervention Services
- High Fidelity Wraparound
- Neonatal Abstinence Syndrome
- Emotional Intelligence

- Behavioral Health Integration
- Building Bridges Initiative

c. Access to and sharing of medical records

Our management information system (MIS) links claims, customer service, case management and utilization review in one secured, interoperable, integrated and purpose-built platform to collect, analyze, process, integrate and report data in support of our enrollees. Using this platform, PCPs, BH specialists, DCBS, community partners and other providers have 24/7 role-based access to a 360-degree view of each enrollees' services and health status that incorporates key clinical, demographic, social and lifestyle data. We provide real time actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the **Medical Passport**, including vital documentation such as birth certificates, so that that SKY enrollees will retain an up-to-date health portfolio and comprehensive summary, throughout placement and health care transitions. We work with **Kentucky Health Information Exchange** and immunization registries to link essential health data to the enrollee record and update our PCP care gap reports. **Telehealth** visits are integrated into the overall care plan, including documentation of the service provided. WellCare also reimburses providers for store-and-forward communications to allow them to share x-rays, MRIs and other documentation to support diagnoses within the medical record. **Other supplemental data** includes laboratory results, pharmacy data, historic state encounter files, electronic health record output files and validated historic hybrid medical record results. EHR output files are used to create transparency and reduce redundancy when sharing enrollee health records. We manually collect EHR data from Providers who do not have the ability to produce output files. This gives us and the PCP insight into services received but not captured on claims and supports utilization by reducing over-utilization and duplication of services.

d. Provider contracting

A Welcome Packet is sent within five days of contract execution and providers are assigned to our dedicated PR Rep, who completes orientation, and other required trainings within 30 days of providers joining our network. The PR rep ensures the provider, and their office staff can access our Provider Portal and easily access online training materials and library of clinical practice guidelines. The PR Rep also engages in a discussion to identify the provider's key challenges and their level of understanding of TIC, DCBS requirements and working with youth in the foster care system. Through enhancements to our credentialing and recredentialing processes, we will systematically identify providers with formal training in areas of TIC care, the use of behavioral health assessment instruments, and the use evidence-based practices like trauma-focused cognitive behavioral therapy (TF-CBT), dialectical behavioral therapy (DBT), parent-child interactional therapy (PCIT), rapid eye movement desensitization and reprocessing (EMDR), and others. We will also identify areas of subspecialty focus include sexual abuse, physical abuse, domestic violence, human trafficking and others to direct enrollees to providers unique to their needs.

e. Provider education and ongoing support

Provider education and ongoing support starts with on-boarding and initial training (see Section a-d above). This is supported with WellCare's **Clinical Practice Guidelines** which incorporate

Healthy Foster Care of America American Academy of Pediatrics (AAP) guidelines for PCPs; the national Building Bridges framework with a focus on reducing seclusion and restraint for hospitals, PRTFs, and private childcare providers. For all youth, our guidelines align with AAP Bright Futures guidelines for health supervision of infants, children and adolescents to support developmental screening for, and sensitivity to, mental health needs, exposure to violence and adverse events during health care visits. In addition, WellCare's **Internal Integrated Clinical Team** uses a variety of methods to help providers understand TIC and coordinated care on a case specific basis, including: assistance with discharge planning; integrated clinical case conferences; weekly integrated "Medical Behavioral Grand Rounds" on complex cases; and integrated care plans for all SKY enrollees. **Behavioral Health and EPSDT Toolkits,** support providers as they deliver care including ACE, trauma and substance use screens, medication guides, comorbidity, intervention, and referrals to promote recovery and resiliency.

f. Performance monitoring

We continuously monitor performance and assess the quality of our provider's practice, regularly presenting the results using the following tools and reports we offer education on performance and identify opportunities.

P360 Program	P360 establishes the initial baseline and improvement benchmarks for provider's quality and continually measures progress towards meeting these goals.
HEDIS® Provider Performance Profiles	A monthly dashboard that shows each provider their performance on quality metrics as compared to his state peers and national benchmarks. Patient level detail is also provided to help providers determine which patients need attention.
P4Q Portal	This interactive portal has drill down capabilities to show providers current incentive earnings and potential earnings based assigned Members and services.
Provider Dashboard	Our Enterprise Provider Dashboard (EDP) Report integrates with our online provider portal aggregating quality, utilization, risk adjustment and operational data to create an overall performance dashboard. Produced at the individual provider, practice, regional and statewide level, the EDP compares Providers to their peers for quality, risk, utilization, and operations. The EDP includes Items such as care needs reports that can be drilled-down at the Member level; P4Q data; 7 and 30 day readmission rates, ED visits, inpatient claims and more.

Member and Provider Grievances, Complaints	Member support representatives review, log, and categorize grievances and complaints by cause, disposition, type for review and follow-up. Data is shared with our PR Reps for provider follow-up
Quality of Care Incidents	Quality of Care (QOC) incidents are identified through claims and grievance data, a root cause analysis is conducted on each incident. We track and trend QOC events to determine if there are issues needing PEM follow-up with the provider.
Annual Medical Record Review	We sample provider charts for compliance with our CPGs and provide feedback to Providers on identified quality issues.

g. Cultural competency

We routinely share disparity data with providers, including race, ethnic, gender, and geographic disparities for assigned-Members and an analysis of the impact on the region. During trainings the PR Rep reviews the practice's obligation to deliver services to assigned-Members in a culturally competent manner as well how to access: member materials developed in English, Spanish, and large-print; oral translation through the WellCare language line supporting over 200 languages; free onsite sign and oral interpretation service that providers can schedule online prior to patient visits; free interpreters through Video Relay Service so patients who are deaf or hard of hearing will never be at a disadvantage when visiting the practice; Cultural Competency Training, through our Provider Portal including how to deliver effective cross-cultural communication; how to recognize bias in communication; and how to understand and respect cultural and religious preferences in care planning.

h. Community engagement

To design community collaboration strategies in Eastern Kentucky we leverage our Community Connections Model and existing Kentucky relationships. Together we conduct an initial gap analysis to determine how our support and expertise will be of greatest benefit to address gaps and opportunities for health. We deploy local teams dedicated to collaboration, Community Engagement Partners identify and continually engage with organizations for ongoing and future investment opportunities around unmet health-related social resource needs. Community Impact Councils (CIC), comprised of local community leaders, social service organizations, and WellCare representatives, bring stakeholders together to find solutions and address gaps. Knowing Eastern Kentucky is a predominately rural area, the local Community Engagement Partner would work with Susan Howard, Regional Administrator for DCBS to create a CIC similar to one conducted in rural Western Kentucky that supported a regional conference providing training on TIC. In Eastern Kentucky, WellCare would invite representatives from local organizations in the Eastern Mountain Service Region of Breathitt, Floyd, Johnson, Knott, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike and Wolfe counties. Some of these organizations would include representatives from the Kentucky River Health Department, Mountain Comprehensive Care Center, Judi's Place for Kids, Kentucky River Children's Advocacy

Center, Hazard-Perry County Community Ministries, East Kentucky Dream Center, local DCBS offices, Appalachian Regional Hospital, Highlands Health Systems, and Pikeville Medical Center. The CIC guides local projects to improve TIC and support healthy childhoods for our SKY enrollees. WellCare brings a strong community focus to all of our programs. In June 2019, WellCare was recognized, for the third consecutive year, as one of the 50 most community-minded companies in the U.S to by Points of Light, the world's largest organization dedicated to volunteer service.

G.13. USE CASE 2 - KIMBERLY

Kimberly, 15 years old, has been in foster care for two years with placements in three different Service Regions during that period. She was placed in foster care following a report from her school that she came to school exhausted and hungry. Kimberly's teacher, who had been concerned about her outbursts at school, was able to get Kimberly to describe violence at home between her mother, Linda, and Linda's boyfriend. Kimberly would care for her two younger siblings, ages five and two, when the adults in the house fought and used drugs. Twice a week, Kimberly asked neighbors for food for her siblings, and occasionally stole money from Linda's boyfriend to buy food at a nearby gas station/food mart.

Upon investigation, the Social Service Worker found a filthy house without food in the refrigerator or kitchen cabinets. Kimberly's siblings were dirty and hungry. Kimberly told the Social Service Worker that Linda and her boyfriend would fight and use drugs "all of the time". Kimberly's siblings were placed in separate foster homes but have since been reunited with their mother. Linda now lives in eastern Kentucky, approximately 200 miles from Kimberly's current foster home.

After coming into foster care, Kimberly has been suspended from school four times for behavior issues. She has a pattern of absences, and is currently failing most of her classes. Kimberly has a 17 year old boyfriend and is sexually active. Attempts at reunification with her mother have failed after Linda expressed concerns over Kimberly's anger and hostility.

During a recent appointment for birth control, the PCP noted multiple cuts on Kimberly's arms and legs as well as healed scars. She told her physician that she was depressed, couldn't focus on school, and wanted to run away from home. The PCP prescribed an antidepressant and referred her to a behavioral health specialist. Kimberly was reluctant

to visit a specialist and scheduling appointments was challenging for her foster parents given the lack of providers within 45 miles of their home. Kimberly's foster parents contacted the Social Service Worker about their concerns over Kimberly's behavioral health issues and the availability of providers.

To her classmates and on social media, Kimberly began describing her suicidal thoughts. Over the weekend, Kimberly's foster parents found her unconscious with a suicide note on the bedside table. Kimberly had overdosed on pain medication she found in her foster parents' medicine cabinet.

Kimberly had to stay in the ED for three days pending availability of a bed. Her foster parents discussed care options with the Social Service Worker and described their fears once Kimberly returns home. The Social Service Worker was unable to find a residential facility with an available bed and the hospital initiated plans to discharge Kimberly.

Describe how the Vendor would address Kimberly's situation and coordination with the DCBS Social Service Worker, the ED, residential facilities, behavioral health providers, foster parents, and mother. At a minimum, address the following programs and services:

a. Care management, including coordination with the foster parents;
b. Discharging planning between levels of care;

c. Network adequacy and availability of services;
d. Availability and utilization of telehealth for behavioral health services;
e. Applicable evidence based practices; including psychotherapeutic interventions;
f. Prescribing psychotropic medications and documentation in medical records (e.g., rationale, follow-up assessments and monitoring, etc.);
g. Coordination of transportation, if needed;
h. Provider contracting;
i. Provider education and support;
j. Access to and sharing of medical records; and
k. Maintenance of the care plan.

G.13. USE CASE 2 - KIMBERLY

WellCare's discussion of this Use Case includes additional information about Kimberly and her family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare understands the importance of Trauma-Informed Care for children, youth and their families. Through our comprehensive discharge planning processes and telehealth network Kim will have consistent access to behavioral health care regardless of where she is living. Kim's WellCare Care Coordination Team will ensure that Kim has voice and choice in her care planning and that her foster home has the training and support they need to keep Kim safe. In alignment with the DCBS case plan, Kim's WellCare care plan includes safe discharge into the most appropriate, least restrictive setting possible, access to physical and behavioral health, social services and eventual reunification with her biological mother and two younger siblings.

Innovations for Kimberly

- Hospital-based staff
- Respite in the ED for Foster Parents
- Telehealth access to Behavioral Health services
- Intensive In Home Supports
- Technology enabled visits with mom and siblings
- Technology enabled life coaching (JOOL) and self-management (MyStrength)

a. Care management, including coordination with the foster parents.

Identification and Enrollment: The WellCare Care Coordination staff are alerted to Kim's ED admission by the WellCare hospital-based care management team. In addition to having hospital based staff onsite in our larger hospitals and automated ADT feeds, all WellCare network hospitals are required to alert us when any of our SKY members are seen in the ED with behavioral health (BH) issues. Kimberly is immediately assigned to Ellie, a WellCare Care Coordinator serving Owenton, Kentucky. Ellie is a master's level Social Worker and has extensive experience working with adolescents with BH challenges. Ellie has been trained and certified in High Fidelity Wraparound. During Kim's first 30 days of enrollment, Ellie will work to fully assess and determine Kim's on-going Care Coordination and Care Plan needs.

During Kim's stay in the ED, the WellCare hospital team works with ED staff to transition Kim to an acute inpatient setting with SUN Behavioral Health. Kim and her foster parents are

introduced to our respite support team, who are specialized respite providers with crisis stabilization training who offer the foster parents breaks during Kim's ED and inpatient stay.

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, and School Staff: Within the first 24-hours of engagement, Ellie will speak directly with the DCBS social worker to confirm Kim's most recent case plan goals, level of family involvement, Care Coordination Team (CCT) members, including her assigned Guardian Ad Litem and obtain the DCBS Service Plan 106B. Ellie will confirm Kim's PCP with Warsaw Family Practice and dental home with the Owen Dental Center. Ellie verifies that all releases of information are up-to-date and documented in CareCentral, WellCare's fully integrated care management system. Ellie obtains and populates CareCentral with information from Kim's most recent DCBS trauma screenings and Child and Adolescent Needs and Strengths Assessments (CANS) assessment.

Comprehensive Needs Assessment: During the first five days of enrollment and as Kim's medical condition stabilizes, Ellie schedules a face to face meeting with Kim to get to know her and understand her perspective on what she needs and wants. Because Kim is sexually active, Ellie confirms with the hospital that a pregnancy test was completed. Ellie will also collaborate with Kim's PCP to determine if changes in Kim's birth control method may be exacerbating Kim's depression and anxiety. Ellie meets with the hospital discharge planners, DCBS, and Kim's foster parents, the Bells, to understand Kim's readiness for step down as well as what the foster family needs to support Kim. In addition, with DCBS consent, Ellie schedules a call with Kim's biological mother Linda and the DCBS workers assigned to Kim's younger siblings. Kim's younger siblings are also enrolled in WellCare, Ellie speaks with their WellCare Care Coordinator in Pike County to be introduced to Linda via a 3-way call.

Ellie's goal is to gain a holistic understanding of Kim's needs and personal strengths, caregiver strengths, preferences, abilities, social service barriers, physical health and BH status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs; youth and family support, caregivers, and engagement with providers; back-up caregiver plans; emergency response plans; school, post-secondary education; and vocational needs. During the assessment process the team will also determine if this is Kim's only suicide attempt and whether it was impulsive based on the coincidental discovery of the pain medication or planned in advance. Ellie's information gathering and comprehensive assessment reveals a variety of factors influencing Kim's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• No recent dental visits • PCP visit for birth control • Pregnancy test negative • Doesn't want medication – wants to avoid becoming like "her loser mother" • Able to perform all ADLs and IADLs • Foster parent lack education on: proper medication disposal and storage	• Has not processed trauma of parental neglect and being separated from her siblings • Regrets not keeping younger siblings safe; parentification • Depressed and fearful for younger siblings • Angry at "the system" • Kim regrets overdose, and reports it was impulsive not planned • Cutting historically spikes with each placement change • No therapists within 45 minutes of foster family	• Wants to see siblings • Has not had contact with bio Mom, since mother got clean and sober • Supportive foster family, concern over lack of resources, moderate to high risk of unplanned placement change • Foster family does not have back-up caregivers • Kim does not affiliate with any religion • English is primary language • Very active on social media
Educational/Vocational	**Legal**	**Transitions**
• Struggling in school • Has no current career goals	• Guardian Ad Litem not active since last placement change • Linda is clean and sober and is approved to work on reunification with Kim • Linda has CASA support	• Multiple placement changes • Wants to be with younger siblings • Linda is 200 miles away in Pike County

Integrated Care Planning and Care Coordination Team Ellie speaks with the hospital discharge team to determine if Kim can safely return to her foster home with intensive Wraparound supports. Ellie also arranges a discussion with the NorthKey Community Mental Health Center's crisis stabilization and support team regarding the ability for intensive in home services as Kim discharges. Currently, NorthKey offers only outpatient services in Owenton. The wait to see a female therapist in the Owenton clinic is far too long for Kim's needs and the closest therapist is 45 minutes away. Through an agreement with NorthKey by using a single case agreement, NorthKey has agreed to provide intensive in home services with a Community Support Specialist and individual therapy two times a week with licensed clinician via telehealth. NorthKey also offers crisis services in Owenton to support Kim and the Bells. Discharge includes:

- Intensive in home services via single case agreement with NorthKey, dates and times and duration scheduled with foster parents and Kim
- Introduce Kim to a therapist through NorthKey, who can support Kim, regardless of her physical location, via a telehealth connection and WellCare issued tablet
- Update Kim's Child and Adolescent Needs and Strengths (CANS)
- Complete a psychiatric evaluation, including assessments such as the Clinician Assessment of Post-Traumatic Stress (CAPS-5) and Minnesota Multiphasic Personality Assessment (MMPI-A), as recommended by the NorthKey child psychiatrist.

- Develop a signed Suicide Prevention/Safety Plan and Contract with Kim including:
  - Foster family education on proper medication storage and disposal. This includes understanding what other medications are in home, disposal of those no longer needed and providing a lockbox for current medications, including over the counter drugs that could be lethal in large quantities.
  - A safety contract with Kim that identifies her triggers, people who she feels safe talking to and agreements on how the adults will respond to keep her safe.
  - NorthKey mobile crisis team clinician participation in safety plan development and access to CareCentral progress reports from the CCT for the most up-to-date information to stabilize the situation, should a crisis response be required.
  - Adding the safety plan and contacts to Kim's Medical Passport

Care Plan Monitoring and Follow-up: During Kim's intensive in home service period, Ellie checks-in daily with the foster parents. Ellie and the CCT will identify the longer term services and supports Kim and her caregivers need to be successful, including addressing Kim's trauma, planning for family reunification and preventing future suicide attempts and hospitalizations.

PCP Follow-up: Ellie will follow-up with the PCP to ensure that Kim has received education around her birth control and is adhering to her refill schedule. WellCare medical homes are required to coordinate with Kim's behavioral health providers. Ellie monitors and supports coordination through discussions with Kim, her foster parents and the CCT.

Social and Peer Support: Peer Support Specialist (PSS) serve as mentors, navigators and recovery supports for youth in crisis. Ellie offers Kim the option of working with a PSS to help her understand treatment options, and social and recreational activities are available in the community. Kim agrees to meet Athenia. Athenia becomes a mentor that Kim can to talk when she is feeling unsure about where to go for help. Through our closed-loop referral system with community partners, Ellie also connects Kim with FosterClub. FosterClub helps Kim connect with peers online, provides education and support to help youth realize their goals. Ellie provides Kim with information on free events at the Owenton library such as yoga, walking, and painting which can help reduce stress and promote wellness. Ellie teaches Kim about WellCare's life coaching app, JOOL. Through the app, Kim will complete her own health risk assessment and identify core values and goals most important to her. Once goal setting is complete, Kim enters daily notes; overtime the app provides daily tips, customized for Kim and her goals.

Foster Family Support: Ellie provides the Bells with psychoeducational material on depression and trauma. Ellie will explore whether Kim can get involved in after school activities or tutoring to assist with her school performance and provide the Bells with a break in caregiving. Ellie works with DCBS to ensure that the Bells have access to approved formal respite at least monthly, the DCBS respite services can be augmented as needed for the Bells through WellCare 's value added benefit. With the services received, the Bells begin to feel more supported and better able to help support Kim with her recovery journey.

Coordination with the School: Ellie confirms with DCBS that Kim's school plan includes the development of an individual education plan, 504 plan, or other education plan as needed. Ellie coordinates with The Family Resource Youth Services Center Coordinator, Janetta Briscoe at

Owen County High School to make sure key staff are aware of Kim's safety plan and trauma informed interventions. Ellie will explore Kim's strengths at school, including teachers, paraprofessional staff or coaches who may provide mentoring, respite or tutoring for Kim. As part of the single case agreement with NorthKey, in school support is available as needed. As Kim transitions back to school, her NorthKey will consult and arrange for individual therapy immediately after school on her first and third days back to assess how she is doing.

Family Reunification: Ellie, Linda, Linda's Court Appointed Special Advocate (CASA), the WellCare team serving Pike County and the DCBS case worker assigned to Kim's younger siblings discuss reunification support. Kim's reunification plan includes supportive family meetings that involve the Bells, Linda and Kim as well as parent/child sessions for Linda and Kim. Linda has access to our secure video conferencing capabilities at local provider sites to keep in touch with Kim and attend sessions. Linda also receives education in understanding Kim's anger and how to address Kim's outbursts. Kim's goals, programs and services include:

Member/Family Goal	Programs and Services	Focus Area
Kim: I want to see my siblings	• Technology enabled virtual visits weekly • Trauma informed parent/child sessions with Linda via telehealth monthly • In person visits as recommended by therapist	Permanency
Kim: I want to be happy	• Trauma Informed Cognitive Behavioral Therapy via telehealth • MyStrength and JOOL apps with WellCare tablet • Peer Support Specialist • FosterClub	Behavioral Health
Foster parents: We want Kim to be healthy	• PCP follow-up within 7-days of SUN discharge and regular EPSDT visits	Physical Health
	• Dental assessment and visits	Oral Health
Foster parents: We want Kim to do well in school	• Family Resource Center engagement • In school support by community support specialist as part of single case agreement with NorthKey	Educational
Foster parents: We want to support Kim	• Education and skill building with Foster Family to understand Kim's triggers and how to respond • Respite	Behavioral Health
Linda: I want to know Kim and I can get along	• Education and skill building with Linda to understand Kim's triggers and how to respond	Behavioral Health

b. Discharging planning between levels of care.

At each key junction in Kim's care; from the hospital to her foster home; and foster home to home, Ellie remains in daily and weekly contact with the CCT. Prior to each discharge Ellie completes a comprehensive evaluation of Kim's physical and behavioral health and social service needs; identifies services and supports needed to support a successful transition; verifies that services are in place prior to discharge. Following her transition to a new setting

Ellie follows-up within 24 hours of Kim's discharge to verify the transition, assess Kim's stability, answer questions, and resolve any new barriers to care.

Hospital to Foster Home: Following her return to the foster home, the CCT meets to assess the effectiveness of the intensive in home services. Over the next 30, 60 and 90-days the team monitors the frequency and intensity of services, Kim progress in using new coping skills and the Bell's level of understanding and comfort with Kim's in-home plan and adjusts accordingly.

Foster Home to Home: As Kim works to reunite with her mother, Ellie and CCT work with Kim's providers to develop trauma-informed safety plan with Linda. As family sessions progress from video to face-to-face meetings and home visits; Ellie collaborates with the Orphan Care Alliance (OCA) in Pike County to provide additional support for Linda and Kim. OCA works to wrap services around the family to assist with the reunification. OCA offers to help Linda with items such as transportation, and handyman services as she reestablishes her family in Pike County. Ellie will also provide a connection to the East Kentucky Dream Center (EKDC) in Pikeville for access to clothes, toiletries, and food for families in need through food boxes and free meals.

c. Network adequacy and availability of services.

Our Kentucky network includes more than 34,500 providers statewide. We continually monitor access and availability. In the first quarter of 2019, 100% of Pediatricians provide urgent care within 48-hours and 97.8% were able to see enrollees within 30-days for routine care. During that same period 91.9% of our specialty providers were compliant with urgent standards and 98.2% were compliant with routine standards.

d. Availability and utilization of telehealth for behavioral health services.

Kim's care plan includes a connection to a NorthKey telehealth provider as part of her hospital discharge plan. While NorthKey has a clinic in the Bells' home town, access to a therapist to meet Kim's needs is not available. Kim's in-home Community Support Specialist provides direct consultation to her foster home and in the school. As Kim progresses through her treatment and begins to transition back home in Pike County, Kim will have access to her clinician via her WellCare issued tablet. Ellie also sets up secure video conferring with the Pike County WellCare team to support Linda's participation in care planning and engagement in family sessions with Kim.

e. Applicable evidence based practices; including psychotherapeutic interventions.

Ellie uses our evidence-based Clinical Practice Guidelines that integrate Trauma-Informed Care, High Fidelity Wraparound, Trauma-Informed Cognitive Behavioral Therapy (TI-CBT), and more to guide the psychotherapeutic interventions in Kim's care plan. Based on Kim's assessment results, TI-CBT is identified as most appropriate to address her depression and anger. Kim and her therapist will work on understanding trauma, understanding Kim's triggers and how she can manage her thoughts and behaviors in response to those triggers. Ellie also introduces Kim to the WellCare suite of online self-help BH tools, MyStrength, which Kim can access on any internet platform and discuss with her therapist. MyStrength offers modules for understanding insomnia, anxiety, panic and phobias; alcohol and substance use; and depression.

f. Prescribing psychotropic medications and documentation in medical records (e.g., rationale, follow-up assessments and monitoring, etc.).

Ellie ensures that all consents and releases are obtained, properly executed and included in Kim's electronic record. Kim has indicated an unwillingness to take anti-depressants. Ellie shares this concern with DCBS and Kim's PCP. DCBS honors Kim decision. Ellie and the CCT talk with the PCP to determine if other medications, such as Kim's birth control may be contributing to her depression and anger. For all medications, pertinent information such as dosage, frequency and duration are recorded in CareCentral, contraindications, side effects and red flags are documented and Kim and her caregivers receive individualized education, including how to administer and monitor.

g. Coordination of transportation, if needed.

Kim initially reconnects with her mother and siblings through WellCare telehealth network and technology enabled 'virtual visits' and BH family sessions. To support in-person visits Ellie will work with DCBS and the foster parents to develop a schedule whereby the SSW and Bell's rotate transport to Pike County and locate half-way points that work for Linda to meet them for in-person supervised visits.

h. Provider contracting.

WellCare will draw on our longstanding relationship with Kentucky providers to form the foundation of our network. WellCare has established a Preferred Provider status for PCP's and other providers who complete trauma-informed trainings and demonstrate that tools and techniques have been integrated into their practice. Preferred Provider status reward providers who exemplify evidence based practice with differential rates and performance incentives. While NorthKey is a network provider, the services Kim needed were not available in her region. A single case agreement, outlining the services (frequency, duration and payment rates) was developed to support Kim's intensive in-home supports.

i. Provider education and support.

Kim will benefit from a well-trained and fully supported WellCare provider system. Our provider training is based on the American Academy of Pediatrics Healthy Foster Care of America guidelines. Ellie works as part of locally based team with WellCare's Provider Relations Representatives (PR) who live and work in the communities they serve. Ellie and the PR team review health care gaps, barriers to care and provider performance to identify any provider that may need additional support. Throughout Kim's care Ellie and the WellCare PR team speak directly with the PCP, dentists, BH providers, and office staff to answer questions about DCBS, managed care and Kim's health care needs.

j. Access to and sharing of medical records.

CareCentral integrates physical and BH, pharmacy and community support information into our Care Coordination processes. Using this platform, Ellie, Kim's PCP, DCBS, community partners and the CCT have 24/7 access to a 360-degree view of Kim's services and health status that incorporates key clinical, demographic, social and lifestyle data. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history,

authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the Medical Passport using functionality in our Member portal. This will include vital documentation such as birth certificates, so that SKY enrollees retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

k. Maintenance of the care plan.

Kim's care plan will be maintained electronically in CareCentral, including signed copies. Ellie will review and update the care plan monthly, the care plan will reflect and include a detailed description CCT members and their involvement in the Care Plan including the Kim's PCP, dental home, BH providers, specialist, community partners and caregivers. The care plan will include frequency and method for updating and revising goals, monitoring and follow-up activities.

G.13. USE CASE 3 - SHAKIRA

Shakira, 16 years, entered foster care two months ago after her primary caregiver, her grandmother, Mrs. Miller, passed away. Shakira was nine years old when she went to live with her grandmother in Lexington after her mother was incarcerated twice for shoplifting and drug possession with intent to sell.

Before the death of her grandmother, Shakira was an excellent student, a member of the swim team, played the clarinet in the school band, and hoped to go to the University of Kentucky (UK) to fulfill her dream of becoming a veterinarian. She had a boyfriend, Mike, who was the star player on the school's baseball team. Mrs. Miller had a full-time job with a modest income and was supportive of her granddaughter's studies and extracurricular activities. Shakira and her grandmother had discussed UK scholarship opportunities with the high school counselor.

Three months ago, Shakira's PCP confirmed that she was pregnant in her first trimester. Shakira and her grandmother discussed options: keep the baby, adoption, and abortion. Eventually, they decided to keep the baby to raise in their home. Mike and his parents strongly recommended adoption and refused to be involved in the baby's support or upbringing. Within a week of the final discussion with Mike, Mrs. Miller died from a myocardial infarction. She was found in her home by Shakira when she came home from band practice.

Shakira stayed with school friends for two weeks but the school counselor contacted DCBS and Shakira was placed in foster care. After two weeks in a Lexington group home, Shakira was placed in a private foster home in Bowling Green. Shakira began seeing an OB/GYN and made plans to keep her baby. She was also diagnosed with depression resulting from the death of her grandmother and transition to a foster home in Bowling Green. Shakira stopped talking about her dream to become a veterinarian.

Shakira's foster parents wanted both Shakira and her baby to stay with them as a teen mother and baby in foster care. The foster parents expressed concerns to the DCBS Social Service Worker, however, about Shakira's depression, poor school performance, and development of her skills to care for a baby.

Describe how the Vendor would address Shakira's situation and coordination with the DCBS Social Service Worker, the foster family, physical and behavioral health providers, transition from the family to the community, and community resources. At a minimum, address the following programs and services:

a. Care management;
b. Access to and coordination between physical health providers (e.g., OB/GYN, pediatrician) and behavioral health providers;
c. Access to network providers;
d. Discharge planning for all levels of care;
e. Coordination of school based services and an Individualized Education Plan
f. Community services for parenting skills;
g. Applicable evidence based practices;
h. Coordination of transportation, if needed; Options for aging out of foster care and risk management;

j. Social determinants of health;
k. Provider education and support;
l. Access to and sharing of medical records; and
m. Maintenance of the Care Plan.

G.13. USE CASE 3 - SHAKIRA

WellCare's discussion of this Use Case includes additional information about Shakira and her family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare uses a strengths-based and integrated approach to empower Shakira, and youth like her, to actively engage in health care decisions. WellCare engages Shakira in goal setting and care plan development, ensuring voice and choice in her care. We will work with the school, DCBS and her social support network in Lexington to identify Fictive Kin to support a return to Lexington, her friends and the school where she was most successful, if possible. Shakira will benefit from our comprehensive prenatal, infant health and early childhood supports program, WellCare BabySteps. In alignment with the DCBS case plan, Shakira's WellCare care plan will support her through a healthy pregnancy and successful transition to adulthood.

Innovations for Shakira

- Enrollment staff co-located with DCBS
- Integrated pre-natal, behavioral and infant health care, including telehealth
- Collaboration to find Fictive Kin
- College Welcome Kit and Scholarship
- Technology enable Medical Passport
- Support through adulthood

a. Care management

Identification and Enrollment: Kim, our WellCare Field Outreach Coordinator, who is co-located with DCBS in Lexington, alerts the Care Coordination Supervisor in Bowling Green of Shakira's placement and that she is pregnant. Kim works with the Child Benefit Worker and WellCare team to verify all paperwork is submitted and that Shakira's WellCare enrollment is complete. This includes the selection of PCP through Graves Gilbert with Shakira's DCBS Social Service Worker (SSW). Within 24-hours of her enrollment with WellCare Shakira is assigned to Beth, a WellCare Care Coordinator with maternity experience who has been trained and certified in High Fidelity Wraparound. For the next 30-days, Beth will employ the high fidelity wraparound model to assess and develop Shakira's care plan

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, School Staff: Beth calls Shakira's SSW to verify members of Shakira's CCT, including Shakira's current caregivers, guardians, OB and selected PCP with Graves Gilbert. Beth obtains a copy of the DCBS Service Plan 106B and discusses the status of Shakira's school performance and her educational needs. Beth and the SSW agree on a case management plan, and schedules a visit to meet Shakira and her foster family within one week. Beth contacts Shakira's former PCP in Lexington to augment her information with past visit information and her OB/GYN in Bowling Green to obtain the most up-to-date records of recent visits. Beth ensures the OB/GYN has attended WellCare's SKY Training Program and sends web links and material to the OB/GYN

office to make sure they understand their responsibilities for KY SKY members including information on trauma-informed care. Beth verifies that Shakira's labs are up-to-date and common causes of depression in pregnancy, such as transient hypothyroidism or anemia have been assessed and ruled out. She verifies Shakira has a Dental Home and makes sure all of her providers are documented in CareCentral system, our integrated care management system.

Comprehensive Needs Assessment: During her home visit Beth meets first with Shakira, she completes a PHQ-9, a pregnancy risk assessment, and Comprehensive Needs Assessment. Beth has obtained access to the DCBS trauma screening tools and schedules a Child and Adolescent Needs and Strengths Assessments (CANS) with a clinician specifically trained to complete this assessment through our agreement with LifeSkills Community Mental Health Center. Beth's goal is to gain a holistic understanding of Shakira's needs and personal strengths, caregiver strengths, preferences, abilities, social service barriers, physical health and BH status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs; youth and family support community, caregivers, and engagement with providers; back-up caregiver plans; emergency response plans; school, post-secondary education; and vocational needs. The assessment reveals a variety of factors influencing Shakira's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• Healthy, athletic • Proud of healthy lifestyle e.g., swimming • Committed to prenatal care and her baby's health • No current pregnancy complications • Does not want medication for depression for fear it will harm baby • Able to perform all ADLs and IADLs	• Has not processed trauma of finding her grandmother • Depression resulting from the loss of her grandmother and hometown (i.e., situational, adjustment disorder) wants to be able to visit her grandma's grave "whenever I want" • Swimming is joyful and calming • Music makes her feel energized • No current suicide risk	• Wants to see friends in Lexington and baby's father • Has strong connection to her church, friends of grandma and swim coach • Supportive foster family, low risk of unplanned placement change • Likes foster family, wants to be treated like an adult • Foster family has back-up caregivers (DCBS approved) and transportation • Not sure how to care for a newborn/uncertain about being a young mom • English is primary language
Educational/Vocational	**Legal**	**Transitions**
• Struggling in school • Was college-bound and hasn't given up totally but unsure how to do it now • Scholarship possibilities • Was pursuing veterinary	• Recently assigned Guardian Ad Litem, has not met • Has Fictive Kin possibilities • Baby's father not involved	• Did not feel comfortable in group home • Wants to return to Lexington

During her visit, Beth also meets jointly with Shakira and her foster parents, the Bells. Beth explains the WellCare program and how it can help coordinate home, school, social and both physical and behavioral health needs. Beth discusses the WellCare BabySteps maternity care

management program, which includes specialized maternity support and education, rewards for prenatal visits, and post-delivery follow-up. Shakira will receive childbirth and parenting education, nutritional services, assistance with WIC sign up, breastfeeding education, counseling and depression screening both prenatally and after delivery. Shakira is proud of her healthy lifestyle and athletic background, she is committed to good prenatal care. Beth makes sure the Bells and Shakira are aware of the "FRESH RX for Moms" program at the Community Farmers Market in Bowling Green. The program, launched with support from WellCare, offers moms-to-be on Medicaid $20 in fresh fruits and vegetables weekly over a 21 week period. "FRESH RX for Moms" also includes incentives, taste testing, and assistance from a registered dietitian. Beth talks to Shakira about the opportunity to meet new friends; many of the moms-to-be are new to the area and bond over their shared experience. Beth uses motivational interviewing and her expertise in trauma-informed care and high-fidelity wraparound to help convince Shakira to talk to someone about her depression and her grief. With her permission, Beth helps Shakira and the Bells schedule an appointment to meet with a therapist at LifeSkills Community Mental Health Center. Beth is aware that LifeSkills can help Shakira develop and maintain a therapeutic connection, regardless of her placement, via our telehealth network agreement. Beth expedites Shakira's appointment through WellCare's close and longstanding relationship with the administration at LifeSkills, who have also undergone WellCare's extensive SKY Training program. No prior authorization is required for the first twelve therapy sessions, including initial evaluations. Beth schedules a visit in five days.

Integrated Care Planning and Care Coordination Team: Prior to making her second home visit, Beth discusses the viability of moving Shakira back to Lexington with her SSW. The social worker agrees that it may be an option but is concerned about timing and ensuring access to Fictive Kin who are able to support both Shakira and her baby. Beth shares the names of significant social supports that Shakira mentioned during their meeting. As Beth learns of more church and community connections, she shares them with the DCBS team to explore Fictive Kin placement in Lexington. Beth schedules a call with her WellCare team members in Lexington to discuss local resources and the viability of a transition home for Shakira. A WellCare Care Coordinator serving Lexington joins Shakira's team via video conference to ensure any transition back to Lexington, if possible, is seamless. Shakira asks that her former swim coach and grandmother's pastor be added to her CCT. Beth also adds Shakira's LifeSkills therapist and newly appointed Guardian Ad Litem (GAL). Shakira's goals and services include:

Member/Family Goal	Program and Services	Focus Area
Shakira: I want to be back in Lexington	• Provide DCBS with information on potential Fictive Kin placements	Permanency
Shakira: I want to stay healthy for me and my baby	• Schedule regular PCP, Dental and OB/GYN visits • Ensure a global authorization is entered in CareCentral to streamline access to prenatal care • Provide Shakira with Well Care smartphone to access prenatal advice, appointment reminders,	Prenatal Care

Member/Family Goal	Program and Services	Focus Area
Shakira: I want to be happy	• Assessment and counseling with LifeSkills, including art and music therapy • Reconnect Shakira to swimming program	Behavioral Health
Shakira: I want to keep in touch with friends and Mike	• Provide transportation to local and regional swim meets for Shakira to support her friends • Work with the GAL to approve outreach to baby's father, Mike	Behavioral Health
Shakira: I want to be able to provide for my baby	• Support Shakira's college plans	Education
	• Introduce Shakira to HOPE Center for Pregnancy for baby supplies and support • Enroll Shakira in the Family Enrichment Center for parenting classes • Share WellCare BabySteps educational material and access to enhanced supports	Social Determinants of Health
Foster Family: We want to support Shakira and her baby	• Family sessions with Shakira at LifeSkills • Confirm back-up caregiver plans and respite	Behavioral Health
Foster Family: We want Shakira to be successful in her new school	• Enroll Shakira in South Warren High School's veterinary program • Work with Family Resource Center and Shakira's old school to transfer previously successful strategies	Education

The Care Plan is completed in CareCentral and is signed by Beth, Shakira, her SSW and the Bells. The signed care plan is distributed to all members of the CCT, who also have access to the care plan electronically to monitor for changes and support interventions they are accountable for.

Care Plan Monitoring and Follow-up: Now that the assessments are completed and the initial care plan has been developed, WellCare's stratification engine, which factors in risks, cost and impactability as required in Section 41.10.2, is activated. Our stratification process also factors in specific SKY and pregnancy criteria as well as a predictive modeling algorithm. While Shakira is relatively stable, her newness to Foster Care, recent behavioral health decline, trauma and pregnancy, trigger the Intensive Care Management program. (The WellCare BabySteps program automatically moves pregnant adolescents to more intensive care management due to the complexity of teen pregnancy.) Beth monitors progress and supports communication across providers through monthly care plan meetings, sharing of written progress notes and meeting summaries with CCT members. Through the guidance of Shakira's GAL, connection with the baby's father is arranged. While this formal plan is owned by DCBS and the GAL, WellCare assures our processes are in alignment. If the baby's father is identified as a WellCare member, additional service options and coordination may be offered as appropriate. Once the baby is born, and if the father maintains his legal rights, WellCare will work with him, along with

Shakira, to ensure the baby's medical and social service needs are meet. As the team tracks real-time changes in Shakira's needs, Beth, Shakira and her CCT continually reassess her Level of Care designation and adjust the frequency of care plan and in-home meetings accordingly.

b. Access to and coordination between physical health providers (e.g., OB/GYN, pediatrician) and behavioral health providers.

While our provider agreements require this kind of provider collaboration, Beth monitors and supports coordination through discussions with Shakira, her foster parents and the CCT. Shakira's PCP serves as her medical home responsible for communication and integrated care planning with all specialty providers. Shakira's CCT is critical to coordination between Shakira's physical, behavioral health and dental home. During one of Shakira's CCT meetings, Shakira's LifeSkills therapist updates the team on Shakira's progress. While her depression hasn't abated completely, continued therapy is favored over anti-depressant medication. The team agrees to re-visit progress every two months.

c. Access to network providers

WellCare's Kentucky network includes more than 34,500 providers statewide. We continually monitor access and availability. In the first quarter of 2019, 100% of Pediatricians provide urgent care within 48-hours and 97.8% were able to see enrollees within 30-days for routine care. During that same period 91.9% of our specialty providers were compliant with urgent standards and 98.2% were compliant with routine standards.

d. Discharge planning for all levels of care

The WellCare team will provide continuity and consistency for Shakira, regardless of her physical location, throughout her pregnancy and postpartum. If Shakira transitions to Lexington, WellCare teams in both locations will work simultaneously in CareCentral to update information, appointments and CCT membership in real time. Our integrated system assures that communication is seamless for Shakira and her providers. WellCare BabySteps follows Shakira through pregnancy and the baby's first year of life. Records for Shakira and her baby will be linked and the CCT will have role-based access to immunization records, well-child visits and developmental progress. As Shakira makes progress in her behavioral health treatment, the CCT will explore group sessions, peer supports and other step downs in the intensity of her care plan and services.

e. Coordination of school based services and an Individualized Education Plan

Beth verifies that DCBS, Shakira, the school and foster family are coordinating around her IEP needs. Beth speaks with the Warren County Public Schools Student Support Services foster care coordinator to ensure that Shakira has resources to be successful in school. The CCT recommended that DCBS pursue enrollment at the South Warren High School. LifeSkills. Shakira is introduced to the schools veterinary program where the "bring your animal to school day" may help rekindle her interest in college. The school also offers swimming and band to support areas where Shakira excelled in the past. Beth connects Shakira with the Family Enrichment Center for parenting classes, which include free transportation for Shakira to attend.

f. Community services for parenting skills

Beth enrolls Shakira in WIC and engages the Barren River District County Health Department Health Access Nurturing Development Services (HAND). The HAND provides Shakira a mentor to walk her through her child's development and help her build a healthy and safe home for her child. At LifeSkills she will also receive assistance from Sandy Hackbarth, the Early Childhood Mental Health Specialist and the Early Childhood Coordinator who works with families, DCBS, hospitals, and OBs to make sure the infant gets the needed services pre and post-delivery to prevent further DCBS involvement.

g. Applicable evidence based practices

WellCare protocols rely on evidence based practices in trauma informed and responsive care, High Fidelity Wraparound, assessing adverse childhood events (ACES), Cognitive Behavioral Therapy (CBT) and more. Our BabySteps program is based on American College of Obstetricians and Gynecologists (ACOG) and other national guides. Shakira's care plan will be customized to build on her strengths and internal motivating factors, i.e., veterinary sciences, swimming and band with these guidelines as its base. Her therapist works to Shakira and her foster family adjust and understand each other's strengths. Beth arranges for a WellCare smartphone for Shakira that will provide Shakira will tools and tips on prenatal care, her baby's growth as well as appointment reminders. Shakira is empowered with education on nutrition, lactation, and tools to monitor her health status. Once her baby is born, Beth will continue to guide Shakira in caring for her newborn using EPSDT guidelines.

h. Coordination of transportation, if needed

Shakira foster parents have indicated a willingness to provide transportation for Shakira. However, should she need additional support Beth educates Shakira and her foster parents on how to contact and schedule rides through the NEMT provider. Beth also provides contact information and route information for the Community Action of Southern Kentucky's GO BG transit service and reminds Shakira that the Family Enrichment Center will provide free transportation to parenting classes.

i. Options for aging out of foster care and risk management

WellCare recognizes that Shakira will need support as she strives to raise her young child and return to the college track. Beth continually assesses Shakira's strengths and risk and her parenting skills. As Shakira reaches age 17, Beth will discuss her options for leaving foster care at age 18, what that means for her baby's custody status and services and supports. Beth will engage the DCBS Independent Living Specialist through the Kentucky RISE program to assist with these discussions about independent living planning and secondary education. If Shakira wants to pursue veterinary education, her CCT will help identify the ancillary supports she will need to be successful in college such as knowing resources on campus, who to contact and how to ask for help. WellCare will support Shakira with a Welcome Home Dorm Kit to help her settle into her college dorm or apartment with bedding, towels and help outfitting their room. Shakira is also eligible for a $1000 in support for expenses not covered by the Commonwealth. At each juncture in Shakira's life, her transition plan will include an updated assessment of the: home and community support's Shakira needs for independence; social barriers to health and

independence; educational or workplace supports; risks for her and her baby, such as transportation, childcare and food security; peer support and employment. Shakira's CCT will help Shakira understand the benefits and risks for remaining in foster care as well as transitioning out of custody so that she can make good decisions.

j. Social determinants of health

When Beth conducts her initial Comprehensive Assessment, it includes an evaluation of Shakira's social barriers to health. Beth evaluates new risks and barriers during her weekly and monthly meetings with Shakira and her caregivers. Beth accesses our Community Connections database of local partnerships with community organizations and makes closed loop referrals. Beth connects Shakira to the Youth Services Center Coordinator at South Warren High School to support Shakira in following through with her plans for college. The Family Enrichment Center, offer Shakira added support for parenting; their twelve session course offers day or night classes, free transportation and includes topics on discipline communication, self-esteem, and conflict resolution. Beth also provides a walk-through of WellCare Works, an online program which Shakira can access at home to help her with assessment tools, resume building, job search, and interviewing practice for volunteer and paid employment opportunities, such as volunteering at Bowling Green Humane Society.

k. Provider education and support

Our provider training is based on the American Academy of Pediatrics *Healthy Foster Care of America* guidelines. Beth works as part of locally based team with WellCare's Provider Relations Representatives (PR) who live and work in the communities they serve. Throughout Shakira's care Beth and the PR team will speak directly with the PCP, OBGYN, and office staff to answer questions about the foster care system, managed care and any health care gaps or barriers to care that Shakira may have.

l. Access to and sharing of medical records

Our CareCentral platform integrates physical and behavioral health, pharmacy and community support information into our care coordination and care management processes. Using this platform, Beth, Shakira's providers, DCBS, community partners and the CCT have 24/7 role-based secure access to a 360-degree view of Shakira's services and health status that incorporates key clinical, demographic, social and lifestyle data. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the Medical Passport using functionality in our Member portal. This will include vital documentation such as birth certificates, so that SKY enrollees retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

m. Maintenance of the care plan

Shakira's care plan will be maintained electronically in CareCentral, including signed copies. Beth will review and update the care plan monthly, the care plan will reflect and include a detailed description of CCT members and their involvement in the Care Plan including the Shakira's OB/GYN, dental home, BH providers, specialists, community partners and caregivers.

The care plan will include frequency and method for updating and revising goals, monitoring and follow-up activities.

G.13. USE CASE 4 - KIRK

Kirk is a 3 year old with cerebral palsy (CP), hydrocephalus with a ventriculoperitoneal (VP) shunt, and seizures. He was placed in foster care when he was two months old after his parents terminated parental rights. Kirk has been in six different foster homes in four different Service Regions. He is on multiple medications for his CP symptoms, including anticonvulsant medication. His infant VP shunt was replaced when Kirk turned two years old but two foster homes have reported problems with the shunt and repeated followup visits with the pediatrician and pediatric neurosurgeon. Access to a pediatric neurosurgeon and the availability of Kirk's medical records as his placements change have been a significant problem. In addition, medication management and pharmacy records are problematic for the DCBS Social Service Worker and foster parents.

Kirk's current foster family lives in a rural community in Webster County. They have discussed adoption with the Social Service Worker but expressed concerns with access to the care that he needs in the long-term. The family has attempted to access care at the nearest children's hospital but availability of appointments was problematic. The family now must travel to Cincinnati Children's Hospital, which is more than a nine hour roundtrip commute. The travel and time off from work are hardships for the foster family but their primary concern is for Kirk's health. The foster family is concerned about availability of primary care and dental providers, clinical specialists (e.g., pediatric neurosurgeons), specialists to support his cognition, behavior, communication and developmental needs, medications to treat his CP symptoms and associated conditions, physical therapy, durable medical equipment, planned family respite care, etc.

Describe how the Vendor would address Kirk's situation and coordination with the Social Service Worker, the foster family, in-state and out-of-state providers, and community resources. At a minimum, address the following programs and services:

a. Care management, including coordination to address fragmented care and timeliness of care;
b. Availability of services and network access, including out-of-state providers;
c. Availability of services, such as skilled nursing services;
d. Access to school based services;
e. Applicable evidence based practices;
f. Coordination of transportation, as needed;
g. Community resources;
h. Social determinants of health;
i. Planned respite care;
j. Provider education and support;
k. Access to and sharing of medical records; and
l. Maintenance of the care plan.

G.13. USE CASE 4 - KIRK

WellCare's discussion of this Use Case includes additional information about Kirk and his family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions. WellCare understands that availability and access to care are critical for all KY SKY enrollees and life sustaining for our medically complex enrollees. To close gaps in access in rural areas, our network includes cross-border Providers, we work aggressively in rural counties to enroll providers and support them with technology enabled consultations with larger health systems and specialist and through telemedicine. In alignment with the DCBS case plan, the overall goals of Kirk's WellCare care plan include access to necessary services to stabilize his medical condition and address developmental needs, support for Kirk's foster family and his DCBS permanency plan.

Innovations for Kirk

- Largest Provider Network in Kentucky, including cross-border providers
- Enrollment staff co-located with DCBS
- Foster Parent Training, Respite Support and long-term planning
- Technology-enabled Medical Passport

a. Care management, incl. coordination to address fragmented care and timeliness of care

Identification and Enrollment: Kirk's case comes to the attention of Jenny, a WellCare Field Outreach Coordinator who is co-located with the DCBS staff. Jenny works with DCBS to verify that Kirk has been identified and approved as Medically Complex through the DCBS Medical Support Section. Jenny confirms that Kirk's transition to WellCare and enrollment is complete. WellCare uses a fully integrated IT platform to enroll new members and immediately assign them to a team in their region. CareCentral, our care management information system, is immediately populated with details from the enrollment 834 files, DCBS daily enrollment report and one year's claims history. Within 24-hours of his enrollment Kirk is assigned to Molly, a WellCare Nurse Case Manager, who is an RN, trained and certified in High Fidelity Wraparound, serving Webster County.

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, School Staff. Molly immediately reaches out to the DCBS worker to verify and gather Kirk's foster family and provider contacts, most recent Individualized Health Plan (IHP), his DCBS Service Plan 106B and confirm DCBS case plan goals. Molly and DCBS worker agree on a case management plan and discuss the best match of a PCP and dental home for Kirk and his foster parents. Kirk is in a rural region with limited access to Medicaid enrolled providers. Molly contacts the network team to discuss Kirk's options and whether single case agreements are needed to support Kirk's access to care. The network team has located an in network pediatrician at the Bridgewater Medical Center, Dr. Michael Jones, to serve as Kirk's PCP. Molly contacts Kirk's foster family to schedule an in-home meeting. At the same time, Molly will outreach to the Medically Complex Liaison, and Kirk's former MCO to request his most recent care coordination notes. She will speak directly with her MCO counterparts to understand Kirk's Individual Health Plan (IHP) and continuity of care needs. Molly ensures that all necessary authorizations are entered and approved in CareCentral. CareCentral is automatically populated with one year's claims history upon Kirk's enrollment so that Molly can evaluate care gaps and identify providers. Molly speaks with Kirk's care team at the Cincinnati Children's Hospital to request records and ensure CareCentral includes his most up-to-date lab results and physician recommendations.

Comprehensive Needs Assessment. During the first week of Kirk's enrollment, Molly makes her first home visit. Molly verifies the information gathered from her file review and enrollment research. In addition, Molly determines if Kirk and his foster family, the Strongs have unmet care needs. Molly learns that the Strongs are very committed to supporting Kirk, however access to care, including PCP, dental and other specialist has been an issue. Traveling nine hours roundtrip to the Cincinnati Children's Hospital is exhausting for Kirk. The Strongs are worried that overtime, neither Kirk nor they will be able to maintain the travel routine. Molly explains the WellCare program to the Strongs and discusses her role as a Nurse Case Manager. Molly and the Strongs worked to identify other gaps and also talk about who should be added to Kirk's Care Coordination Team. Molly's goal is to gain a holistic understanding of Kirk's needs, caregiver strengths, needs, preferences, abilities, social service barriers, functional needs, physical and BH status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs to accelerate access to needed services; child and family supports, caregivers, and engagement with providers; back-up caregiver plans; emergency response plans; early childhood education and developmental services. The assessment reveals a variety of factors influencing Kirk's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• CP and problems with VP Shunt; seizures • Specialized Care is 9 hours roundtrip • No assigned PCP or dental • No recent EPSDT screenings • No recent medication reconciliation • Needs assistance with ADLs	• Kirk was relinquished at two months • Frequent placement moves disrupting attachment to care givers • Kirk does not have friends due to unstable medical condition and multiple placement changes	• Supportive foster family, moderate to high risk of unplanned placement change due to care giving burden • Foster family does not have consistent access to respite • Foster family has not received training specific to Kirk's home care routine • English is primary language
Educational	**Legal**	**Transitions**
• No recent developmental assessments • IEP in process	• TPR at two months old • Foster Home is interested in adoption • Guardian Ad Litem, assigned but located in another region	• Continuity of Care closer to home

Integrated Care Planning and Care Coordination Team. Learning that the Strongs have no information on Kirk's medications and only know what is printed on the bottles in his bag when he arrived, Molly uses CareCentral's claims history to reconstruct Kirk's medication history and determine his most recent prescribers. Molly reviews Kirk's medical history with the WellCare Pharmacist to determine if his claims history aligns with his medication plan and whether drug interactions, dosage or side effects may be concerning. The WellCare Pharmacy Director reaches out directly to Kirk's prescribers and joins Molly in a discussion with DCBS and the Strong's to review concerns and questions. Molly consults with the WellCare interdisciplinary team, including our pediatric care Medical Director, Pharmacist, Nurse Case Managers and

Community Advocates, during the team's weekly case conference. Molly discusses Kirk's problematic shunt and seizures. The team notes Kirk's placement history, having lived in six different homes and four different regions, it is likely that his caregivers were not adequately trained on his specific needs and VP shunt monitoring and care routine. Molly works on developing a Kirk-specific, in-home caregiver checklist to train Kirk's foster parents and caregivers and promote consistency. The Medical Director also joins Kirk's Care Coordination Team (CCT) and speaks directly with the Cincinnati Children's Hospital team to discuss their observations and care plan.

The WellCare Network team identify Vanderbilt Children's Hospital as the hospital closest to Kirk's home and speak directly with our contract liaison at the hospital to secure an appointment for Kirk. Molly reaches out to DCBS and the Strong's by phone to let them know Vanderbilt is available and that a transfer of Kirk's care will reduce their commute time by 5 hours (more than half the current trip). Kirk's PCP at the Bridgewater Medical Center will also serve as a telehealth location whereby the Strongs can check-in with Vanderbilt team, reducing the number in-person visits and commutes each month. With DCBS approval Molly completes the referral to the Complex Care Program at the hospital which specifically works with patients who have Cerebral Palsy along with other health issues such as seizures and hydrocephalus. The team also agrees that Molly will engage the Owensboro Office of Children with Special Health Needs to help identify in-home home PT services, pediatric neurology closer to home and to work as a partner to provide in-home training of caregivers.

Recognizing the need to establish life-long supports for Kirk and his caregivers, Molly discusses a referral to the River Valley Community Mental Health Center with DCBS. River Valley can determine Kirk's eligibility for a Michelle P or Home and Community Based Service waiver. The CMHC is a valuable partner in finding and training in-home support workers and specialized transportation to support the foster parents and minimize caregiver burnout.

Following several discussions with the CCT, including the Medically Complex Liaison, Kirk's goals, program and services include:

Member/Family Goal	Program and Services	Focus Area
Foster Family: We want to better understand Kirk's needs and how to help him	• Education and training on Kirk's medical condition and shunt care by WellCare Nurse Case Manager • Education and training on Kirk's IEP rights and foster parent responsibilities • Referral to Kentucky Cerebral Palsy Resources • Develop a home care checklist for Kirk's medical care	Permanency
Foster Family: We want to know services are there Kirk anytime day or night	• 24/7 Nurse Advice Line, with on-call staffing from nurses up-to-date in Kirk's plan and medical needs	Health
DCBS: We want to stabilize Kirk's medical condition and maintain continuity of care	• PCP assignment with Dr. Jones • Medication Reconciliation with PCP • PCP referral for skilled nursing in-home with Office for Children with Special Health Care Needs to monitor shunt and caregiver training	Health

Member/Family Goal	Program and Services	Focus Area

	• Establish Dental home
	• Developmental evaluations for Kirk's cognition, behavioral, and communication needs and determining his need for:
	  • Physical therapy (in-home)
	  • Mobile vision screening
	  • Speech language services (in-home)
	  • Durable medical equipment	

DCBS: We want to support Kirk moving to adoption	• Transition of Care closer to home using Vanderbilt and Office for Children with Special Health Care Needs in Owensboro for pediatric neurology and in-home services • Training for foster parents on Kirk's medical routine • WellCare supported Foster parent respite to augment DCBS respite hours • Transportation Support for the foster family	Permanency
DCBS: We want Kirk to have a network of long-term services and supports	• Referral to Early Childhood Director at Webster County Schools to address IEP needs	Educational
	• River Valley Community Mental Health assessment and eligibility determination for Michelle P and HCBS waivers	Long Term Services and Supports

Care Plan Monitoring and Follow-up. Molly's care plan monitoring and on-going follow-up with Kirk and his caregivers is designed to coordinate all aspects of his care and ensure provider communication. Molly will stay in contact with the Strongs at least weekly, including two face to face visits with Kirk and a monthly plan update. Molly will also ensure that the IHP is reviewed with the Medically Complex Liaison and team members no less than every three months. Molly schedules a full IHP update meeting at least every six months. Molly verifies the contact information for Kirk's team members and creates an IHP meeting calendar for the coming year. This meeting calendar is accessible to all team members via the WellCare portal which provides them with up-to-date information on Kirk's care, providers, upcoming appointments, care plan meetings and assessments. Additionally, Molly ensures that everyone receives meeting invitations, summaries, reminders and a signed copy if the IHP.

b. Availability of services and network access, including out-of-state providers

WellCare's network agreements include access and availability standards that are continually monitored. In the first quarter of 2019, 100% of Pediatricians are compliant with urgent appointment availability standards (within 48-hours) and 97.8% were able to see enrollees within 30-days for routine care. Our network includes cross border hospitals and health systems. Kirk's dental care will be provided through Avesis and Community Care of Kentucky Inc. Avesis offers Sensi-Dentistry, a special needs dentistry program for individuals with special health care needs. The program includes: training for providers to help understand the needs of individuals with special health care needs; detailed assessment of the provider's ability to meet the needs of individuals with special health care needs; a Find-a-Dentist tool to help families

find dentists who have completed the Sensi-Dentistry training; education for families on how to be choose a dentist to meet an individual's needs; a pre-appointment visit for the child and family to meet the dentist and explore the dental office; provider reimbursement for additional time needed to serve individuals with special health care needs.

c. Availability of services, such as skilled nursing services

We work with the Office for Children with Special Health Care Needs in Owensboro, to access skilled nursing services for Kirk. Molly helps the Strongs identify optimal days and times for Kirk and discusses authorizations with the PCP. To limit fragmentation and care gaps Molly is able to authorize services and supports identified through the Initial IHP and care plan without additional prior authorizations. During each subsequent plan update, Molly verifies Kirk's providers understand the required steps and have submitted all necessary information for continued authorization of identified services.

d. Access to school based services

Molly works with DCBS to confirm that an IEP is in progress to support a potential referral for Kirk to the Peggy Grant of Audubon Area Head Start. Head Start promotes school readiness for young children birth to age five. Molly and DCBS reach out to Kim Saalwachter, the Early Childhood Director at Webster County Schools to discuss Kirk's early educational needs. Molly also stops by the Family Resource Center to pick-up information to help the foster family understand Kirk's special education rights and services.

e. Applicable evidence based practices

Molly uses evidence-based condition-specific guidelines that are fully integrated and embedded into all aspects of our care coordination program, including CareCentral. Molly will help the Strongs learn how to recognize and identify signs and symptoms of exacerbations of Kirk's conditions using WellCare clinical practice guidelines and teach-back methods. The team develops a "Kirk-specific" checklist for his VP shunt monitoring and care routine. The checklist becomes part of Kirk's automated Medical Passport to promote consistency across caregivers and settings. Molly also trains the Strongs in trauma informed care, explaining that Kirk's multiple foster home placements may cause issues with attachment and relationship building. Through this teaching process, the Strongs gain an understanding of the trauma and are better prepared to address Kirk's needs.

f. Coordination of transportation, as needed

Kirk's foster parents will receive mileage reimbursement for all trips over 120 miles from their home, in addition Molly will educate the foster parents on how to contact and schedule rides through the NEMT provider. Molly and the CCT also craft the care plan to limit the frequency of trips, using telehealth capacity in the PCP office for check-ins and consultations with the Vanderbilt team.

g. Community resources

Molly leaves a list of online support groups and parent groups for children with Cerebral Palsy, including how to access the Kentucky Cerebral Palsy Resource website. She also discusses the availability of the Ronald McDonald House in Tennessee which is 5 blocks from the Vanderbilt

Children's hospital. While sitting with Kirk at the hospital his foster parents can access the Ronald McDonald Family room where families and friends of seriously ill children can enjoy quiet time, have snacks and the support of caring volunteers. To assist in easing some of the tension that Kirk's foster parents will naturally feel they can access information regarding his medical conditions via Vanderbilt's Family Resource Center.

h. Social determinants of health

All WellCare assessments include an evaluation of social determinants of health for both Kirk and his caregivers. Molly will assess Kirk's and his families support needs regarding health literacy, food security, peer support, economic security and transportation. WellCare leverages the power of our community partnerships to support our Members. WellCare's Community Connections model includes a robust resource directory of organizations that can provide non-covered services. Molly has direct access to Community Connections, our data base of over 335,000 resources supporting access child-care, food, employment, health literacy, vocational and other supports necessary to holistically support Kirk and his foster family.

i. Planned respite care

Molly verifies that the Strongs are receiving planed respite through the DCBS medically complex foster care agreement. She identifies that the Strongs have had long gaps between respite visits due to a lack of caregiver training and availability. Molly works with the Owensboro Office of Children with Special Health Needs to develop a list of trained respite workers suitable to match Kirk's needs. She also talks with the school team about teachers and para-educators who may be interested in additional work outside of the classroom. Kirk's plan includes added respite services, paid for by WellCare, to offer the Strongs additional support.

j. Provider education and support

For children with complex medical conditions, the WellCare Medical Director and Pharmacy Director speak directly with treating physicians to understand and support their care plan. In addition, Molly works as part of locally based team with WellCare's Provider Relations Representatives (PR) who live and work in the communities they serve. Molly and the PR team review health care gaps, barriers to care and provider performance to identify any provider that may need additional support. Throughout Kirk's enrollment, Molly and the WellCare PR team are in communication with his providers to answer questions about the foster care system, managed care and health care gaps.

k. Access to and sharing of medical records

Serving as the backbone and focal point of our electronic care management system, the CareCentral platform integrates physical and BH, pharmacy and community support information into our Care Coordination processes. Using this platform, Molly, Kirk's PCP, DCBS, community partners and the CCT have 24/7 role-based access to a 360-degree view of Kirk's services and health status that incorporates key clinical, demographic, social and lifestyle data. This view is continually refreshed, and Molly and the CCT are automatically alerted to updates in Kirk's information so that they can quickly identify any needs and address them in real-time. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with

DCBS to fully automate the Medical Passport, including vital documentation such as birth certificates, so that that SKY enrollees will retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

l. Maintenance of the care plan

Kirk's IHP and Care Plan will be maintained electronically in CareCentral, including signed copies. Molly will review and update the IHP monthly, as needed, based on her home visits and Medically Complex service team discussions and no less than every six months. The IHP will reflect and include a detailed description CCT members and their involvement in the IHP and signatures including Kirk's PCP, dental home, BH providers, specialist, community partners and caregivers. The IHP and Care Plan will include frequency and method for updating and revising goals, monitoring and follow-up activities.

G.13. USE CASE 5 - ENRICO

Enrico, age 16, has a history of violence, aggression, and destructive behavior. Both parents live in the home and Enrico has five siblings, ages two – nine years. Spanish is the primary language spoken by his parent and Enrico often had to interpret for his parents when talking with health care professionals, school officials, and law enforcement. He has a history of harming his parents, siblings, and a family pet. When in middle school he started fires at school and physically bullied younger students. Once in high school, Enrico began experimenting with drugs and alcohol, and was suspended twice for bullying students and destruction of school property. After physically attacking a high school teacher, Enrico was arrested and placed in a DJJ regional juvenile detention center. The charges against Enrico were later dropped so that he could receive treatment.

Enrico's parents refused his request to return home and DJJ and DCBS coordinated his placement in foster care. His behavioral issues in a private foster home (e.g., aggression and destructive behavior) caused him to be relocated to a group home. Despite repeated requests from Enrico, there has been no contact between Enrico and his family since he entered foster care.

Enrico has been prescribed two psychotropic medications at the higher end of the dosage range but hasn't been evaluated by his PCP or behavioral health provider in over a year.

In addition to his ongoing behavioral issues, Enrico has moderate persistent asthma and has a history of several ED visits and one hospitalization related to his asthma over the past two years. His BMI is 25.

With his Social Service Worker, Enrico discussed his loneliness, desire to return home, and regrets over hurting his family, especially his parents. Enrico especially misses his siblings and is anxious to see them or to talk with them over the phone. He expressed his frustration over not being able to talk with his family to discuss how they "can be a family again." He shared his confusion over who could help him with talking or meeting with his family.

Enrico is ambivalent about remaining in foster care once he reaches his 18th birthday. Sometimes he expresses a desire to leave foster care and, at other times, he states his understanding of the support needed to transition into the community and possibly reconcile with his family. Enrico's poor performance in school has intensified his feelings of failure and caused him to question whether staying in foster care will be of any value to him.

Describe how it would address Enrico's situation and coordination with the DCBS Social Service Worker, group home, physical and behavioral health providers, and his family. At minimum address the following programs and services:

a. Care Management, including coordinated management of his physical and behavioral health conditions
b. Discharge planning for all levels of care;
c. Language accessibility;
d. Psychotropic medications and documentation in medical records (e.g., rationale, follow up assessments and monitoring);
e. Evidence based psychotherapeutic interventions;

f. Social determinants of health;
g. Community resources;
h. Aging out of foster care;
i. Access to and sharing of medical records; and
j. Maintenance of the care plan.

G.13. USE CASE 5 - ENRICO

WellCare's discussion of this Use Case includes additional information about Enrico and his family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare's Healing Futures program was designed specifically with children like Enrico in mind. Focused on identifying children at risk for numerous health, social, and behavioral problems throughout their lifespan, including substance use disorders, WellCare Healing Futures uses evidenced based practices, such as trauma-informed care and high-fidelity wraparound to help our young members stabilize and ease into adulthood with an individually defined path to recovery and resiliency. Enrico will benefit from an integrated approach to care planning that includes culturally competent processes and providers to address his asthma, physical and behavioral health, pharmacological, juvenile justice and social needs. In alignment with the DCBS case plan, WellCare's overall approach is to help Enrico identify his goals and priorities, promote improved family dynamics and successfully transition to adulthood.

Innovations for Enrico

- Enrollment staff co-located with DCBS
- Technology enabled meetings with family
- Technology enabled life coaching (JOOL)
- WellCare Works support through adulthood

a. Care management, including coordinated management of his physical and behavioral health conditions.

Identification and Enrollment: WellCare uses a fully integrated IT platform to enroll new members and immediately assign them to a team in their region. CareCentral, our care management information system, is immediately populated with details from the enrollment 834 files, DCBS daily enrollment report and one year's claims history. The Care Coordination Supervisor also receives additional information from Jerry, a WellCare Field Outreach Coordinator who is co-located with DCBS staff to support all aspects of eligibility and enrollment. Jerry compiles the most recent case notes and information on Enrico's residential placement and uploads it to CareCentral. Jerry works with DCBS Social Service Worker (SSW) to select a PCP that matches Enrico's needs and is accessible to his group home placement, at the Boys and Girls Haven in Louisville. Most of the members at Boys and Girls Haven work with Dr. Matthew Kinney for primary care at the Opens Arms Clinic at Home of the Innocents. WellCare confirms Dr. Kinney as the PCP assignment with the SSW. Within 24-hours of enrollment, Enrico is assigned to Maria, a WellCare Care Coordinator serving Jefferson County, who has been trained and certified in High Fidelity Wraparound. Maria has extensive experience working with adolescents. For the next 30 days, Maria will employ the high fidelity wraparound model to assess and work with Enrico to develop his care plan.

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, School Staff: Maria immediately reaches out to the SSW to verify contact details for Enrico's Care Coordination Team (CCT), obtain the DCBS Service Plan 106B and confirm DCBS case plan goals. DCBS and Maria discuss a dental home assignment for Enrico, the Open Arms Clinical at Home of the Innocents that provides dental services. Maria reviews the DJJ Community Services Case Plan, the Criminogenic Needs Questionnaire and the Risk and Criminogenic Needs Assessment; and the DCBS results from Enrico's DCBS Child and Adolescents Needs and Strengths (CANS). Maria recognizes that Enrico's involvement with DJJ requires that the Judge receive regular progress updates. Maria being part of a panel discussion at a local WellCare community training workshop, has presented to Judges, law enforcement, local district and county attorneys and others about High Fidelity Wraparound, Trauma and cultural considerations in working with youth. Maria will speak with DCBS and Enrico about inviting the Judge in Enrico's case to join the CCT. Maria, DJJ and DCBS agree on a case management plan.

Comprehensive Needs Assessment: That same week, Maria meets with Enrico and the group home staff to gain a holistic understanding of Enrico's needs and personal strengths, his family's strengths, abilities preferences, social service barriers, physical and behavioral health status, and goals. Maria will identify: guardians/surrogate decision makers; urgent and short-term needs to accelerate access to care; youth and family supports, other caregivers, level of engagement with providers; back-up caregiver plans; emergency/crisis response plans; school, post-secondary education; and vocational needs. Maria asks Enrico a series of questions about what he enjoys doing, what he feels good about and what accomplishment he is most proud of this month. Enrico talks about playing soccer with his father and younger brothers. Enrico reports being bored in school, he is most proud when he solves a "real life problem" like how many hours he needs to work to buy a smartphone. Maria asks Enrico about his asthma and other medications. Enrico notes he does not like taking medication, he views it as a sign of weakness. Maria learns that Enrico did not understand many medical terms used by his former PCP, thus Enrico would ignore them when he translated for his mother.

Following her meeting with Enrico, Maria uses the WellCare language line, providing real time translation services, to contact Enrico's parents. Maria will determine what Enrico's family needs to participate in care planning. Enrico's mother, Camila, reports that her husband Mateo refuses to allow Enrico in the house until he "proves he is a man and not a bully". Using motivational interviewing techniques, Marie elicits concrete goals and expectations that Camila and Mateo have for their son. Camila expresses concern over how to attend meetings with her younger children. Maria asks about the most convenient times, day or evening and talks to Camila about meeting via secure video conferences at a provider or WellCare office location. Maria offers to ask DCBS to request a Court Appointed Special Advocate (CASA) to help Camila understand the DJJ process and resources. The results of Maria's assessment reveal several factors influencing Enrico's health.

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• Asthma and BMI of 25 • No recent PCP or dental visits	• Lacks comprehensive, culturally sensitive, biopsychosocial evaluation • Unclear diagnosis	• Spanish is parents primary language, Enrico speaks English and Spanish

• Enrico and his family do not understand his health needs • Enrico and his family view medication as a sign of weakness • No asthma action plan • Able to perform all ADLs and IADLs	• At risk of placement change due to history of aggression • Sad over not seeing family • Confused about why parents won't let him come home • Does not get along with peers, aggressive • No current suicide risk	• Family does not understand legal or health care system • Parents don't want Enrico home due to past violence with younger siblings • Parents have no back-up caregiving support • Parents cannot attend meetings due to five younger siblings and work schedule
Educational/Vocational	**Legal**	**Transitions**
• Struggling in school • Likes "real world" work • Likes math	• No CASA involved • No Guardian Ad Litem • DJJ involved, charges dropped in lieu of treatment	• Enrico does not know what he wants other than to "be a family"

Integrated Care Planning and Care Coordination Team: Maria consults with the WellCare interdisciplinary team, including the Medical Director, Pharmacist, Nurse Care Managers and Community Advocates, during the team's weekly case conference. WellCare's Medical Director is concerned about Enrico's medications and dosage given the lack of a Substance Use Disorder assessment, Enrico's history of non-compliance with his medication and lack of a clear diagnosis. The Medical Director schedules a call with Dr. Kinney at Open Arms. Maria and the WellCare team discuss the need to obtain a child and adolescent psychiatric assessment and recommendations for any additional psychological testing for Enrico. Although he is fluent in English, Enrico's results may not be accurate if cultural considerations are not addressed in testing. **The team prioritizes a complete Biopsychosocial evaluation by a Board Certified Child and Adolescent Psychiatrist**, through our agreement with Centerstone. No prior authorization is required for Enrico's BH assessment. Centerstone will also complete and update CANS during the evaluation process. Because Enrico has a strong connection and loyalty to his family, the CCT works to support his group home placement and does not recommend introducing Enrico to a new foster home. The results of Enrico's testing include a diagnosis of disruptive mood dysregulation disorder (DMDD). His substance use assessment confirmed that Enrico is not currently using drugs and alcohol but is at risk to reoffend due to his unresolved trauma and DMDD. Maria uses the results of his updated assessments and Enrico's personal goals and preferences, as well those of his family, to guide CCT discussions with Enrico and his team in developing his care plan which includes:

Member/Family Goal	Programs and Services	Focus Area
Enrico: I want to see my younger siblings	• Technology enabled virtual visits with siblings, as guided by Enrico's BH plan with Centerstone and with Boys and Girls Haven	Permanency

Member/Family Goal	Programs and Services	Focus Area
Enrico: I want to play soccer with my brothers	• Disease management education for Enrico to understand his asthma and triggers with PCP	Physical Health
	• Creation of Asthma Action Plan with PCP and shared with home, school and group home	Physical Health
	• Sports physical and soccer club membership through WellCare's value added benefit program	Physical Health
	• Assign dental home to assess dental health and needs	Oral Health
Enrico: I want to be a family again	• Anger management group at Boys and Girls Haven	Behavioral Health
	• Substance use education and prevention through Boys and Girls Haven	
	• Individual therapy to understand his diagnosis, process his trauma of removal from home and learn self-management and social skills with Centerstone	Behavioral Health
	• Facilitated family meetings with Enrico and his parents to develop respectful communications and realistic expectations with Centerstone	Permanency
	• Medication assessment and reconciliation with Centerstone in consultation with Boys and Girls Haven	Behavioral Health
Enrico: I want to study real world stuff	• Enrollment in Boy and Girls Haven School Program	Education
	• Aptitude assessment with Boys and Girls Haven	Education
Enrico: I want to stand on my own two feet	• Assess work-based learning opportunities at the Kentucky Youth Career Center	Vocational
	• WellCare Works online to learn about volunteer and employment options, coaching and resume writing	Social Determinants of Health
	• Life Coaching, goal setting and self-management with JOOL, online app.	Social Determinants of Health

Member/Family Goal	Programs and Services	Focus Area
Parents: Enrico needs to be a man and stop being a bully	• Family education and training with Camila and Mateo to understand DMDD and Asthma with certified medical translator • Create family goals and identify steps for success with Enrico, Camila and Mateo with certified medical translator	Behavioral Health
Parents: Enrico needs to be responsible for his illegal actions	• Engagement with CASA	Legal

Care Plan Monitoring and Follow-up: Now that the assessments are completed and the initial care plan has been developed, WellCare's stratification engine, which factors in risks, cost and impactability as required in Section 41.10.2, is activated. Our stratification also factors in specific criteria, such as number of placement changes, as well as a predictive modeling algorithm. Enrico has an elevated risk of placement change, due to his history of violence and substance use, this coupled with his age and transition to adulthood triggers the Intensive Care Management program. Maria uses monthly care plan meetings, sharing of written progress notes and meeting summaries with CCT members to support coordination.

b. Discharge planning for all levels of care

WellCare's KY formal discharge planning program includes a comprehensive evaluation of Enrico's physical and BH and social service needs; and the identification of services and supports needed to transition into the most clinically appropriate, least restrictive setting possible. Discharge planning will focus on the frequency and duration of services he may need from the Boys and Girls Haven. Using a "Building Bridges" framework, the Boys and Girls Haven will work on transitioning Enrico from 24 hour supervision and intervention, to intermittent check-ins. Centerstone will work on moving Enrico from individual therapy once a week, to every other week, to once a month as he progresses. The frequency of family meetings and therapy will increase as progress is discussed and Enrico and his family become comfortable with a return home. Maria will transition the services Enrico receives at the group home to community and home based settings based on his family needs. Enrico will begin overnight visits with his family as they work towards eventual discharge. Once home, in-home supports will be added, such as respite and behavioral supports. In alignment with Family First Preservation Services Act, Centerstone will complete the CANS assessment (every 3 months) to ensure that Enrico continues to meet criteria for placement. If Enrico is assessed to be ready to step down into a home environment before his family is ready to accept him home, the CCT will explore Fictive Kin placements or supervised community living. To assist with continuity of care, WellCare works with Centerstone and Boys and Girls Haven to use telehealth for therapy and psychiatry appointments when Enrico returns home.

c. Language accessibility

Enrico's parents and providers use WellCare's certified medical translators to support his health care planning and decision making. Maria, his parents and entire team have 24/7 access to WellCare's language line. The WellCare language line provides real-time translation in over 200 languages. In addition, all WellCare staff receive training in: how to access translation services and TTY devices for the hearing and speech impaired; how to deliver effective cross-cultural communication; how to recognize bias in communication; and how to understand and respect cultural and religious preferences in care planning.

d. Psychotropic medications and documentation in medical records (e.g., rationale, follow up assessments and monitoring)

Maria ensure that all consents and releases are obtained, properly executed and included in Enrico's electronic record. WellCare Medical and Pharmacy Directors consult with Enrico's guardian and providers to help them understand the risks and benefits of each medication and answer any questions they may have. The CCT ensures that Enrico's medication protocol is designed to minimize any exacerbation of his asthma and weight due to his psychotropic medications and possible psychiatric systems due to this asthma inhalers/systemic steroids. Maria will monitor Enrico's claims and PCP reports in CareCentral to ensure that Enrico is attending appointments, is refiling his medication, is receiving routine bloodwork and adheres to his Asthma Action and BH plan. Because WellCare is a fully integrated health plan, our physical and behavioral health, and pharmacy staff are available to Enrico, the group home staff, providers and Enrico's family to meet and discuss questions, concerns and options. All pertinent information such as dosage, frequency and duration are recorded in CareCentral, contraindications, side effects and red flags are documented and Enrico and his caregivers receive individualized education on his medications, including how to administer, monitor and follow-up with providers. In addition, Maria will assess Enrico's medication adherence and answer any questions at each face to face meeting and ensures the Dr. Kinney completes a medication reconciliation at least monthly.

e. Evidence based psychotherapeutic interventions

Maria uses WellCare Clinical Practice Guidelines that include trauma informed and responsive care, High Fidelity Wraparound, Child and Adolescent Mental Health, understanding families and the impact of adverse childhood events (ACES), Cognitive Behavioral Therapy (CBT), crisis stabilization and more to guide the psychotherapeutic interventions in Enrico's care plan. The CCT addresses his DMDD, trauma involved in his removal from the home and his Asthma Action Plan. Centerstone has therapists that are trained in cognitive behavioral therapy, certified in trauma focused cognitive behavioral therapy and trained in interpersonal therapy for adolescents.

f. Social determinants of health

All WellCare assessments include an evaluation of social determinants of health. Maria leverages the power of our community partnerships to support Enrico and his family to better participate in care planning. Community Connections, our data base of over 335,000 resources offers Maria access to information on child-care, food, employment, health literacy, vocational

and other supports. Maria identifies the Cabbage Patch Settlement House to assist Camila with her younger children's needs. Cabbage Patch offers basic supplies (clothing, food) and assistance with rent, utilities and medical expenses. The Americana Community Center also helps Camila in learning English.

g. Community resources

Maria introduces Enrico to WellCare Works, which provides him with online tools, training, and other resources to promote social engagement and empowerment. WellCare Works serves as a complement to his Boys and Girls Haven learning plan and helps with finding on-the-job training and volunteer opportunities, resume writing; and community supports to address social barriers such as transportation to and from work. WellCare Works will get Enrico on the road to "being a man and not a bully" as his father has stated.

h. Aging out of foster care

Maria meets with Enrico and the DCBS Independent Living Specialist to create a plan for exploring career and secondary education options. Maria also works with Enrico to use our on-line life coaching app, JOOL. Our JOOL Life Coach mobile application is aimed at engaging and improving purpose in life of transition aged and former foster care youth to improve health and life engagement, energy (vitality), willpower (self-control), resilience, lifestyle change, and health care costs. Through a series of self-guided steps, Enrico completes a basic health screening. He enters his core values such as kindness, independence, family, tradition and his goals. After charting his daily progress, the app generates "Daily JOOLS", tips customized for him that get smarter over time to encourage Enrico to build a healthier lifestyle and taking responsibility for his health.

As Enrico reaches ages 17, 20, and 25, his transition plan will include an updated assessment of: home and community support's he needs for independence; social barriers to health and independence; educational or work place supports; risks such as medication compliance to stabilize his DMDD; and any specialized supports to address his BH needs such as Peer Support or other BH services. Enrico's CCT will help him understand the benefits and risks for remaining in foster care as well as transitioning out of custody so that he can make good decisions. The CCT will help Enrico weigh all his options when he turns 18 and plan for, if leaving care, where will he live, what income will he have, and plan for his health. If he stays in care, he can access independent living options that can support him with an apartment and access to supervision/mentoring to help him as he transitions into adulthood. Enrico is eligible for DCBS college support and WellCare's value added benefits of a Welcome Kit (e.g., towels, bedding, household supplies) for his dorm or apartment. The CCT will make sure Enrico knows the resources on campus and in the community and who contact.

i. Access to and sharing of medical records

Serving as the backbone and focal point of our electronic care management system, the CareCentral platform integrates physical and BH, pharmacy and community support information into our Care Coordination processes. Using this platform, Maria, Enrico's PCP, BH specialist, DCBS, community partners and the CCT have 24/7 role based access to a 360-degree view of Enrico's services and health status that incorporates key clinical, demographic, social

and lifestyle data. This view is continually refreshed, and Maria and the CCT are automatically alerted to updates in Enrico's information in real-time. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the Medical Passport using functionality in our Member portal. This will include vital documentation such as birth certificates, so that SKY enrollees retain an up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

j. Maintenance of the care plan

Enrico's care plan will be maintained electronically in CareCentral, including signed copies. Maria will review and update the care plan monthly; the care plan will reflect and include a detailed description of CCT members and their involvement in the Care Plan including Enrico's PCP, dental home, BH providers, specialist, community partners and caregivers. The care plan will include frequency and method for updating and revising goals, monitoring and follow-up activities.

G.13. USE CASE 6 - MARY

Mary is a five year old who was placed in foster care in Louisville when her mom left her in the car for six hours while visiting and drinking with friends. This is Mary's second placement in foster care within the past year.

Based on the initial assessment by her PCP, it was determined that Mary is deaf, has numerous dental caries, and is malnourished. She has almost no language (minimal speech) and has not been taught sign language. Her affect is flat, and she has almost no expression. After a more detailed assessment, Mary was diagnosed as being cognitively delayed.

The DCBS Social Service Worker was unable to locate medical, dental or pharmacy records, or evidence that Mary had been prescribed hearing aids. Mary's mother provided vague information about visits to a pediatrician, immunization history, and dental care.

Describe how the Vendor would address Mary's situation and coordinate with the DCBS Social Service Worker, parent, and providers. At minimum, address the following programs and services:
a. Care Management including coordination of multispecialty developmental evaluations and care;
b. Discharge planning for all levels of care;
c. Applicable evidence based practices;
d. School based services;
e. Social determinants of health;
f. Community resources;
g. Access to and sharing of medical records; and
h. Maintenance of the care plan.

G.13. USE CASE 6 - MARY

WellCare's discussion of this Use Case includes additional information about Mary and her family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare's approach to supporting Mary, starts with a comprehensive evaluation of her physical, behavioral, social service, and pharmacological needs. Our local approach to care planning is child focused and family centered. WellCare will leverage our long standing relationships with our network providers to fill in gaps in Mary's medical history and create a unified health record that will follow Mary, regardless of her location. In alignment with the DCBS case plan we will address her hearing and developmental needs, coordinate with the school, support the foster family and Mary's permanency plan.

Innovations for Mary

- Enrollment Outreach staff co-located with DCBS
- Streamlined access to care in one location

a. Care Management including Coordination of Multispecialty Developmental Evaluations and Care

Identification and Enrollment: Kim, a WellCare Field Outreach Coordinator who is co-located with the DCBS staff in Louisville is briefed on Mary's recent placement during her daily new enrollment meeting with DCBS. Kim works with the DCBS social worker to complete Mary's eligibility paperwork and confirms with the Child Benefit Worker that Mary's eligibility is complete. She will verify with the team that Mary is formally enrolled with WellCare. WellCare uses a fully integrated IT platform to enroll new members and immediately assigns Mary to a WellCare Team in Louisville. CareCentral, our care management system, is populated with one year's claims history, details from the 834 enrollment files and DCBS new enrollment report regarding Mary's services and providers. Kim alerts the Care Coordination Supervisor that Mary's records are missing and her health history is unclear, they discuss Mary's special needs and review options for a PCP and dental home. Kim shares this feedback with the DCBS social worker and Open Arms Children's Health where Dr. Matt Kinney will be assigned Mary's PCP is confirmed. In addition, Open Arms offers dental services and will become Mary's dental health home. Within 24-hours of her enrollment Mary is assigned to Jane, a WellCare Care Coordinator in Louisville who is a master's level social worker with early childhood experience, trained and certified in High Fidelity Wraparound. Kim uses the CareCentral messaging system so that Jane is aware of recent DCBS discussions and decisions. For the next 30 days, Jane will employ the high fidelity wraparound model to assess and develop Mary's care plan

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, School Staff: Jane immediately reaches out to the DCBS worker to gather Mary's foster family and CCT information. Jane obtains the DCBS Service Plan 106B and confirms DCBS case plan goals and the level of involvement of Mary's biological mother in care planning. Mary's biological mother Ellen, has not complied with her court ordered treatment and is currently unable to have contact with Mary. Jane ensures that all necessary consents and releases are entered in CareCentral. Jane also contacts Mary's former MCO to determine her level of engagement in care coordination. She will speak with her MCO counterparts to understand Mary's care plan and continuity of care needs. Jane learns that Mary's mother did not engage in her former MCO's care coordination program. Jane reviews Mary's claims history to identify past providers, labs, medications, hospital and ER visits. Jane will also access Mary's history through the Kentucky Health Information Exchange, including immunization records. Using CareCentral Jane is able to recreate Mary's provider history and see where gaps exists in her well-child visits, developmental, vision and lead screens and immunizations. Jane also verifies that Mary did not receive audiology services. Jane evaluates Mary's EPSDT screening history and resets her periodicity schedule based on her age, AAP Bright Futures guidelines and identified gaps. Jane forwards this information to the PCP. Jane reviews all the information gathered with the DCBS worker and together they agree on a case management plan.

Comprehensive Assessment: During Mary's first week of enrollment, Jane visits Mary's foster family, the Kelletts, to meet Mary and discuss her role as Care Coordinator. During her visit Jane explains the WellCare program. Jane verifies the information she has gathered from her file review and enrollment research. In addition, Jane asks the Kelletts a series of questions to determine if they have concerns or unmet needs in supporting Mary. Jane's goal is to gain a

holistic understanding of Mary's needs, caregiver strengths, needs, preferences, abilities, social service barriers, functional needs, physical and BH status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs to accelerate access to care; youth and family supports, caregivers, and engagement with providers; back-up caregiver plans; emergency/crisis response plans; early childhood education and services.

The Kelletts outline multiple gaps in their information for Mary. They note that they have not had training in how best to communicate with Mary. They are concerned that Mary shows little to no affect. Jane discusses common behaviors secondary to hearing loss, as well those common to young children who have suffered neglect and who have been removed from their home. She offers education to support them in understanding what Mary may be experiencing. Jane's comprehensive assessment reveals a variety of factors influencing Mary's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• Gaps in EPSDT screenings • Missing most recent immunizations • Malnourished • Multiple dental needs • Hearing loss, no evidence of audiology services • No language development • Can complete ADLs with age appropriate non-verbal prompts	• Parental neglect and two placements this year disrupting attachment to care givers • Flat affect	• Supportive foster family, currently low risk of unplanned placement change • Foster family does not have consistent access to respite • Foster family has not received training specific to Mary's trauma or health needs • Limited social skills and interaction with peers • Foster Family does not know sign language
Educational	**Legal**	**Transitions**
• Recently assessed as cognitively delayed • No kindergarten or preschool history	• Mother not complying with court ordered treatment • No Guardian assigned	• 2nd placement in foster care this year

Integrated Care Planning and Care Coordination Team: Jane schedules a CCT team meeting for the following week. Jane reports that audiology and other services are being coordinated through an appointment with the Open Arms Children's Health Clinic at Home of the Innocents (HOI). Jane explains that Open Arms will provide a complete medical, dental and behavioral assessment, including pediatric audiology services and outpatient physical, speech and occupational therapies, nutrition and vision services. Because of our partnership with the HOI, Mary will be able to access services in one location. This alleviates the need to have the Kelletts coordinate across providers or schedule multiple appointments across the city.

Home of the Innocents also offers psychological services by Dr. Lisa Powell. Dr. Powell reviews Mary's recent cognitive assessments and will assess Mary for autism as well as failure to thrive. If autism is suspected, the team agreed on a referral to HopeBridge, a WellCare specialized

provider, for autism treatment. The CCT and the Kelletts discuss questions they have in understanding their role in making decisions for Mary relative to Mary's biological mother, DCBS and Guardian Ad Litem. The CCT clarifies roles and discusses an in-home support plan for the Kellett's to be guided by the results of Mary's HOI assessments. Mary's plan includes:

Member/Family Goal	Programs and Services	Focus Area
Foster Family: We want to better understand Mary's needs and how to help her	• Education and training on Mary's hearing loss by HOI	Communication
	• Education and training on Mary's trauma by HOI	Behavioral Health
	• Support groups and education from Kentucky Hands and Voices	Communication
	• Education and training on dental health by HOI on how to maintain Mary's dental health and identify when she might need urgent or emergent dental care	Oral Health
	• Education and training on nutritional needs by HOI	Physical Health
	• Respite Support supplemented by WellCare	Permanency
	• ASL classes at Southeast Christian Church	Communication
	• 24/7 Nurse Advice Line, with on-call staffing from nurses up-to-date in Mary's plan, behavioral and medical needs	Health

DCBS: We want to make sure all Mary's health needs are met	• Developmental evaluations at HOI for Mary's behavioral, and communication needs and determining her need for:
	  • Autism/failure to thrive
	  • Physical therapy
	  • Vision screening
	  • Speech language services
	  • Supplemental Nutrition
	  • Durable medical equipment/Communication Devices and hearing aids/diapers
		Physical and Behavioral Health

	• Supplemental Nutrition	Physical Health
	• In-home speech, OT/PT and nutrition as recommended by CCT	
DCBS: We want to complete Mary's IEP process	• Support and coordinate with Mary's IEP • Referral to the Heuser Hearing and Language Academy for Kindergarten	Educational

Care Plan Monitoring and Follow-up: Now that the assessments are completed and the initial care plan has been developed, WellCare's stratification engine, which factors in risks, cost and impactability as required in Section 41.10.2, is activated. Our stratification also factors in specific SKY criteria such as risk of placement change, and special health needs as well as a predictive modeling algorithm. Although Mary has an all-inclusive medical home and is stable, her special health needs triggers the Complex Care Management program. The team confirms a schedule for monthly team meetings to review Mary's care plan and how to access Mary's WellCare Member portal which will provide them with up-to-date information on her care plan, providers, upcoming appointments, care plan meetings and assessments. Jane monitors her progress and supports communication across providers through monthly care plan meetings, sharing of written progress notes and meeting summaries with CCT members.

b. Discharge planning for all levels of care

Decision on Mary's level of care will be guided by the results of her CANS and updated assessments competed by the Open Arms Children's Health Clinic. Discharge planning will be very slow for Mary because of the complexity of her needs. It will take time to assess her hearing needs and if hearing aids or potential surgery can assist. It will take time for her to learn to communicate any of her thoughts and needs to the adults around her. It will take time for the Kelletts to feel comfortable providing care to Mary without consistent support from the CCT and Home of the Innocents. Because of Mary's age and level of complex needs, her plan is updated monthly with careful attention to her service needs as she demonstrates progress. Speech therapy, occupational therapy, communication training, parent support of the Kelletts, and behavioral health services will be monitored monthly by the CCT and adjusted as needed. Once the assessment for autism has been completed and Hopebridge is engaged, discharge planning from Hopebridge will also be a gradual transition. Hopebridge provides education and therapy. Services range from 2 to 3 days a week for 3 hours to 8 hours daily. As Mary makes progress in her services, decisions to reduce frequency and intensity will be made.

c. Applicable evidence based practices

Jane will WellCare's Clinical Practice Guidelines to guide the physical and behavioral interventions in Mary's care plan, including Trauma-informed are and attention to Mary's hearing loss, dental care and developmental needs. Mary's audiology services will be provided by Little Ears within Home of the Innocents. Services will focus on identifying the level of Mary's hearing ability and will be guided by EPSDT special service guidelines to develop interventions. The primary work will be on helping Mary and the Kelletts communicate with each other. Mary will work on expressing her wants and needs, such as when she is hungry, sleepy or upset. The Kelletts will work on how to express encourage, praise and words of comfort. ASL classes will help both the Kelletts and Mary learn communication skills, which will supplement Mary's speech therapy. If needed, Hopebridge offers behavioral consultation and plans developed by a certified ABA providers. Mary's dental coverage will be provided through our Home of the Innocents in partnership with WellCare's dental provider, Avesis. Avesis has trained the dentists at Home of the Innocents in Sensi-Dentristry, a special needs dentistry program for individuals with special health care needs. The program includes: training for providers to help understand the needs of individuals with special health care needs; detailed assessment of the provider's ability to meet the needs of individuals with special health care

needs; a Find-a-Dentist tool to help families find dentists who have completed the Sensi-Dentistry training; education for families on how to be choose a dentist to meet an individual's needs; a pre-appointment visit for the child and family to meet the dentist and explore the dental office; provider reimbursement for additional time needed to serve individuals with special health care needs.

d. School based Services

Jane and the CCT determine that Mary's mother never enrolled her in pre-school or Kindergarten. DCBS sets up an IEP meeting and Jane provides the social worker with any up-to-date list of Mary's most recent assessments, to avoid duplication of diagnostic services. Jane and the team discuss the feasibility of enrolling Mary in Kindergarten with the Heuser Hearing and Language Academy. The Academy can support her with cognitive development and work on improving Mary's social skills.

e. Social determinants of health

All WellCare comprehensive assessments include an evaluation of social determinants of health for both Mary and her caregivers. Jane will assess the Kellett's needs such as health literacy, food security, peer support, economic security, child-care and transportation. Jane has direct access to Community Connections, our data base of over 335,000 resources supporting these social service needs. The Southeast Christian Church, who is teaching ASL, also has support services as part of their ministries and the Orphan's Care Alliance, located in Louisville, can be a direct support to the Kelletts. Jane also engages the assistance of WellCare's peer support parent, Brittany, to help guide and support the Kelletts as they access services, appointments and address Mary's needs. Making sure that Mary is able to be warm, have access to food, have a safe place to sleep, have clean clothes, and people to respond to her attempts to communicate is paramount.

f. Community resources

Acknowledging the importance of ongoing support for the foster family, Jane refers the Kelletts to Kentucky Hands & Voices. This parent-driven organization provides families with resources and information needed to improve communication and learning outcomes for children who are deaf. The Kelletts have access to emotional and social guidance with the "Guide By Your Side" family support program. By enrolling in the program, a specially trained "guide", who is a parent of a child who is deaf or hard of hearing, would be assigned to support them as they foster Mary. The guide will answer questions and address any reservations they might have in supporting Mary. Jane also discusses American Sign Language classes for the Kelletts that are offered free at Southeast Christian Church. As their skill level grows, the Kelletts also support Mary's sign language acquisition at home and better understand her social support needs. The Kelletts may also access education and support through the Kentucky School for the Deaf, Statewide Family Support Center. The Center provides workshops, resources, and networking with other families.

g. Access to and sharing of medical records

Serving as the backbone and focal point of our electronic care management system, the CareCentral platform integrates physical and BH, pharmacy and community support information into our Care Coordination processes. Using this platform, Jane, Mary's PCP, BH

specialist, DCBS, community partners and the CCT have 24/7 role based access to a 360-degree view of Mary's services and health status that incorporates key clinical, demographic, social and lifestyle data. This view is continually refreshed, and Jane and the CCT are automatically alerted to updates in Mary's information so that they can quickly identify any needs and address them in real-time. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the Medical Passport, including vital documentation such as birth certificates, so that that SKY enrollees will retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

h. Maintenance of the care plan

Mary's care plan will be maintained electronically in CareCentral, including signed copies. Jane will review and update the care plan monthly, the care plan will reflect and include a detailed description CCT members and their involvement in the Care Plan including the Mary's PCP, dental home, BH providers, specialist, community partners and caregivers. The care plan will include frequency and method for updating and revising goals, monitoring and follow-up activities.

G.13. USE CASE 7 - JULIE

Julie is a 17-year-old who has been in the foster care system for ten years. She has minimal contact with her family.

Julie has been placed in residential care. She has been diagnosed with an intellectual disability and low IQ and has a long history of mental health treatment in outpatient and inpatient settings. She has highly variable emotional states, typically brief in duration and reactive to circumstances.

At the time of admission to residential care Julie's medication regimen included chlorpromazine, fluoxetine, lurasidone, lamotrigine, trazodone, and oxcarbazepine. There is limited information about the chronology of medication treatment and no records of psychotherapy services. Julie is not able to provide much information about her response to the medication regimen, and there are no other sources of information. She continues to demonstrate frequent shifts in emotions and aggressive behaviors. On one occasion, she became physically aggressive, which led to assault charges and a 72-hour incarceration.

The Social Service Worker and behavioral health providers are evaluating treatment in a setting that is a lower level than acute care but more structured than a PRTF.

Describe how the Vendor would address Julie's situation and coordination with the DCBS Social Service Worker, and physical and behavioral health providers. At minimum address the following programs and services:

a. Care Management;
b. Discharging planning for all levels of care;
c. Prescribing psychotropic meds and documentation in medical records (e.g., rationale);
d. Evidence based psychotherapeutic interventions;
e. Viability of aging out of foster care;
f. Option for transitioning to an applicable waiver;
g. Access to and sharing of medical records; and
h. Maintenance of the care plan.

G.13. USE CASE 7 - JULIE

WellCare's discussion of this Use Case includes additional information about Julie and her family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee any limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare's approach to supporting Julie starts with a comprehensive reevaluation of her physical, behavioral, social service and pharmacological needs. Our Pharmacy, Medical and Long Term Services and Support (LTSS) specialist will provide consultation and guidance to Julie's Care Coordination Team (CCT). Julie's level of care determination will be guided by evidence based clinical practice guidelines that take into

Innovations for Julie

- Enrollment staff co-located with DCBS
- Technology enabled Medical Passport
- Long standing partnerships with Maryhurst and other specialized providers

account behavioral and physical health needs of persons with an ID/DD. In alignment with the DCBS case plan we will work to identify the least restrictive, most clinically appropriate and integrated care setting for Julie as she transitions to adulthood.

a. Care Management

Identification and Enrollment: WellCare uses a fully integrated IT platform to enroll new members and immediately assigns them to a WellCare Team. CareCentral, our care management system, is populated with one year's claims history, details from the 834 enrollment files and DCBS new enrollment report regarding Julie's services and providers. Kaya, our WellCare Field Outreach Coordinator, who is co-located with DCBS, alerts the Care Coordination Supervisor that Julie is in an out-of-state residential placement and requires expedited assessments and appointment scheduling. Kaya verifies that all paperwork is submitted and that Julie's WellCare enrollment is complete. This includes the selection of PCP with Julie's DCBS Social Service Worker (SSW) that is familiar with working with enrollees who have ID/DD and mental health challenges. Within 24-hours of her official enrollment with WellCare Julie is assigned to Sharon, a WellCare Care Coordinator who has experience working with individuals with ID/DD and who is trained and certified in High Fidelity Wraparound. For the next 30 days, Sharon will employ the high fidelity wraparound model to assess and develop Julie's care plan.

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, School Staff: Sharon reviews Julie's enrollment information and contacts her DCBS Social Worker (SSW) to discuss Julie's most recent case plan activity and obtains the DCBS Service Plan 106B. The DCBS social worker indicates that a referral was made to Purchase Youth, however due to her low IQ, recent aggression, assault charges Purchase Youth declined Julie's referral. Because of the complex and specialized nature of Julie's enrollment profile, DCBS works with the Children's Review Program to refer to the Maryhurst 5S Pathways to Permanency program. Maryhurst accepts Julie and she is admitted to the program. Maryhurst partners with Dr. Elaine Martin for primary care services. Sharon works with DCBS to assign Julie to Dr. Martin for PCP assignment and Foundations Family Dentistry as her dental home. Sharon confirms whether Julie's family is part of her CCT. The DCBS worker shares that Julie's only remaining family is an Aunt who maintains minimal contact. Sharon confirms Care Coordination Team (CCT) membership including Julie's Guardian Ad Litem, the residential program, Julie's aunt if she can be located, and DCBS social worker. Julie is also a member of the team, however her DCBS social worker has reservations about Julie's ability to actively participate. Sharon and the SSW agree on a case management plan. Sharon schedules a visit to the residential facility, within the week, to meet with Julie and her Guardian Ad Litem (GAL).

Comprehensive Needs Assessment: Sharon's goal in meeting with Julie and her guardian is to gain a holistic understanding of Julie's needs and personal strengths, caregiver strengths, preferences, abilities, social service barriers, physical health and BH status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs to accelerate access to needed services; social service needs and barriers; youth and family support community, caregivers, and engagement with providers; back-up caregiver plans; emergency/crisis response plans; school, post-secondary education; and vocational needs.

Sharon is trained in all aspects of person-centered planning, which includes proven methods for engaging Julie in the process. Sharon explains to Julie and the GAL who she is and how she helps people sort out where they want to live and what they like to do during the day. Sharon spends time with Julie on the first visit to get to know her. Sharon asks Julie about her likes and dislikes and who she likes to spend time. Julie responds in simple one or two word answers, but asks to go outside after about 20 minutes. Julie's GAL indicates she has had Julie on her caseload for approximately four years. Sharon learns that Julie is an only child and suffered neglect and abuse as a young child. Julie's aunt is her only surviving family and is not able to support Julie due to her own cognitive limitations.

During her first week of interviews with the GAL, residential staff, Julie's DCBS history files and claims data Sharon attempts to recreate when and why various medications where added to Julie's regime. The goal of Sharon's research is to identify the behavioral triggers and antecedents for each of the medications. Sharon's research uncovers reports of Julie wandering away during the day, trying to climb out windows at night, and screaming at staff uncontrollably. Maryhurst staff report that Julie has a disrupted sleep cycle whereby she is up at night and dozes many times during the day. The results of Sharon's comprehensive assessment reveals a variety of factors influencing Julie's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• No PCP or dental history • No recent adolescent well care visits • Multiple antipsychotic medications • Julie appears active and likes to swing and play outside after dinner • Able to perform all ADLs • Julie cannot perform IADLs	• Trauma/early sexual abuse, and neglect untreated • Unstable mood, inadequate treatment • No BH provider history • No recent psychological or functional assessments • Problems sleeping • Effectiveness of medications unclear	• Minimal contact with Aunt, only surviving relative • Julie cannot engage in community activities unsupervised • Julie does not have a support network and does not affiliate with a 'hometown' • English is primary language • No affiliation with religion or culture
Educational/Vocational	**Legal**	**Transitions**
• In residential school program, often dozes off • No recent cognitive or functional assessments	• Involved Guardian Ad Litem • No family or Fictive Kin to serve as guardian	• No LTSS planning or applications completed

Integrated Care Planning and Care Coordination Team: Sharon consults with the WellCare Pharmacy and Medical Director to review Julie's current medication list. During her meeting with the Maryhurst staff they provide Sharon with a list of six different medications, with no medication history, data on effectiveness or recent PCP reconciliation. Using the WellCare automated system, the Pharmacy team identifies at least fifteen serious drug-drug interactions.

The Medical Director works directly with Dr. Nichols at Maryhurst to coordinate a review of Julie's medication with DCBS; together with the WellCare Pharmacist, they determine what meds to stop and which to titrate to a lower dose. WellCare uses a shared decision making process to develop a safe and measured approach to deprescribing whereby they discuss the risks associated with each medication and drug-drug interactions, as well as potential side effects of each medication. Sharon schedules check-ins weekly between Medical staff at the facility and the WellCare pharmacy and BH specialist to discuss Julie's physical and behavioral health needs as her medications are adjusted and her behaviors are carefully documented by the Maryhurst team. Julie's initial Care Plan goals and focus areas include:

Member/Family Goal	Programs and Services	Focus Area
Julie: I want to be happy	• Julie will received trauma-informed therapy from a Maryhurst therapist with experiencing working with youth with ID/DD	Behavioral Health
GAL: I want Julie to get consistent evidence based care	• Julie will be assigned to Maryhurst PCP Dr. Elaine Martin	Physical Health
	• Trauma-informed dental assessment	Oral Health
	• Medication assessment and monitoring with Dr. Nichols at Maryhurst	Physical and Behavioral Health
	• Maryhurst will create an individualized plan to assess and develop skills to live as independently as possible in the least restrictive setting	LTSS
	• Maryhurst will determine Julie's eligibility for an SCL waiver and prepare necessary applications	LTSS
GAL: I want Julie to received individualized educational supports	• DCBS and Maryhurst will work with Julie's IEP team to update and align her IEP with most recent assessments	Education

Care Plan Monitoring and Follow-up: Now that the assessments are completed and the initial care plan has been developed, WellCare's stratification engine, which factors in risks, cost and impactability as required in Section 41.10.2, is activated. Our stratification also factors in specific SKY criteria, such as placement changes and medication history as well as a predictive modeling algorithm. Because Julie transitioned from out of state to a new facility and has multiple unmet needs, she remains a Complex Care Coordination program until her medications are stable and all dental, PCP and behavioral health and educational assessments are completed. Sharon's monitoring and on-going follow-up with Julie and her caregivers is designed to coordinate all aspects of her care and ensure communication across providers, Maryhurst, her guardian and DCBS. Sharon monitors her progress and supports communication across providers through monthly care plan meetings, sharing of the signed care plan, written

progress notes and meeting summaries with CCT members. In all CCT meetings, Julie will be invited and encouraged to share her voice regarding her care. If she continues to struggle with this, Sharon will connect the WellCare Youth Peer Support team member, Athenia, to meet with Julie and help guide her through the CCT process. Athenia is a former foster youth with lived experience in the foster care system. She has an idea of what Julie is going through and can offer support and guidance.

b. Discharge planning for all levels of care

Should Julie require hospitalization, Sharon will work with Maryhurst to ensure that a bed-hold is authorized and Julie's supports are maintained. During the course of any hospitalization Sharon works with the hospital based planning team, DCBS and Maryhurst staff to create a safe and successful discharge to Maryhurst. If it is determined that Maryhurst is not able to care Julie's changing needs, Sharon will work with DCBS to develop a plan for her step down. As Julie begins to stabilize and make treatment progress, discharge planning will be focused on reducing the frequency and intensity of her treatment services. This will begin with decreasing the amount of time needed for individual therapy and group therapy. Julie will begin to demonstrate better self-care skills and demonstrate that she can be away from 24-hour a day supervision at small amounts of time. As this happens, Julie will be able to go for walks without staff, go on outings in the community, and possibly volunteer or find a part time job. Eventual discharge from Maryhust will also be discussed and planned. Because of Julie's age of 17, it is likely that she will turn 18 while still in treatment at Maryhurst. Depending on the treatment progress made, Julie will have different options to consider for her discharge plan. The CCT will monitor Julie's progress carefully. The DCBS worker and GAL will determine if Julie will be able to provide her own self-care as an adult or if she will need a structured setting with supervision as an adult. Options for discharge are discussed as part of the planning process. To be in compliance with Family First Preservation Services Act, the CCT engages Centerstone to complete the CANS assessment every three months. This assessment confirms that Julie continues to need the qualified residential treatment provider level of care and can remain at Maryhurst. If at any time the CANS assessment determines that Julie is ready for a home environment, the CCT will work to identify an appropriate home environment to meet her needs.

c. Prescribing psychotropic meds and documentation in medical records (e.g., rationale)

Sharon ensures that all consents and releases are obtained, properly executed and included in Julie's electronic record. The WellCare Medical and Pharmacy Directors consult with Julie's guardians and providers to help them understand the risks and benefits of each medication and answer any questions they may have. WellCare Medical Director and Pharmacy Directors will consult with Julie's guardian and providers to ensure that her medication protocol is designed to stabilize her mood and support her participation in care planning. Sharon will monitor Julie's claims and PCP reports in CareCentral to ensure that Julie is receiving routine bloodwork and health checks. Because WellCare is a fully integrated health plan, our physical and behavioral health, and pharmacy staff are available to Julie, the Maryhurst staff, providers and Julie's family to meet and discuss questions, concerns and options. All pertinent information such as dosage, frequency and duration are recorded in CareCentral, side effects and red flags are

documented and Sharon reviews them with the Maryhurst staff during monthly care plan meetings.

d. Evidence based psychotherapeutic interventions

WellCare embraces a fully integrated approach to care, built on evidence-based and best practices. Our Clinical Practice Guidelines integrate physical and behavioral health considerations and address availability, accessibility, coordination and continuity of care. WellCare protocols rely on evidence based practices in trauma informed and responsive care, High Fidelity Wraparound, Child and Adolescent Mental Health, understanding families and the impact of adverse childhood events (ACES), Cognitive Behavioral Therapy (CBT), crisis stabilization and more. Sharon will use these Clinical Practice Guidelines to support evidence based practice and guide psychotherapeutic interventions in Julie's care plan to address her sleep issues and trauma. Maryhurst has therapists available with specific training and certification in trauma focused cognitive behavioral treatment and are skilled in working with individuals with intellectual disabilities. Maryhurst also employs the Building Bridges Initiative model. This model is focused on ensuring that Julie has her voice in her treatment and life planning as well as ensuring her safety through the reduction in seclusion and restraint. Because of the trauma informed model Maryhurst and the CCT uses, Julie begins to feel safe, begins to discuss her memories of trauma, and begins to find her voice in her treatment and life planning.

e. Viability of aging out of foster care

Even though Julie is beginning to make small increments of treatment progress, Julie's GAL and Maryhurst team indicate that Julie is unable to navigate a transition out of foster care. Sharon meets with Julie's GAL and the Maryhurst staff to create a plan for exploring waivers and home and community based services and supports as Julie moves into adulthood. At each juncture in Julie's life, her transition plan will include an updated assessment of: home and community support's Julie needs for independence; social barriers to health and independence; educational or work place supports; health status; risks such as medication compliance; and any specialized supports to address her behavioral health needs; communication devices, adaptive equipment or home modifications. While Julie is upset that she will not be able to be on her own at 18, she is gaining insight that she does need help and support. Julie begins to identify the types of supports she may need and what helps her the most. Julie is able to state that she needs help remembering to take her medication, remembering her coping skills when she gets upset, and needs to know someone is around to help when she needs that help. It is decided with Julie's agreement that she will recommit to DCBS at age 18 and will continue in care until age 21. During those three years, Julie will continue her treatment at Maryhurst, transitioning into Treasure Home, a community based home under the Maryhurst continuum of care. At Treasure Home, she will practice her "adulting" skills yet have the support of staff that she has verbalized she needs. Treasure Home helps her prepare for eventual transition into Supportive Community Living (SCL). Sharon ensures that the Treasure Home staff are aware of and access to WellCare Works, our suite of online tools that helps Julie and her providers learn about jobs and find volunteer and paid employment options to support her to be as independent as possible. Prior to her 21st birthday, DCBS will refer her to a SCL provider.

f. Option for transitioning to an applicable waiver

Sharon works with Julie, DCBS and the GAL to outline a timeline for Julie's eligibility determinations and waiver application. Sharon identifies all social service needs including housing, transportation, food, peer support, assistance with utility payments, etc. Sharon collaborates with the CCT to begin the Supported Community Living waiver application for Julie. Julie is referred to Centerstone for the application process to begin. Once the application process has concluded, including any testing needed that identify Julie's need for this type of long term program, Julie will be placed on the SCL wait list. Because Julie will essentially be homeless if she has to leave Maryhurst, she will be placed at the top of the SCL waitlist and classified as "emergency".

g. Access to and sharing of medical records

Serving as the backbone and focal point of our electronic care management system, the CareCentral platform integrates physical and BH, pharmacy and community support information into our Care Coordination processes. Using this platform, Sharon, Julie's PCP, BH specialist, DCBS, community partners and the CCT have 24/7 role-based access to a 360-degree view of Julie's services and health status that incorporates key clinical, demographic, social and lifestyle data. This view is continually refreshed, and Sharon and the CCT are automatically alerted to updates in Julie's information so that they can quickly identify any needs and address them in real-time. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the Medical Passport using functionality in our Member portal. This will include vital documentation such as birth certificates, so that SKY enrollees retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

h. Maintenance of the care plan

Julie's care plan will be maintained electronically in CareCentral, including signed copies. Sharon will review and update the care plan monthly, the care plan will reflect and include a detailed description CCT members and their involvement in the Care Plan including the Julie's PCP, dental home, BH providers, specialist, community partners and caregivers. The care plan will include frequency and method for updating and revising goals, monitoring and follow-up activities.

G.13. USE CASE 8 - AMANDA

Amanda, 10 years old, was born with multiple heart defects that affected blood flow between her heart and lungs. Amanda was placed into foster care when she was five (5) after her mother, a substance abuser, was incarcerated for neglect of a dependent. She has had multiple openheart surgeries, bouts of pneumonia, and frequent ED visits. Amanda's initial placement was with her aunt who could no longer care for her due to the stress of managing Amanda's level of care. Amanda's second foster home placement is with a family located in eastern Kentucky with two (2) additional foster children, ages 6 and 8, in the home. The family has one car and transportation is an issue when it is needed to transport Amanda to appointments with her PCP, pediatric cardiologist, behavioral health therapist, dentist, and other specialists. Amanda's foster father works full-time as an assistant bank manager and her foster mother does not work outside of the home.

Amanda is on thirteen (13) medications and is oxygen dependent. She frequently exhibits behaviors such as defiance, impulsivity, and disruptiveness. She has been diagnosed with depression and has extended crying spells that trigger tachycardia and cyanotic episodes. Amanda has growing fatigue and is refusing to eat anything other than yogurt, fruit, and breakfast cereal. Amanda has multiple caregivers who assist with activities of daily living, medication management, and monitoring oxygen levels. Amanda participates in home bound school services provided by the public school system, as her health permits.

Over the past six months, Amanda has been to the emergency room nine (9) times for respiratory/cardiac distress. She had three inpatient admissions for pneumonia and evaluation of her cardiac status. During her last visit with the pediatric cardiologist, the family was advised that Amanda's oxygen levels were worsening with significant changes in cardiac function. The pediatric cardiologist recommended another open heart surgical procedure, but advised the family that a heart transplant may be the only viable long-term solution. The foster family met with the cardiologist's Nurse Practitioner to develop a plan for building Amanda's strength prior to surgery or placement on a transplant list. The foster family is struggling to figure out how to keep up Amanda's spirits up and improve her appetite.

Amanda meets the designation of a Medically Complex Child pursuant to 922 KAR 1:350, The Kentucky SKY Contractor is responsible for providing Care Management and nursing consultative services to enrollees who are determined by the Medical Support Section staff to be Medically Complex.

Describe how the Vendor would address Amanda's situation and coordination with the DCBS Social Service Worker, Medically Complex Liaison, foster family, all providers, and community resources. At minimum, address the following programs and services:
a. Care management, including the assignment of the Nurse Case Manager;
b. Involvement of Medically Complex service team;
c. Discharge planning between levels of care;
d.Individual Health Plan development and maintenance within specified timeframes;
e. Availability of and access to providers;
f. The Medical Passport;
g. Training and support for caregivers;
h. Coordination of transportation, as needed;

i. Coordination of physical and behavioral health services;
j. Community resources;
k. Assistance with the Individualized Education Plan;
l. Social Determinants of Health;
m. Planned respite care;
n. Applicable evidence-based practices;
o. Sharing and review of medical records; and
p. Maintenance of the care plan.

G.13. USE CASE 8 - AMANDA

WellCare's discussion of this Use Case includes additional information about Amanda and her family for the purpose of better demonstrating how we support KY SKY members. ***WellCare does not foresee limitations or exceptions to providing the programs and services listed.***

Overall Approach and Assumptions: WellCare understands that medically complex youth, such as Amanda require an integrated approach to care. Our Transplant Team works seamlessly with the Care Coordination Team to assess and create an integrated plan for her developmental, behavioral and physical health, pharmacological, educational and social service needs, as well as the needs of her caregivers.

Innovations for Amanda

- Enrollment Outreach staff co-located with DCBS
- Integrated behavioral and physical health care
- Remote patient monitoring

a. Care management, including the assignment of the Nurse Case Manager

Identification and Enrollment: Amanda's comes to the attention of Kim, a WellCare Field Outreach Coordinator who is co-located with the DCBS staff in Laurel County. Kim confirms that Amanda's transition of care paperwork is complete, and Amanda has been enrolled with WellCare. This includes the selection of PCP with Amanda's DCBS Social Service Worker (SSW) who matches the needs of Amanda and her foster parents. Amanda receives her pediatric services, including cardiology through University of Kentucky Health Care and receives dental services through Dr. Ronald Dowell. Kim sends Amanda's case summary and most recent Individualized Health Plan (IHP) directly to the WellCare Nurse Case Management supervisor. The Case Management Supervisor immediately assigns Amanda to Molly, a WellCare Nurse Case Manager who is an RN trained and certified in High Fidelity Wraparound. Molly outreaches, to Amanda's former MCO and speaks directly with her MCO counterparts to understand Amanda's health status and continuity of care needs. Molly verifies that all necessary authorizations are entered and approved in CareCentral, our WellCare integrated care management system. Molly also alerts the WellCare Medical Director and Transplant Team to Amanda's medical history. Molly will employ the high fidelity wraparound model to assess Amanda's care coordination needs, her Individualized Health Plan and develop a care plan

Engagement with DCBS, DJJ, Youth, Family, Fictive Kin, Foster Parents, Guardians, Providers, School Staff: Molly contacts the Medically Complex Liaison and DCBS SSW to verify Amanda's CCT membership and contact information. Molly and the SSW confirm DCBS case plan goals, review the DCBS Service Plan 106B and agree on a case management plan. Molly confirms the

level of involvement of Amanda's family in her care. Although she was overwhelmed with caregiving, Amanda's Aunt is not restricted from seeing Amanda. Molly ensures that all necessary releases are authorized and entered in CareCentral. CareCentral is automatically populated with one year's claims history upon enrollment so that Molly can evaluate care gaps and identify providers. During her first week, Molly schedules an in-home meeting. While Molly is engaging with Amanda and the foster family, the WellCare Medical Director and Transplant Team reaches out to Amanda's cardiologist to discuss her profile and most recent health issues.
Comprehensive Needs Assessment: During Molly's first home visit, she verifies the information gathered from her file review. Molly learns that the Rings have two other foster care children in the home with medical needs, whose conditions are stable. Because the children were placed at different times, from different regions, they received services from different health plans and provider networks. The Rings report that they spend a great deal of time coordinating provider visits and in-home caregivers. The Rings are committed to Amanda and concerned they don't understand her behavior and finicky appetite. Molly explains the WellCare program and discusses her role as a Nurse Case Manager. Molly's goal is to gain a holistic understanding of Amanda's needs, caregiver strengths, needs, preferences, abilities, social service needs and barriers, functional needs, physical and BH status, and goals, including the identification of: guardians/surrogate decision makers; urgent and short-term needs to accelerate access to care; youth and family supports and caregivers; engagement with providers; back-up caregiver and emergency plans; education and developmental services.
Molly meets with Amanda and asks her a series of questions about what she enjoys doing, how she spends her free time and who is important to her. Amanda talks about her Aunt and how she enjoyed living with her. Amanda reports that she still talks to her Aunt on the phone and sometimes her Aunt comes to visit her at the Rings house. Amanda reports not liking very many things to eat and how sad and frustrated she gets when she can't do things. She misses her friends. Molly's assessment reveals a variety of factors influencing Amanda's health:

Medical/Pharmacological	Behavioral	Social/Family/Cultural
• Multiple heart defects • History of pneumonia and ED use • Fatigue and refusing to eat all but limited menu items • Multiple medications	• Early childhood trauma/neglect • Depression, with crying that triggers tachycardia and cyanotic episodes • Misses her Aunt and other friends • Defiance, impulsivity, can be disruptive	• Supportive foster family, moderate to high risk of unplanned placement change due to care giving burden • Foster family has multiple medically fragile children in the home with differing services and in-home providers • English Amanda's primary language • Family has one car
Educational	**Legal**	**Transitions**
• Home Bound IEP plan	• Mother incarcerated • Guardian Ad Litem	• Complex Medical issues making transitions more difficult

Integrated Care Planning and Care Coordination Team: Molly schedules a care planning meeting with the Rings, DCBS and the Medically Complex Liaisons. Molly guides the Care Plan conversation based on her most recent assessment and talks about the alignment of Amanda's Individualized Health Plan (IHP) with her Care Plan. The team agrees that UK HealthCare will serve as Amanda's medical home. Her PCP with Parkway Pediatrics will offer a location for telehealth visits, consults and coordinate with UK and her dental provider as needed. The CCT agrees that the IHP, Care Plan and CCT activities will be combined into a unified care plan driven by the UK's medical team with WellCare support for Amanda and the Rings. The UK team also schedules an evaluation for Amanda with a UK psychiatrist familiar with working with children who have medically complex needs and depression. In addition, an OT/PT/Speech Language evaluation will be scheduled to work on her strength and to determine if her eating habits are due to sensory or other issues. The UK psychiatrist and medical team will consult with the foster family and Amanda's local therapist to address her crying and depression and determine how to best address her eating habits. During her care plan discussions with Molly, Amanda expressed an interest in having more predictable visits with Aunt. DCBS agrees that Molly can extend an invitation for the Aunt to join the CCT. Molly will also talk with her about providing back-up care and respite. Lastly, Molly recognizes that stability of foster placement is essential for Amanda to maintain her medical team and focus on her strength. Molly ensures that the Rings have the support they need to care for Amanda and their other foster children. Molly asks her WellCare colleagues supporting the other foster children in the Rings home to meet jointly so that they can develop:

- A coordinated plan for all in-home services supporting the children to minimize disruptions and improve predictability of household and transportation schedule
- A plan with the 24/7 Nurse Advice Line that includes alerting the Nurse Case Manager familiar with Amanda's needs and those of the other youth in the Rings home.
- Routine respite for the Rings, whereby they have no caregiving responsibilities for any of the three foster youth

Amanda's care plan includes:

Member/Family Goal	Programs and Services	Focus Area
Amanda: I want to talk to my Aunt more often	• Amanda and her Aunt will talk every Sunday night	Behavioral Health
Amanda: I want to see my friends from my Aunt's neighborhood	• Amanda and the Rings will set up 'virtual visits' for Amanda and her friends via Skype on her WellCare issued tablet	Behavioral Health
Foster Parent: We want Amanda to be happy and to eat	• Amanda will be evaluated by a UK psychiatrist familiar with medically complex children	Behavioral Health
	• Amanda will meet with a therapist via telehealth service to help her process early trauma, depression and her feelings on having a limiting health condition	Behavioral Health
Foster Parent: We want to support Amanda the best we can	• Transportation support through "Healthy Stops"	Physical Health
	• WellCare supported Foster parent respite to augment DCBS respite hours	Permanency

Member/Family Goal	Programs and Services	Focus Area
	• Behavioral health consultation and education for the Rings to understand Amanda's challenges and create an in-home plan to address her behavior	Behavioral Health
	• Coordination of all in-home caregiving schedules	Permanency
Amanda: I don't want to be sick anymore	• Attend all scheduled cardiologist visits and follow doctor recommendations • Set up office-based and telehealth check ins with physician office for monitoring	Physical Health
DCBS: We want Amanda to get stronger	• Nutritional consultation and supplemental nutrition	Physical Health
	• OT/PT/speech language evaluation and in-home follow-up as determined	Physical Health
	• In-home respiratory services and remote patient monitoring	Physical Health

Care Plan Monitoring and Follow-up: Molly's care plan monitoring and on-going follow-up with Amanda and her caregivers is designed to coordinate all aspects of her care and ensure provider communication. Amanda will remain a Complex Care Coordination enrollee. Molly will stay in contact with the Rings at least weekly, including two face to face visits with Amanda and a monthly plan update. Molly provides CCT members with up-to-date information on Amanda's care, providers, upcoming appointments, care plan meetings and assessments. Molly sends meeting invitations, summaries, reminders and a signed copy of the IHP and Care Plan.

b. Involvement of Medically Complex service team. Molly is part of a team of Nurse Case

Managers who are specifically trained to work with the Medically Complex Service Team. Within the first 30 days, Molly works with the Medically Complex Liaison to schedule a meeting to review and update Amanda's IHP. The WellCare Medical Director, Pharmacy Director, Behavioral Health Medical Director and Transplant Team Coordinator also attend the first IHP meeting. Molly ensures that the DCBS SSW, Family Services Office Supervisor (FSOS), Medically Complex Liaison, foster parents, caregivers, Amanda's aunt, and other providers are invited to each IHP meeting. Molly provides consultation services to Amanda's SSW, FSOS, foster parents, and caregivers and works directly with the Medically Complex Liaison and care team to answer questions, assess and address barriers to care. Molly will distribute the signed copies to the medically complex service team members. Every three months the team will re-evaluate the IHP and services. Every 6 months, a new IHP will be developed.

c. Discharge planning between levels of care

Our contract agreements require that hospitals notify us when a SKY enrollee has been admitted to the hospital (ED or Inpatient). Molly works directly with hospital staff to reassess Amanda's needs. Molly and CCT add a remote patient monitoring program to Amanda's plan to help minimize the need for ED visits. Amanda receives a pulse oximeter which measures the amount of oxygen in her blood and send updates directly to Molly and her physician, in real time, to proactively address signs of a worsening condition. Through telehealth, Mrs. Ring is able to connect with Amanda's cardiologist nurse practitioner and determine if an earlier appointment is needed or if other urgent care is warranted. Amanda is also enrolled in our in-

home respiratory therapy program where a respiratory therapist visits two times weekly to assess Amanda's condition and report progress to her cardiologist. During all hospitalizations, Molly works with the hospital discharge team to assess Amanda's medical, BH and social service needs prior to discharge and to determine her ability to be safely transitioned. This includes meeting with the Rings to ensure their understanding of Amanda's health condition, any necessary medication protocols, including side effects and availability of refills as needed. Molly reviews the in-home caregiver schedule to make sure it aligns with the discharge plan. Molly provides scheduling assistance to ensure necessary follow-ups are scheduled prior to her leaving the hospital. Prior to the day of discharge, Molly confirms that all necessary in-home equipment has been delivered and the Rings and Amanda's caregivers are trained in its use. On the day of discharge Molly checks in with the Rings to answer any questions, review medication protocols, and reconciles Amanda's medications. Molly will continue with check-ins, daily if needed, and no less than weekly, until the Rings are confident in the routine and Amanda's condition is stable.

d. Individual Health Plan development and maintenance within specified timeframes

Molly will also ensure that the IHP is reviewed with the Medically Complex Liaison and team no less than every three months. Molly schedules a full IHP update meeting at least every six months. Molly verifies the contact information for Amanda's team and makes sure they have secure role based access to information via the WellCare member and provider portal which will provide them with up-to-date information on Amanda's care, providers, upcoming appointments, care plan meetings and assessments. Molly sends meeting invites, summaries, and a signed IHP.

e. Availability of and access to providers

WellCare of Kentucky currently has the largest network in the Commonwealth. We routinely works with UK HealthCare and other large health systems on behalf of enrollees who are medically complex. Our Care Coordinators, Medical and Pharmacy Directors work as part of one team, with care decisions driven by peer-to-peer discussions and authorizations verified as part of the care planning process.

f. The Medical Passport

WellCare will work with DCBS to fully automate the Medical Passport using functionality in our Member portal. This will include vital documentation such as birth certificates, so that SKY enrollees retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions. DCBS or the Rings can retrieve information as needed through the portal. Molly updates Amanda's passport so that Amanda always has a comprehensive summary and up-to-date health portfolio.

g. Training and support for caregivers

Molly will provide education and training for the Rings to understand Molly's medical and behavioral health needs as well as how to use remote monitoring and other equipment. The Rings have access to the 24/7 Nurse Advice Line that includes an alert to the Nurse Case Manager, familiar with Amanda's needs and those of the other youth in the Rings home. Molly will also provide education, in collaboration with Amanda's BH provider, regarding how to address her social and developmental needs in light of her early trauma and medical needs.

Molly explains that early neglect and her multiple placement changes may cause issues with attachment and relationship building. Molly will work Amanda's providers to develop a checklist for her home care and monitoring care routine. The checklist becomes part of Amanda automated Medical Passport to promote consistency across caregivers and settings. Through this teaching process, the foster family is better prepared to address Amanda's needs as they arise. Amanda's aunt will also participate in training and uses the checklist to monitor when Amanda visits.

h. Coordination of transportation, as needed

Molly works with the Rings to determine what level of transportation support they need. She provides them with information on the "Healthy Stops" a program built in partnership with WellCare and community agencies in Laurel County, that allows individuals to access Rural Transit Enterprises Coordinated, Inc. (RTEC) public transportation for medical trips; including dental, vision, behavioral health, primary care, pharmacy, labs, and any other doctor's appointments as well as education, trips for job placement, food access, and to non-profit organizations.

i. Coordination of physical and behavioral health services

Amanda's CCT is critical in supporting coordination between Amanda's physical and behavioral providers, including her dental home. While our provider agreements require this kind of collaboration from providers, Molly monitors and confirms collaboration is occurring by holding CCT meetings and check-ins with her foster home and providers. UK serves as her medical homes responsible for communication and integrated clinical care with her PCP and specialty providers.

j. Community resources

Molly connects the foster family to the Orphan Care Alliance (OCA), an organization dedicated to serving children and families affected by foster care and adoption. The OCA assist the Rings with education and support. The Family Support ministry offers trainings on trauma based on various intervention tools including Empowered to Connect, Trauma Competent Caregiving and Trust Based Relational Intervention (TBRI ®).

k. Assistance with the Individualized Education Plan

Currently, Amanda's IEP includes homebound education due to her fragile medical condition. As Amanda improves, the IEP will be adjusted to allow Amanda to attend school in small increments. With the permission of DCBS, Molly will reach out to the Family Resource Center Coordinator and IEP coordinator to communicate Amanda's improvement and help the school identify when it may be appropriate to adjust the IEP to accommodate Amanda's changing health needs.

l. Social Determinants of Health

To support the Rings in their challenges to find healthy foods that Amanda likes, Molly gives them information on how to access Come-Unity Cooperative Care. This community non-profit is a WellCare partner for food pantry services and can provide food items for Amanda to try. In addition, the Come-Unity Cooperative can support Amanda and the Rings with clothing and household needs to support Amanda's placement.

m. Planned respite care

Molly will review the Rings respite needs. She will ask whether in-home or out-of-home respite is most useful and what days and times are most supportive. Molly will supplement the Rings DCBS respite allowance, if needed, with WellCare's value-added benefit. Molly works with DCBS to develop a list of trained respite workers suitable to match Amanda's needs. She also talks with the Family Resource Center liaison about teachers and para-educators who may be interested in additional work outside of the classroom.

n. Applicable evidence-based practices

Providers in the WellCare network are trained in trauma informed care, the understanding of ACEs, and the American Academy of Pediatric Healthy Foster Care America guidelines. Dr. Ronald Dowell, Amanda's dentist, has been trained by WellCare's dental provider, Avesis in Sensi-Dentist, a program focused on helping dentists engage individuals with special health care needs. Because of her heart condition, Dr. Dowell has to be in constant contact with Amanda's PCP and cardiologist when providing care. Intrust Health Care uses an in-home trauma-informed cognitive behavioral treatment model. Amanda's therapist is able to engage the Rings in family sessions, helping them to gain more understanding of Amanda's trauma and triggers.

o. Sharing and review of medical records

Serving as our core electronic care management system, the CareCentral platform integrates physical and BH, pharmacy and community support information into our Care Coordination processes. Using this platform, Molly, Amanda's PCP, Cardiologist, DCBS, community partners and the CCT have 24/7 access to a 360-degree view of Amanda's services and health status. CareCentral provides actionable data, such as care gaps, admissions, ED visits, claims and prescription history, authorizations and Clinical Practice Guidelines. WellCare will work with DCBS to fully automate the Medical Passport using functionality in our Member portal. This will include vital documentation such as birth certificates, so that SKY enrollees retain a comprehensive summary and up-to-date health portfolio, which follows them throughout DCBS and health care transitions.

p. Maintenance of the Care Plan

Amanda's IHP and Care Plan will be maintained electronically in CareCentral, including signed copies. Molly will review and update the IHP monthly, as needed, based on her home visits and Medically Complex service team discussions and no less than every six months. The IHP will reflect and include a detailed description CCT members and their involvement in the IHP and signatures including Amanda's PCP, dental home, BH providers, specialist, community partners and caregivers. The Care Plan and IHP will include frequency and method for updating and revising goals, monitoring and follow-up activities.

J.

PERFORMANCE BOND

J. PROOF OF ABILITY TO OBTAIN PERFORMANCE BOND IN THE AMOUNT OF $30,000,000

Please see the attached letter which proves WellCare of Kentucky and WellCare Health Plans' ability to obtain a performance bond in the amount of $30 million. It is named **Attachment 60.6.J Performance Bond Letter.**

Adam Rehn
Commercial Surety Consultant
2055 Sugarloaf Circle, Suite 300
Duluth, Georgia 30097
Phone: 678-417-3925

January 10, 2020

Commonwealth of Kentucky
Finance – Office of Procurement Services
702 Capitol Ave, Capitol Annex Room 095
Frankfort, KY 40601

RE: WellCare Health Insurance of Kentucky, Inc. d/b/a WellCare Health Plans of Kentucky
Solicitation No: RFP 758 2000000202

To Whom it May Concern:

Since 2008, Liberty Mutual Surety has had the continued privilege of providing surety bonds for WellCare Health Plans, Inc. and their subsidiaries to include WellCare Health Insurance of Kentucky, Inc. d/b/a WellCare Health Plans of Kentucky. Liberty Mutual has provided favorable consideration to performance and payment bonds in excess of $30,000,000 in the past for WellCare on contracts in excess of $50,000,000. WellCare Health Plans, Inc. continues to remain an account in excellent standing with Liberty Mutual Surety and qualifies for significant surety credit.

Liberty Mutual Surety has reviewed Solicitation No: RFP 758 2000000202 for WellCare Health Insurance of Kentucky, Inc. d/b/a WellCare Health Plans of Kentucky and in our view WellCare qualifies for the underlying bond. At WellCare's request, Liberty will support the required performance and payment bonds.

You understand of course, that any arrangement for surety credit is a matter between WellCare Health Plans, Inc., their wholly owned subsidiary WellCare Health Insurance of Kentucky, Inc. d/b/a WellCare Health Plans of Kentucky, and Liberty Mutual Surety and we assume no liability to third parties or to you if for any reason we do not execute a final bond. Liberty Mutual Surety reserves the right to review terms and conditions of any proposal, contract documents, bond forms, financial arrangement and other underwriting considerations at the time of a final bond request.

Liberty Mutual Insurance Company has an A.M. Best rating of A, financial category XV, and US Treasury Listing of $1,289,139,000.

If you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

Adam Rehn
Commercial Surety Consultant
Attorney-in-Fact
Member of Liberty Mutual Group

WellCare
Beyond Healthcare. A Better You.

This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Liberty Mutual SURETY

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Certificate No: 8202076-977128

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Anne Baker; Jay S. Barton; Lisa M. Brissey; Kevin M. Cranford; Meghan Doyle; Kimberly Farmer; LaTrena S. Gibson; Dana B. Henderson; William C. Hicklin; Aaron M. Hill; Wendy Howe; Allen Hudson; Steve Kelley; Jordan K. Macon; Karen L. Martin; Crystal Neal; Adam Rehn; Gabriel Schlappi; Byung So; Tiffany Soko; J. Ryan Turner; Richard D. Whitmire

all of the city of Duluth state of Georgia each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 6th day of September, 2019.

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

State of PENNSYLVANIA
County of MONTGOMERY ss

On this 6th day of September, 2019 before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS: Section 12. Power of Attorney.
Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts: Section 5. Surety Bonds and Undertakings.
Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 10th day of January, 2020.

By: _____
Renee C. Llewellyn, Assistant Secretary

LMS-12873 LMIC OCIC WAIC Multi Co_062018

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

APPENDIX

- Attachment X Contract Compliance Matrix (Provided Electronically)