



WellCare of Florida, Inc. dba Staywell Health Plan of Florida

A member of the WellCare Group of Companies

Medicaid and Children's Health Insurance Program

2015

MEDICAID

QUALITY IMPROVEMENT

PROGRAM DESCRIPTION

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I. Background and History

WellCare of Florida, Inc. (the “Plan”), a Florida corporation, was incorporated on May 17, 1985. Originally incorporated under the name Well Care HMO, Inc., the Plan is headquartered in Tampa, Florida and provides managed care services to government-sponsored Medicaid and Medicare programs. The Plan is contracted with the Agency for Health Care Administration (“AHCA”) as WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida. We are using the names “WellCare Health Plans, Inc.” or “WellCare” to refer to the corporate entity and “WellCare of Florida” as reference to the entity of Staywell. The Plan has contracted with AHCA to provide services under the Florida Medicaid program since 1994. In addition, the Plan, WellCare of Florida, Inc. d/b/a Staywell is currently contracted with the Florida Healthy Kids Corporation to provide services for the Children’s Health Insurance Program. WellCare of Florida currently operates their Healthy Kids Plans in 65 of 67 counties.

WellCare of Florida, Inc. d/b/a Staywell was awarded the Managed Medical Assistance (MMA) contract in eight of the eleven regions in the State of Florida. The MMA Program began operating May 1, 2014 and was fully implemented in each of the eight regions by October 1, 2014.

II. Mission Statement

Our corporate mission is to:

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

III. Authority

The Plan’s Board of Directors (the **Board**) is the governing body of the Plan and responsible for the general oversight and strategic direction of the Quality Improvement (QI) Program. The Board has ultimate accountability and responsibility for the quality of healthcare and other services rendered to Plan members. In association with oversight responsibilities, the QI Program Description is reviewed by, and subject to the approval of, the Board.

The Board has delegated the following responsibilities:

- Overall oversight of the day-to-day operations of the QI Program to the Senior Director of Quality Improvement, with support from the Vice President, Quality and Performance Improvement and the WellCare of Florida Market Medical Director.
- Authority to approve specific Plan QI activities, (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) to the Quality Improvement Committee (the **QIC**); and.
- Implementation of the Plan’s utilization management program (the **UM Program**) to the Utilization Management Medical Advisory Committee (**UMAC**), a sub-committee of the QIC.
- Review and comment of the Plan’s quality and access standards, grievance and appeals process as well as policy modifications needed based on review of grievance and appeals data, Member Handbook, member educational materials, recommendation of community outreach activities, and Plan and Florida DMS policies that affect members to the Quality and Member Access Committee (**QMAC**), a sub-committee of the QIC.

IV. Scope

The QI Program is comprehensive, systematic and continuous. It applies to all member demographic groups, care settings, and types of services afforded to Medicaid (and State Children's Health Insurance Program, SCHIP) membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include, but are not limited to:

- quantitative member and organizational outcomes,
- confidentiality,
- network adequacy,
- preventive health,
- service utilization,
- disease and care management,
- coordination/continuity of care,
- cultural competency,
- credentialing,
- quality of care/service,
- appeals and grievances,
- member and provider satisfaction,
- components of operational service, and
- reporting requirements.

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. Continuous quality improvement processes identified in the QI Program Description, Work Plan and Annual Evaluation are approved by the applicable Committees and conducted to accomplish identified goals. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources.

The annual QI Work Plan identifies specific activities and projects to be undertaken by the Plan and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The annual QI evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years trending as appropriate. The annual evaluation describes the overall effectiveness of the QI 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; and
- current opportunities for improvement with recommendations for interventions

Each QI process is continually improved by analyzing and acting to ensure consistency across the enterprise, thus becoming more efficient and effective. The Plan-Do-Check-Act (PDCA) method of CQI is utilized throughout the organization. Under the PDCA approach multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis, action plans and re-measurement occur to ensure progress toward established goals.

The CQI strategy noted above is demonstrated in the structure of the QI Program's committees and sub-committees, the QI Program Description, Work Plan and Annual Evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained. Monitoring of quality of care interventions and outcomes through HEDIS® measure reviews, external quality review studies, periodic medical record reviews (for chart maintenance, documentation legibility, disease management compliance; continuity of care coordination, information security) and as required by the Centers for Medicare & Medicaid Services (CMS).

V. **Activities and Resources to Fulfill the Scope**

WellCare of Florida has many ongoing QI activities to fulfill the scope of the QI Program. Listed below is a summary of those activities. Full detail including timeframes for completion, responsible parties, planned monitoring, and evaluation is included in the QI Work Plan.

- Assessment of network adequacy and appointment availability via:
 - Geo-Access reports
 - Appointment and after-hours access audits
- Development and review of clinical practice guidelines
- Assessment of member satisfaction via:
 - Annual satisfaction surveys (CAHPS[®], University of Florida - CAHPS)
 - Member grievance reports
 - Member appeal reports
- Assessment of provider satisfaction via:
 - Annual satisfaction survey
 - Provider grievance reports
 - Provider appeal reports
- Credentialing and re-credentialing of PCPs, specialists, ancillary, and allied health providers
- Assessment of continuity and coordination of care via:
 - Care Management
 - Disease Management
 - Behavioral Health Case Management
 - Medical record review
 - Member grievances
 - Transitional Care Management
- Assessment of provider compliance with national standards of care via:
 - Medical record review
- Assessment of patient safety via:
 - Investigation of quality of care concerns
 - Member grievances
 - Provider site visits
 - Poly-pharmacy monitoring
 - Medication recall monitoring and notification
- Assessment of operational service performance via:
 - Average speed of answer (ASA), abandonment rate (AR), customer satisfaction scores, first call resolution scores, and call monitoring reports for member and provider customer service
 - Behavioral Health Hot Line metrics reporting
 - Accuracy and timeliness of claims processing reports
 - Utilization management services monitoring reports
- Health Services programs and activities:
 - Care Management services
 - Disease Management services
 - Behavioral Health Case Management services
 - High Risk Pregnancy program
 - EPSDT services
 - Smoking Cessation program
 - Performance Improvement Projects
 - HEDIS[®]
 - Emergency Department Utilization
- Ongoing assessment of population changes:
 - Cultural needs and preferences
 - Linguistic needs and preferences

 - Ethnic needs and preferences
 - Racial needs and preferences

- Delegation Oversight activities:
 - Pre-delegation audits
 - Annual oversight audits
 - Quarterly report review and evaluation
- Assessment of QI Program via:
 - QI Work Plan
 - Annual QI Program Evaluation
 - Annual update to the QI Program Description based on QI Program Evaluation findings
- Annual External Quality Review Organization (EQRO) assessment

Technical Resources

Eligibility System

Xcelys®

Customer Management System

Xcelys® - Customer Management Record (CMR)

Clinical Authorization/Information System

Xcelys®

EMMA

Claims System

Xcelys®

Surround

Other Technical Resources and Commercial Programs

Microsoft® Office Suite

Microsoft® Project

Visio® Basic

Sales Force

Quality Spectrum Insight®

Quality Spectrum Hybrid Reporter®

Access

GeoNetworks®

Excel

SAS

Analytical/Reporting Resources(Corproate)

Staff backgrounds in:

Computer programming

Research methodology

Healthcare data analysis

Contracted Programs

Member Satisfaction Survey (CAHPS 5.0H Child, 5.0H Adult, Practitioner Satisfaction Survey)

VI. Purpose

The purpose of the Plan's QI Program is to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services,
- Identify and implement strategies to improve the quality, appropriateness and accessibility of member healthcare
- Facilitate organization wide integration of quality management principles.

The QI Program Description describes:

- The essential structure, resources and processes through which the QI Program is implemented; and,

- The QI Program scope as well as associated accountabilities and responsibilities.

VII. Goals

Goals are established to support the purpose of the QI Program. All goals are reviewed annually and revised as needed. The QI Program goals are primarily identified through:

- ongoing activities that monitor care and service delivery;
- issues identified by tracking and trending data over time;
- issues/outcomes identified in the previous year's QI Program Evaluation;
- a demographic and morbidity analysis of member age, gender, and most frequently diagnosed disease categories (both inpatient and outpatient);
- Internal process reviews; and accreditation, regulatory, and contractual standards.

QI Program Goals:

1. Facilitate the integration, support, and commitment to continuous quality improvement throughout the Plan for sustained improvements;
2. Encourage and evaluate compliance to policies and procedures that standardize approaches to the completion of activities that reflect key program components;
3. Develop and maintain a process through which clinical and operational performance is continuously measured, opportunities for improvement identified, meaningful interventions are initiated as appropriate, and the results of actions taken to improve outcomes are evaluated;
4. Select and conduct meaningful and relevant (high-volume, high-risk, and/or problem prone) population-specific quality improvement initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services;
5. Ensure availability of and access to qualified providers, adhering to established standards for credentialing and re-credentialing of network practitioners and providers;
6. Adopt and disseminate evidence-based guidelines, thereby promoting the delivery of safe clinical practice;
7. Facilitate integration of services to promote continuity and coordination of care, whether resulting from a change in setting or a transition of care, inclusive of both medical and behavioral health care delivery situations;
8. Promote a supportive environment that assists associates and providers to render culturally-competent medical and behavioral health care and/or services, thereby promoting compliance with the WellCare Corporate Cultural Competency Plan;
9. Maintain established safeguards for member privacy, including confidentiality of member health information in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations adopted there under (collectively, *HIPAA*).
10. Encourage member participation in Plan programs and services through the dissemination of information that considers language and readability levels;
11. Engage members in managing, maintaining, and/or improving their current health status through preventive/wellness activities, disease management, care management, and other chronic care initiatives;
12. Maintain a process for members, providers, various healthcare associations and community agencies to receive updates, and offer suggestions, concerns, and recommendation regarding the QI Program and activities;
13. Ensure all aspects of the QI Program and activities are in compliance with contractual, state, federal, and accreditation standards;
14. Collaborate with various internal stakeholders to ensure the Plan's information system supports the collection, tracking, analysis, reporting and historical record keeping of relevant QI Program related data;
15. Establish standards and conduct continuous, comprehensive oversight of all delegated entities;
16. Establish standards and objectives for serving members with complex health needs.

Annually, specific objectives to promote realization of select goals are identified and recorded in the work plan document.

VIII. Objectives

The objectives of the QI Program are to:

- Continuously monitor and analyze key clinical, safety, and service indicators
- Manage disease and care management programs
- Conduct member and provider outreach and health education activities for members
- Ensure members have access to culturally and linguistically appropriate services
- Develop and implement programs for members with special needs
- Conduct performance improvement projects and select clinical and service studies in collaboration with the HSAG and AHCA
- Conduct oversight of delegated services and activities
- Assess member and provider satisfaction through surveys
- Coordinate activities across functional areas to improve care, safety, and service
- Conduct oversight of risk management
- Evaluate the effectiveness of the QI Program

IX. Delegation

The Plan has delegated the following activities:

Vendor Name	Delegated Activities
Access Healthcare	Credentialing
AdminisTEP, LLC	Administrative Print Fulfillment
Advanced Medical Reviews (AMR)	Utilization Management
AIM Healthcare Services, Inc.	Administrative Overpayment
All Asian Group	Administrative Language Translation
All-Med	Claims
All-Med	Credentialing
All-Med	Network Management
All-Med	Utilization Management
ATEB	Medication Therapy Management
Brevard Health Alliance	Credentialing
Brevard Professional Network	Credentialing
CareCore National	Utilization Management
CareNet	Administrative Nurse Advice
Catamaran	Pharmacy Claims
Catamaran	Pharmacy Credentialing
Catamaran	Pharmacy Network Management
CDR Associates, LLC	Administrative Overpayment
Central FL Orthopedic Associates	Claims
Certified Languages International	Administrative Language Translation
Chiropractic Alliance Corp	Claims
Chiropractic Alliance Corp	Credentialing
Chiropractic Alliance Corp	Network Management
Concentrix - Offshore	Administrative Claims
Concentrix - Onshore	Administrative Claims
Connolly Healthcare	Provider Appeals
Council for Affordable Quality Healthcare, Inc.	Administrative Overpayment

Dermatology Network Solutions	Claims
Dermatology Network Solutions	Provider Appeals
Dermatology Network Solutions	Network Management
Dermatology Network Solutions	Utilization Management
Devlin Consulting	Administrative Overpayment
Eliza	Administrative Outreach
Financial Recovery Group	Administrative Overpayment
First Recovery Group	Administrative Overpayment
Firstsource Onshore	Administrative Claims
Focus Health	Utilization Management
Health Data Insights	Provider Appeals
Health Integrated	Behavioral Health Crisis Line
Health Management Systems (HMS)	Administrative Overpayment
	Claims
Health Network One	Credentialing
Health Network One	Network Management
Health Network One	Utilization Management
HealthChoice (ORHS)	Credentialing
HealthPoint Medical Group	Credentialing
HearUSA	Claims
HearUSA	Credentialing
HearUSA	Network Management
iHealth	Administrative Overpayment
Interpretek	Administrative Language Translation
Iron Mountain	Administrative Document Shred
Liberty Dental Plan	Provider Appeals
Liberty Dental Plan	Claims
Liberty Dental Plan	Credentialing
Liberty Dental Plan	Customer Service
Liberty Dental Plan	Network Management
Liberty Dental Plan	Utilization Management
Linkia	Credentialing
Manatee County Rural Health Services	Credentialing
Multi-Lingual Medical Group	Administrative Language Translation
Nemours Children's Clinic - Florida	Credentialing
North Broward Hospital District	Credentialing
Novitex	Administrative Mailroom
O'Neil Data Systems	Administrative Print Fulfillment
Premier Eye Care	Provider Appeals
Premier Eye Care	Claims
Premier Eye Care	Credentialing
Premier Eye Care	Customer Service
Premier Eye Care	Network Management

Premier Eye Care	Utilization Management
Results - Alaska Land	Customer Service
Results - Hermosillo	Customer Service
Results - Lawrence	Customer Service
Results - Paris	Customer Service
Results - Streator, IL	Customer Service
Results - Streator, IL	Utilization Management Intake
Results - Winter Haven, FL	Customer Service
Surgery One, IPA	Claims
Syrtis Solutions	Administrative Overpayment
Take Care Clinics	Administrative Credentialing
Teleperformance - Augusta	Customer Service
Teleperformance - Augusta	Utilization Management Intake
Teleperformance - Columbia	Customer Service
Teleperformance - North Lauderdale	Customer Service
Teleperformance - Tektite	Customer Service
The Myers Group	Administrative Outreach
Translation Station	Administrative Language Translation
TransUnion Corp	Administrative Overpayment
USF Physician Group	Credentialing

The Plan is responsible for ensuring the delegated entity's compliance with internal Plan standards and requirements, as well as federal, state and accreditation standards. Oversight activities include but are not limited to:

- 1) Executing written agreements with each delegated entity that specify the activities to be delegated and those to be retained by the Plan, including data reporting standards
- 2) Evaluating the entity's ability to fulfill delegation obligations through review of the entity's programs, policies, procedures and service delivery, including use and handling of protected health information and other applicable HIPAA privacy and security concerns prior to delegation
- 3) Performing ongoing performance monitoring via review of submitted data reports and ensuring that corrective action is taken, in a timely manner, to address any opportunities for improvement identified
- 4) Completing an annual formalized performance review and re-approving all applicable programs, including the entity's QI program
- 5) Imposing sanctions or revoking delegation if the entity's performance is inadequate

X. Role of Market Medical Director, State of Florida

In partnership with Florida's Senior Medical Director, WellCare's Corporate Medical Director and physician quality leader, the vice president of quality management and the plan president for Florida, oversees Staywell's QI activities, including oversight of a medical management team comprised of a senior medical director for all of the Florida-based products including behavioral health. The Staywell Medical Director is responsible for overseeing the development, implementation, and evaluation of all clinical aspects of the Managed Medicaid Assistance QI program in Florida.

Under the direction of the Staywell Plan President, the Staywell Medical Director is responsible for overseeing the development, implementation, and evaluation of all clinical aspects of the Managed Medicaid Assistance QI program in Florida. The Staywell Medical Director serves as the clinical leader of the Florida Medicaid market, guiding activities and consultatively engaging providers in the QI program; and provides

clinical oversight of the accreditation processes and compliance processes in accordance with state and federal regulations.

The Staywell medical director chairs the Quality Improvement Committee (QIC), the Utilization Management Medical Advisory Committee (UMAC) and Credentialing/Peer Review Committees. The Staywell Medical Director reports to the Senior Corporate Medical Director in Tampa, Florida and is responsible for:

- Overseeing the implementation of the clinical aspects of the QI Program
- Continuously working to improve the overall effectiveness of the QI Program
- Overseeing the appropriateness and effectiveness of clinical care provided by the Plan to Plan enrollees
- Participating in the development of medical policies relative to medical necessity, access, and availability of services
- Actively participating in clinical quality improvement committees and reviewing their findings

XI. Role of the Quality Improvement Department

The Senior Director of Field QI has overall accountability for the day- to-day operations of the QI Program, including acting as primary liaison with the state client in the deployment of various contract-required quality initiatives. The Senior Director of Field QI integrates, coordinates, and manages the overall QI operations of the Plan with enterprise-wide initiatives as appropriate. In addition, the Senior Director of Field QI promotes consistency in the Plan's QI activities and serves as the resource person for quality references, clinical indicators, etc. The Plan's QI Department personnel collaborate with associates in each clinical and administrative department to evaluate quality of care to identify opportunities and implement interventions to improve the healthcare and service delivered to members. Functions of the QI Department staff include, but are not limited to, prioritizing problem areas for resolution, designing strategies for change, implementing improvement activities and measuring the success of interventions. Quality leadership staff report to the Vice President of Quality and Performance Improvement.

The Vice President of Healthcare Quality and Analytics is responsible for the development, coordination and implementation of operational quality strategies and initiatives that consider relevant and meaningful indicators for monitoring and evaluating the quality and appropriateness of care/service across the continuum of care. He/she provides leadership and direction to the quality management teams in each Medicaid state to ensure that the organization's strategic plan is translated into realistic and cost-effective tactical goals and plans for action that guarantee clinical and operational performance objectives are met or exceeded. Organization-wide understanding, communication, and coordination of activity are promoted to produce work effort alignment in centralized and decentralized processes. The Vice President of Healthcare Quality and Analytics works to improve organizational quality scores by leveraging knowledge of healthcare best practice interventions, modeling for application in Plan markets. This individual also deploys sound data collection techniques and establishes reporting systems and controls to ensure compliance with company, regulatory and state contract requirements while reporting to the Chief Medical Officer.

XII. Role of the Behavioral Health Medical Director

The Behavioral Health Medical Director supports and oversees the development, implementation, and evaluation of all behavioral health aspects of the QI Program. The Behavioral Health Medical Director serves as the mental health leader, guiding activities and consultatively engaging providers in the QI program. The Behavioral Health Medical Director reports to the Chief Medical Officer and is responsible for:

- Overseeing the implementation of the behavioral health aspects of the QI Program
- Continuously acting to improve the overall effectiveness of the QI Program
- Overseeing appropriateness and effectiveness of behavioral health care provided by the Plan
- Providing final approval or denial of specific mental health services to Plan members
- Overseeing the development of behavioral health policies relative to necessity, access, and availability of service
- Actively participating in behavioral health quality improvement committees and review findings

XIII. Behavioral Health Services

WellCare incorporates delivery and management of behavioral health services across all aspects of the care delivery system. The Plan provides all medically necessary behavioral health aspects of care delivery that include recovery and are resiliency focused. This means that services provided by the Plan allow individuals to have the greatest opportunities for decision-making and participation in the individual's treatment and rehabilitation plan. All Behavioral Health services are provided in conformance with the access standards established by CMS.

The Plan and its Behavioral Health Providers work collaboratively on key initiatives, including appropriate medication management, instruction on routine tests needed for the dispensing of atypical antipsychotic medications, continuity and coordination of care between medical and behavioral health providers, and medical provider education regarding behavioral disorders commonly seen in primary care settings. This ensures Plan members have improved access to care, coordination and continuity of care through the delivery of mental health and substance abuse treatment.

The Plan maintains a toll-free crisis and emergency Behavioral Health Services hotline that is capable of connecting to a local Suicide Hotline and Crisis Response Hotlines as well as patch capabilities to 911 services.

The Plan's Behavioral Health Care Management and program is integrated into the Care Management program. Further information on the Plan's Behavioral Health Care Management program can be found in Appendix B.

The Plan's Behavioral Health Disease Management and program is integrated into the Disease Management program. Further information on the Plan's Behavioral Health Disease Management program can be found in Appendix C.

XIV. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

The purpose of the EPSDT program in Florida is to ensure WellCare Health Plans, Inc., and its affiliates and subsidiaries (collectively, "WellCare," the "Plan," or the "Company") are in compliance with all statutes, regulations, administrative rules, and Medicaid contract requirements governing child health screenings in the federal periodicity schedule, such as lead testing and dental exams

Definitions:

Child Health Check Up Program (CHCUP) - A set of comprehensive and preventive health examinations provided on a periodic basis to identify and correct medical conditions in children/adolescents. Policies and procedures are described in the Child Health Check-Up Services Coverage and Limitations Handbook.

Health Check Screening - is defined as a program designed to evaluate the health status and potential of an individual. In the process it may be found that a person has a particular disease or condition or is at greater-than-normal risk of its development. Health screening may include taking a personal and family health history and performing a physical examination, tests, laboratory tests, or radiologic examination and may be followed by counseling, education, referral, and/or further testing.

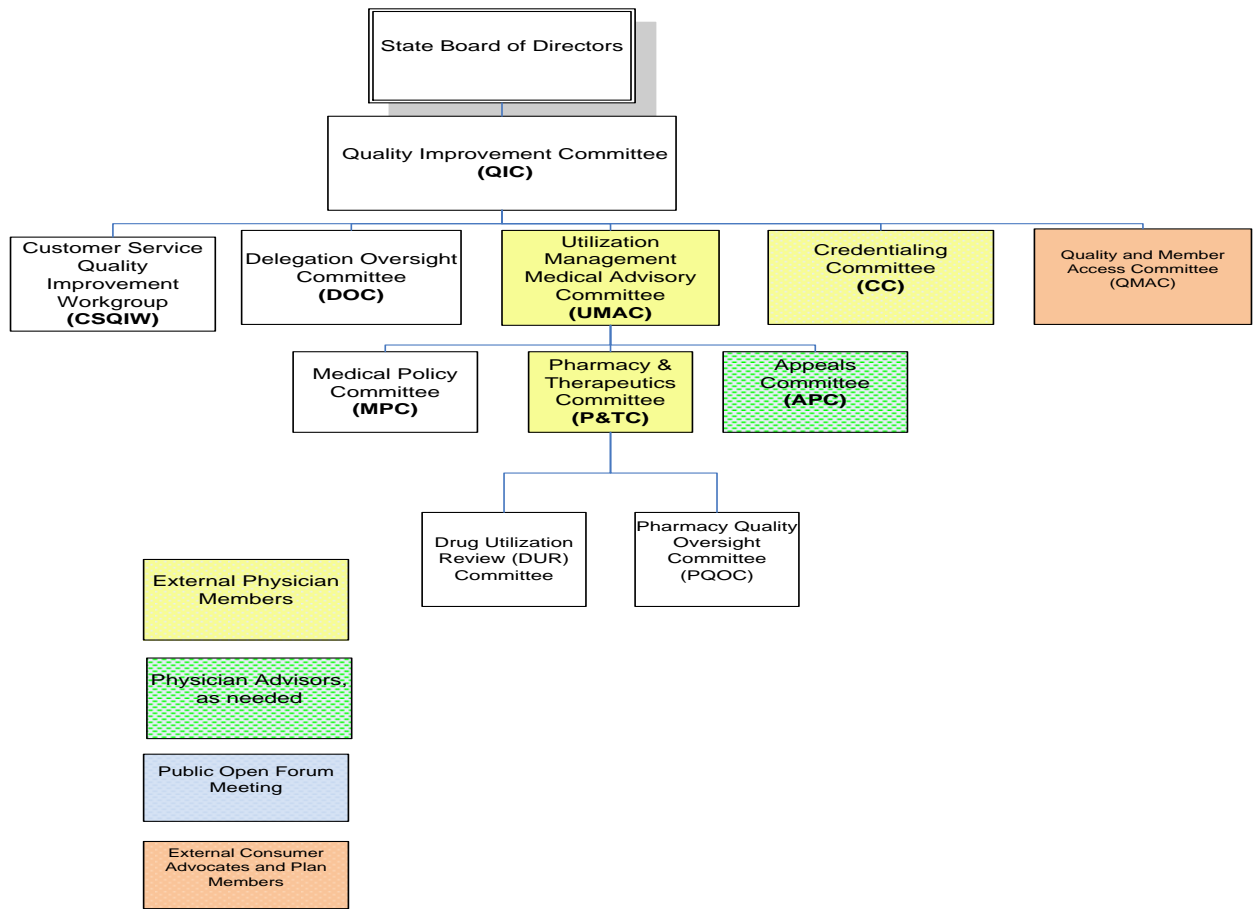
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) - Early Periodic Screening Diagnosis and Treatment or Child Health Check Up (CHCUP) is a statewide program of age appropriate evaluation and assessment for children from infancy to age 21 years of age to identify or detect potential diseases or disabilities and develop treatment plans.

The Plan will provide child health screening visits for all Early Periodic Screening, Diagnosis, and Treatment ("EPSDT") eligible members according to the federal periodicity schedule, including lead

testing and dental exams (if applicable). In addition, eligible members who are identified with defects or needing medically necessary treatment shall receive the necessary referrals and treatment to address the condition(s). To this end the plan will utilize member outreach in the form of member and provider outreach. Members will be reminded of services as indicated in the periodicity table. Providers will be notified of members who are due or past due for recommended services. Please see Policy C7QI-034 for more detail WellCare’s EPSDT program and monitoring.

XV. Committee Structure

QI Program Committee Organizational Chart



Board of Directors, WellCare of Florida, Inc.

Purpose: The Board has overall accountability and responsibility for the quality of healthcare and other services rendered to these members. The Board will support and have the final authority and responsibility for the assurance of a comprehensive and integrated QI Program.

Chairperson: Any Director and/or designee

Membership: The Shareholders elect the members of the Board and other attendees of the Board meetings may include the CEO and/or designee, Regional President, Senior Vice President, Health Care Delivery, Medical Director, and Representative(s) of Executive Management or designees.

Frequency: Meets Quarterly, not less than four times per year.

Minutes: Minutes are recorded and maintained for each meeting.

Quality Improvement Committee (QIC)

Purpose: The QIC promotes the goals and objectives of the QI Program through oversight and approval of Plan QI activities. Primary responsibilities of the QIC include:

- 1) Demonstrating commitment to both the delivery of high quality care and services to members and the organization's performance improvement philosophy.
- 2) Reviewing the QI Program Description on an annual basis, revising it as necessary and approving it prior to its review and approval by the Board;
- 3) Approving the following documents on an annual basis before their presentation to the Board: the UM Program Description and the QI and UM Annual Evaluations;
- 4) Ensuring Plan QI activities are completed in a manner that promotes patient safety, cultural competency and confidentiality;
- 5) Fostering integration of the Plan QI Program with organizational strategic initiatives for synergy, ensuring that quality improvement measures and processes are working effectively throughout the organization;
- 6) Reviewing, revising, recommending, and approving Plan policies, procedures, and standards, based on subcommittee recommendations;
- 7) Monitoring, assessing, evaluating and analyzing progress toward annual QI goals, requiring that objective measures be used to evaluate the quality of care and service being rendered;
- 8) Reviewing and approving periodic subcommittee reports, as defined by formal committee reporting structure;
- 9) Ensuring practitioner participation in the QI Program by engaging in activities related to planning, design, implementation, or review;
- 10) Providing general direction and oversight for program functions and the following activities, voicing recommendations for improvement, requesting corrective action and providing approval where necessary and appropriate.
 - a. Quality measurement studies/ projects
 - b. HEDIS[®] performance measures
 - c. Member and provider satisfaction surveys,
 - d. Medical record reviews
 - e. Complaints and grievances
 - f. Provider network adequacy (availability and accessibility)
 - g. Continuity and coordination of care statistics
 - h. Cultural competency activities
 - i. Patient safety initiatives
- 11) Ensuring appropriate follow-up action as necessary to complete planned program initiatives;
- 12) Reviewing capability assessment and approving initial and/or continued delegation to delegated entities;
- 13) Monitoring and ensuring compliance of QI Program activities with regulatory, contractual and accreditation standards;
- 14) Providing guidance to the development of content and ensuring the dissemination of information regarding QI activities and outcomes to Plan staff, as well as members practitioners, and providers;
- 15) Reporting QIC activities to the Board and appropriate governing authorities at defined frequencies.

Location: The QIC physically meets in Tampa, Florida and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: Medical Director

Additional Membership:

Plan Representation: President, Medical Director, Sr Director, Quality Improvement, State Pharmacy Director, Field Health Services Director, QI Project Manager, Chief Operating Officer, Market Directors, Finance Director, Director of Network Development, Director of Regulatory Affairs, Risk Manager, Member Advocate, Manager of Regional Operations, Human Resources Manager, Director of Hospital Contracting, 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: Vice President, Quality and Performance Improvement, Vice President, Quality Management, Customer Service Director, QI Senior Director – Florida , Credentialing Director, Claims Director, Appeals and Grievances Senior Director, UM Director, UM Medical 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.

Frequency: Meets at least quarterly

Minutes: Minutes are recorded and maintained for each meeting

Reports to: Board

Credentialing and Peer Review Committee (Credentialing Committee)

Purpose: The QIC has delegated credentialing and re-credentialing oversight and approval authority to the Credentialing Committee. This committee is also responsible for peer review of provider quality of care/service and conduct issues.

Primary functions of the Credentialing Committee include:

- 1) Uniformly applying credentialing and re-credentialing criteria and standards of participation to select and retain providers, including facilities, to ensure that qualified providers are approved and maintained as participating providers;
- 2) Conducting peer review of provider quality of care, quality of service and conduct issues and initiating appropriate actions including imposition of corrective action plans, temporary suspension of participation or termination from the Plan network;
- 3) Providing a forum for the review, revision and approval of credentialing policies and re-credentialing policies and procedures.
- 4) Maintaining strict confidentiality regarding credentialing and peer review activities;
- 5) Conducting peer review oversight and approval of delegated credentialing provider activities;
- 6) Ensuring Plan compliance with regulatory, contractual and accreditation entity credentialing and re-credentialing standards.

Location: The Credentialing Committee physically meets in Tampa, Florida and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: Medical Director

Additional Membership:

Plan Representation: Medical Directors (voting privileges)

Provider Representation: Physician advisors representing primary care, behavioral health, surgery and additional sub-specialties as needed. Physician members of the Credentialing Committee have voting privileges and must be licensed in the State for which they practice.

WellCare Corporate Representation: Credentialing Director, Provider Operations Director and other departmental representation as may be deemed appropriate by the Credentialing Committee from time to time. Such non-physician representatives serve as non-voting members.

Frequency: Monthly, not less than nine times per year

Minutes: Minutes are recorded and maintained for each meeting

Reports to: QIC

Customer Service Quality Improvement Workgroup (CSQIW)

Purpose: The CSQIW functions as a multidisciplinary task force to identify opportunities for improvement in customer service. The CSQIW reviews data relevant to member and provider complaints and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, the process is compliant with regulatory standards and issues are referred for system response through the quality improvement process. Dedicated to the continuous quality improvement process, the CSQIW facilitates open and consistent communication among members, providers, the QIC, and WellCare Corporate departments. The focus of the CSQIW is on the systemic analysis of access and quality of service provided to members.

Primary responsibilities of the CSQIW include:

- 1) Identifying and acting on opportunities for improvement through analysis of trends in the following data sources and documents, and developing/implementing corrective action plans as warranted:
 - a. Call center performances statistics
 - b. Translation services utilization
 - c. Web utilization trends
 - d. Member satisfaction surveys
 - e. Claims data
 - f. Confidentiality practices
 - g. Data relevant to member and provider interactions
 - h. Complaint/grievance data
 - i. Requests for PCP changes and member disenrollment;
- 2) Target interventions, implementing process improvements and establishing tracking mechanisms to monitor and evaluate progress;
- 3) Developing performance goals and indicators, review trends, targeting interventions, implementing process improvement and establishing tracking mechanisms to monitor and evaluate progress;
- 4) Identifying and acting on strategies to obtain member input into Plan policies and procedures.
- 5) Reporting identified barriers, progress, implementations and other CSQIW activities to the QIC.

Location: The CSQIW physically meets in Tampa, Florida and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: Director of Customer Service

Additional Membership:

Plan Representation: Sr Director of QI, Market Director, Manager of Field Health Services, and others as may be deemed appropriate by the CSQIW from time to time.

Corporate Representation: Operations Director; Manager, Complaints and Grievances; Manager, Appeals; Director, Provider Relations; Director, Regulatory Affairs; QI Manager and others as may be deemed appropriate by the CSQIW from time to time.

Frequency: Meets quarterly.

Minutes: Minutes are recorded and maintained for each meeting

Reports to: QIC

Consumer Advisory Board/CAB

Purpose: The CAB is responsible for representing the interest of the Member population to ensure that the quality and safety of clinical care, quality of services and access standards are adhered to. The MAC is comprised of Member/individuals from advocacy groups or the community representation and Plan representation. The list of Member participation is submitted to the Florida Department of Medicaid Services annually. Primary responsibilities of the CAB include:

- 1) Providing review and comment on quality and access standards;
- 2) Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievances and Appeals data;
- 3) Providing review and comment on Member Handbooks;
- 4) Reviewing Member education materials prepared by the Managed Care Organization (MCO);
- 5) Recommending community outreach activities; and
- 6) Providing reviews of and comments on Contractor and Department policies that affect Members.

Location: The CAB physically meets in in field offices rotating around the state. and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: Manager, QI

Additional Membership:

Plan Representation: Sr. Director, Quality Improvement, Director, Community Based Medicaid Programs, Director, Network Development, Director, Customer Service, Supervisor Grievances and Appeals, Manager, Account Services, Supervisor, Community Advocacy, and Quality Improvement Behavioral Health Project Manager.

Member Representation: Members, individuals from advocacy groups or the community who represent the interests of the Plan's Member population.

Frequency: Meets quarterly

Minutes: Minutes are recorded and maintained for each meeting

Reports to: QIC.

Delegation Oversight Committee (DOC)

Purpose: The DOC coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory and accreditation requirements.

Primary responsibilities of the DOC include:

1. Conducting the first level of review, revision, and annual approval of delegation policies and procedures and audit tools for on-site reviews.
2. Overseeing pre-delegation audits, annual delegation audits and monitoring delegated entities placed on corrective action plans.
3. Monitoring overall implementation of contracts with delegated entities.
4. Recommending corrective actions, including terminations of delegated entity agreements, to the QIC as necessary.
5. Monitoring data reports, adverse incidents, complaints, grievances and appeals to ensure financial incentives do not compromise quality of care or quality of service.
6. Monitoring, analyzing, tracking and trending the timeliness of oversight audit completion, reporting by delegated entities and overall compliance with contractual standards by delegated entities.

Location: The DOC physically meets in Tampa, Florida and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: Senior Director, Quality Compliance and Delegation

Additional Membership: Plan Representation: QI Director, Regulatory Affairs Director, Medical Director, Florida MMA Director of Product Operations, Network Development Director, UM Director, QI Manager of Delegation, Claims Manager, Credentialing Manager, Customer Service Manager, Regulatory Affairs Manager and others as may be deemed appropriate by the DOC from time to time.

Frequency: Meets monthly, at least nine times per year

Minutes: Minutes are recorded and maintained for each meeting

Reports to: QIC.

Utilization Management Medical Advisory Committee (UMAC)

Purpose: The UMAC oversees all clinical QI, UM and behavioral health activities. The UMAC is a vital avenue through which network providers can offer recommendations regarding Plan practices as well as QI and UM activities. The UMAC comprises practitioner representation from each of the high volume specialties providing care for the population. The UMAC utilizes additional physician input when the need arises for specialty area case review.

Primary responsibilities of the UMAC include:

- 1) Reviewing and evaluating utilization data to facilitate appropriate and efficient allocation of the Plan's healthcare resources and services.
- 2) Reviewing the following documents on an annual basis and presenting recommendations regarding the same to the QIC: the QI and UM Program Descriptions, the QI and UM Work Plans and the QI and UM Annual Evaluations.
- 3) Analyzing and providing feedback regarding any improvement project that would benefit from external physician clinical expertise;
- 4) Recommending strategies to increase provider participation in Plan QI and UM activities;
- 5) Investigating quality utilization related issues, developing corrective action plans and referring issues to the QIC when indicated;
- 6) Analyzing data from the following activities and measures in relation to UM and QI Program goals and providing recommendations for improvement to the QIC:
 - a. Service utilization data, such as Bed Days per thousand, ER Services per thousand and readmission rates
 - b. Over and under-utilization statistics
 - c. Patient safety practices, such as referral/authorization turn-around time and inpatient/outpatient care outcomes
 - d. Appeals data
 - e. Inter-rater reliability statistics
 - f. Care management program data
 - g. Disease management program statistics
 - h. Clinical quality initiatives, including HEDIS® performance measures
 - i. Quality of care and quality of service issues, complaints, grievances and adverse event data
 - j. Member and provider satisfaction survey results
 - k. Medical record review results
 - l. Pharmacy and Therapeutics activities
- 7) Providing a forum for the development, review, revision, and annual approval of clinical and preventive practice and clinical coverage guidelines

- 8) Recommending strategies to increase compliance to clinical policies and procedures and practice guidelines
- 9) Annually reviewing and approving nationally-recognized and evidenced-based medical necessity criteria and guidelines utilized by the UM staff to assist with authorization determinations;
- 10) Reviewing and approving recommendations related to the approval of new technologies, and ensuring congruence with benefit coverage and member communications;
- 11) Facilitating communication with network practitioners and providers regarding the QI and UM Programs, including updates to utilization management processes and progress in achieving QI Program goals, via provider newsletters, fax and Web broadcasting, memorandums and periodic provider meetings;
- 12) Performing oversight to the actions and outcomes of the Appeals Committee monitoring for trends that may indicate the need for additional review of the UM review determinations

Location: The UMAC physically meets in Tampa, Florida and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: Plan Medical Director

Additional Membership:

Plan Representation: Includes, but not limited to, the Senior Manager of Appeals, representatives from Network Providers, Medical Director, QI Director, Manager of Field Health Services, QI Manager, Pharmacy Director, Market Chief Operations Officer, Market; Director, Provider Relations Managers; Vice President of Finance, Director of Network Development, Manager of Medical Economics, Behavioral Health senior management representation, all QI staff

WellCare Corporate Representation: Vice President, Quality Management, Vice President, Quality and Performance Improvement, Senior Director, QI; Senior Director, Case and Disease Management; UM Director, Manager Appeals and additional representation as needed from time to time from Operations, Claims or other ancillary departments

Provider Representation: Participating providers from each of the eight service regions of the state and physician advisors representing primary care, surgery, obstetrics, and additional sub-specialties as needed from time to time to reflect high volume network provider demographics

Quorum: Must have a quorum of at least three (3) the physician members. In the event of a tie vote, the Chairperson shall serve as tie-breaker.

Physician Term: The term of Committee membership for external physicians will be one year. Participation is at the discretion of the Committee Chair and can be terminated at any time by either party. Providers may elect to renew participation at the end of the one year term, subject to approval by the Chair.

Frequency: Meets at least quarterly and on ad hoc basis at the Chairperson's discretion when issues require immediate committee evaluation and action.

Minutes: Minutes are recorded and maintained for each meeting

Reports to: QIC

Appeals Committee (APC)

Purpose: The Appeals Committee is the final authority for all Level I member medical necessity appeals.

Process if Member requests to attend the Appeals Committee

- a. Upon request from the member to present evidence and allegations of fact or law in person and/or in writing, the Appeals Coordinator will inform the member by phone that the Plan is arranging a time to meet or conduct a conference call. The Appeals Coordinator will request the member's availability. The attendees at the meeting or conference call will consist of: the member, the Appeals Coordinator, and two (2) Plan Medical Directors (not involved in the previous decision who are participants in the Appeals Committee).
- b. The Appeals Coordinator will notify the Plan's Medical Directors of the member's request to discuss the issue with the Plan and ascertain their availability for the meeting or conference call.
- c. At the meeting or conference call, the Member will first present his or her evidence. Then, the Plan will advise him or her that it will discuss the evidence and make a determination in writing within the required time frame.

Location: The Appeals Committee physically meets in Tampa, Florida and Tampa, Florida and includes a teleconferencing option so that committee members may attend meetings telephonically.

Chairperson: WellCare Corporate QI Medical Director

Additional Membership:

Plan Representation: Medical Directors, Physician Advisors appropriate to case subject matter two (2) health plan employees.

Corporate Representation: Director of Appeals and Supervisor of Appeals and others, such as members of the Legal Services or Compliance Departments, as may be deemed appropriate by the Appeals Committee from time to time.

Mandatory Recusal: No Medical Director involved in an initial case determination may vote on the matter at the Appeals Committee level.

Frequency: Meets weekly, as needed

Minutes: Minutes are recorded and maintained for each meeting

Reports to: UMAC

Medical Policy Committee (MPC)

Purpose: The MPC is responsible to research, establish, review, and/or revise the Plan's Preventive Health and Clinical Practice Guidelines, Clinical Coverage Guidelines, and New Technology coverage. The MPC reviews utilization, cost and medical necessity of guideline topics.

Chairperson: Director, Clinical Policy Development

Membership: All corporate and market medical directors; VP, Utilization Management, Medical Policy Committee members shall include the Area Leader of Health Services, Senior Corporate Medical Director (Chair), Corporate and Market Medical Directors, North Division Medical Director, South Division Medical Director, Florida/Hawaii Division Medical Director, and Senior Clinical Policy Research Writer. External specialty representatives are to be included as needed.

Frequency: Meets Monthly.

Reports to: UMAC The Medical Policy Committee reports to the Medical Advisory Committees (MACs) and collaborates with the Claims Payment Policy Committee (CPPC).

Pharmacy and Therapeutics Committee (P&TC)

Purpose: The P&T Committee is an advisory group of physicians and pharmacists. The P&T Committee improves the quality of care by promoting appropriate prescribing and drug selection, establishing and adopting standard of care practices, and managing the cost of pharmaceutical care. The P&T Committee also function in advisory, educational, and quality improvements capacities as related to drug use.

P&T Committee Roles/Responsibilities

Formulary/Preferred Drug List Management - The P&T Committee reviews each major therapeutic class annually and as new pharmaceutical information becomes available. Clinical decisions by the P&T Committee, including the addition or deletion of a drug from the PDL or formulary, shall be based on a review of certain established criteria:

- 1) The safety and efficacy of the drug;
- 2) The manufacturer, FDA approved indications, medically accepted indications (off-label use) as referenced in approved compendia (American Hospital Formulary Service Drug Information (AHFS), DRUGDEX Information System, United States Pharmacopeia-Drug Information (or its successor publications)), mechanism of action, pharmacokinetics, dosage form(s), usual dose, adverse drug reactions, contraindications/warnings and drug interactions;
- 3) Patient compliance considerations;
- 4) Cost effectiveness and pharmacoeconomic studies of the drug; and
- 5) Outcomes research data.

The P&T Committee must review for clinical appropriateness the practices and policies for formulary /PDL management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect access. The P&T Committee shall evaluate treatment protocols and prior authorization criteria at least annually and as new pharmaceutical information becomes available. The Committee will use AHCA's PDL for the first year of the MMA Contract.

Location: The P&TC physically meets in Tampa, FL and includes an audio teleconferencing option for off-site members.

Chairperson: Corporate Pharmacy Medical Director

Additional Membership:

Corporate Representation: VP, Pharmacy; Pharmacy Directors; QI Medical Director and others as may be deemed appropriate by the P&T Committee from time to time.

Provider Representation: At least one independent pharmacist and one practicing physician and others as may be deemed appropriate by the P&T Committee from time to time.

Frequency: Meets at a minimum quarterly

Minutes: Minutes are recorded and maintained for each meeting

Reports to: UMAC

Pharmacy Quality Oversight Committee (PQOC)

Purpose:

PQOC serves as a method for oversight of quality processes and initiatives in all Pharmacy Departments. These quality initiatives may include safety initiatives, clinical improvement interventions, appropriate prescribing and drug selection, establishing and adopting standards of care practices regarding medications, managing the cost of pharmaceutical care, and member satisfaction. The purpose of PQOC is to improve the quality of care of pharmaceutical services.

Primary characteristics of the PQOC include:

1. Generally: These procedures assist PQOC to function in an educational and quality improvement capacity as it relates to the various pharmacy departments and states. This department overview is comprised of:
 - a. The Medication Therapy Management Program
 - b. Pharmacy Operations
 - c. Core lines of business MAPD, Medicaid, State-Mandated studies, Expansion
 - d. Clinical and Formulary Services
 - e. Fraud, Waste, and Abuse
 - f. Any pharmacy department directly involved with quality initiatives
2. PQOC Responsibilities:
 - a. To set up quality initiatives and/or performance measures within the Pharmacy Department to help improve the effectiveness and efficiency of the medication use process and management of the pharmacy benefit.
 - b. To review the Pharmacy Department quality processes and data for trends.
 - c. To generate ideas and provide a guide for pharmacists to evaluate and substantiate existing programs and processes, as well as encourage the development of new programs and processes to promote and improve quality.
 - d. To initiate and/or direct DURs, RDURs, and MEIR systems and studies to review the results of such activities.
 - e. To provide ideas, identify resources, and information that will help develop the processes and procedures necessary to collect data to compare quality performance.
 - f. To objectively evaluate clinical data regarding medications and agents for safety and/or quality improvement initiatives.
 - g. To establish or plan suitable educational programs and/or materials for the physicians and pharmacists of WellCare on matters related to quality drug use.
 - h. To study trends related to utilization by the beneficiaries of WellCare or its providers (Physician or Pharmacist).
3. Composition of the PQOC - The PQOC is comprised of Pharmacy Vice Presidents and Directors, Pharmacy State Directors, The Pharmacy Quality Initiative Medical Director, pharmacy managers, and the Pharmacy/PDP Medical Director sitting as chair. Members comprise multiple departments, including pharmacy operations, pharmacy appeals, and formulary services. (Note: pharmacy managers and state pharmacy directors represent the pharmacy management of each market.)
4. Organization of the PQOC -
 - a. The PQOC will meet at least semi-annually. An agenda, supplementary materials, and minutes from the previous meeting will be submitted to the PQOC members at least three (3) business days before the scheduled meeting, for members to review.
 - b. Minutes of the PQOC meetings will be prepared by the recording secretary and maintained as permanent records.
 - c. The P&T Committee will oversee the PQOC. The PQOC will prepare and submit a report and/or minutes to the P&T Committee for approval.

Chairperson: Senior Medical Director, WellCare Prescription Insurance, Inc.

Frequency: Meets at least semi-annually.

Minutes: Minutes are recorded and maintained for each meeting

Reports to: P&T Committee

Drug Utilization Review (DUR) Committee

Purpose:

The DUR Committee is a pharmacy review committee established by the Pharmacy and Therapeutics Committee. The purpose of the committee is to ensure that WellCare Health Plans, Inc. and its affiliates and subsidiaries conduct appropriate drug utilization review. This includes but is not limited to: ensuring that drug therapy meets current standards of care, preventing medication related problems, evaluating the effectiveness of drug therapy, controlling drug expenditures, and identifying areas of practice that require further evaluation of network practitioners.

Primary characteristics of the DUR Committee include:

1. Generally: These procedures assist the DUR Committee to function in an educational and drug utilization review capacity as it relates to the various pharmacy departments and states. This department overview will interact with any pharmacy department directly involved in drug utilization for all core lines of business.
2. DUR Committee Responsibilities:
 - a. To provide comprehensive, structured, ongoing reviews of drug utilization to help ensure appropriate medication use and improve beneficiary outcomes.
 - b. To serve as a forum for the generation of DUR recommendations, which may include evaluations related to drug utilization, protocol reviews, utilization management edits, review of pharmaco-economic data, and evaluation of safety and efficacy data for therapeutic drug classes.
 - c. To develop processes for periodic examination of claims data and other information retrieval systems to identify patterns that suggest overutilization or inappropriate use, with an emphasis on identifying the most costly and utilized drug classes.
 - d. To recommend and coordinate implementation of systematic concurrent and retrospective drug utilization reviews. Reviews shall adhere to standard DUR processes, including the identification of optimal use criteria, measurement and evaluation of actual use against the target criteria, and implementation of corrective actions to improve areas of concern. Recommendations for corrective actions will be presented to the P&T Committee for oversight and approval. DUR recommendations may include implementation of concurrent DUR safety controls at POS, improved use of formulary utilization management (QLs at POS), and/or initiation of clinical case management intervention strategies.
 - e. To develop processes to assess the effectiveness of DUR program implementation and report findings to the appropriate committees (DUR Committee and Pharmacy & Therapeutics Committee).
 - f. To implement appropriate changes to the DUR program as recommended by the DUR Committee with oversight and approval by the P&T Committee.
 - g. To maintain written policies and procedures for established DUR processes.
 - h. To develop DUR program educational and/or outreach materials for providers and beneficiaries of WellCare on matters related to appropriate drug utilization.
3. Composition of the DUR Committee: The DUR Committee is comprised of the VP of Formulary and State Performance, Director of Formulary, Director of Operations, Senior Director of Formulary and State Performance, Director of MTM, Pharmacy Managers, and Director of Analytics. Members comprise multiple departments, including pharmacy operations, pharmacy appeals, and formulary services.
4. Organization of the DUR Committee:
 - a. The DUR Committee will determine the time and place of meetings, provided that meetings occur at least quarterly. An agenda, supplementary materials, and minutes from the previous meeting will be submitted to DUR Committee members at least three (3) business days before the scheduled meeting, for members to review.
 - b. Actions taken by the DUR Committee shall require a majority vote of the members present, with a minimum of three members required to establish a quorum.

- c. Minutes of the DUR Committee meetings will be prepared by the recording secretary and maintained as permanent records.
- d. The P&T Committee will oversee the DUR Committee. The DUR Committee will prepare and submit a report and/or minutes to the P&T Committee for approval.

Chairperson: Vice President of Formulary and State Performance

Frequency: Meets at least quarterly

Minutes: Minutes are recorded and maintained for each meeting

Reports to: P&T Committee

XVI. Risk Management/Patient Safety

The goals of the Patient Safety Plan are to:

- Promote patient safety as an integral component of health care delivery
- Reduce member instances of potential quality issues which put patient safety at risk
- Maintain an internal risk management/patient safety program that includes: at a minimum, patient safety and risk mitigation practices and is designed to identify, investigate, analyze, evaluate and prevent incidents that pose health and safety risk in accordance with Section 641.55, Chapter 59A- 12 of F.A.C. (Florida Administrative Code). The program relies on an incident reporting system to identify adverse events that occur throughout the Plan's healthcare delivery system in order to select the most advantageous method of correcting, avoiding, reducing or eliminating identifiable risks.

The objectives of the Patient Safety Plan are to:

- Consistent application of patient safety and risk mitigation throughout the organization, including all departments and all service locations to comply with Florida statute(s). Specifically, the program objectives outline an approach to:
 - Define the authority and responsibility for implementation;
 - Implement a system for collecting, evaluating and reporting qualifying Adverse Incident to the Florida Agency for Health Care Administration (AHCA);
 - Submit an annual summary report to AHCA;
 - Provide quarterly summary reports for review by the Plan's internal committees and its Board of Directors;
 - Assure new hire Associates receive healthcare risk management training within 30 day of hire;
 - Complete an annual program evaluation to identify opportunities for improvement;
 - Develop appropriate measures to minimize injury and adverse incident to patients and implement an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the Plan to report injuries and adverse events to the licensed healthcare risk manager LHRM (refer to policy C7QI – 066 Incident Reporting Responsibilities)
 - Annually update the Risk Management Program Description and associated policies and procedures.
- Inform members and providers regarding WellCare's progress towards patient safety initiatives
- Encourage the practitioner and provider community to adopt processes to improve safe clinical practices
- Promote members to be participants in the delivery of their own safe health care
- Communicate patient safety best practices

The scope of the Risk Management/Patient Safety Plan encompasses review of medical and pharmaceutical care and also administrative issues, such as provider and patient interactions. The source of risk management/patient safety data could encompass review of the following items: practitioner-to-practitioner

communication, office site visit review results, medical record review findings, clinical practice guideline compliance, adverse incident & potential quality of care (PQOC) incident reporting,, case and disease management program participation, pharmaceutical management practices, member communication and provider/practitioner actions to improve patient safety and mitigate risk. All member demographic groups, care settings and types of services are included in Risk Management/Patient Safety Plan activities.

The activities listed below are planned to fulfill the scope of the Risk Management/Patient Safety Plan. These activities are monitored by the Plan's Board of Directors who has final authority for the Program and assigns responsibility for Program operation to a LHRM, certified in accordance with state regulations. The LHRM annually completes an evaluation of the program to assess compliance with the established objectives and determine opportunities for improvement. In addition, the LHRM annually submits a revised Risk Management Program Description for approval by the Plan's Utilization Medical Advisory Committee (UMAC), Quality Improvement Committee (QIC), and Board of Directors (BOD).

1. Investigation and Reporting of Adverse Incident & PQOC Issues

Risk Management/Patient safety incidents are received by multiple sources and referred to the Licensed Healthcare Risk Manager (LHRM), within the Quality Improvement Department. All referrals are assessed by the LHRM (or designee) for Adverse Incident Reporting (Code 15 Reports) In order for an incident to qualify as a reportable adverse event via the online reporting system for Agency for Health Care Administration (AHCA's) Risk Management & Patient Safety Program, an incident must be associated with one or more categories of medical error in addition to the following criteria:

- an event involving situations where health care personnel could have exercised control and;
- Where there is an association, in whole or in part, with a Medical Intervention, rather than the condition for which such intervention occurred and a determination is made as to the appropriateness for reporting to AHCA.

Those meeting the reporting criteria, established by statute, are reported to AHCA within three days of the event date and the LHRM's receipt, and with a more detailed report submitted to AHCA within 10 days as requested. In accordance with Chapter 395.0197(7), F.S., AHCA provides for filing an extension for investigations requiring additional time to determine appropriateness for reporting. Once filed and approved a copy of the extension will accompany the Adverse Incident Report on the approved extended due date. Extensions will be requested and approved prior completion of the three day period, if warranted; reporting date and the signed/approved copy will be retained for surveyor review.

A database of all incidents reported is maintained from which an ad hoc report is generated upon request utilizing specific, current International Statistical Classifications of Diseases (ICD) codes, included in the *AHCA Code 15 Reporting Instructions*.

On a quarterly basis the LHRM submits program measurement outcomes for review to the UMAC, QIC, and BOD. The report includes numbers of reportable Adverse Incidents for the calendar year according the eight (8) categories defined by AHCA (*Code 15 Reporting*) Risk Management/Patient safety Program:

- a. Death
- b. Brain or spinal damage
- c. Performance of a surgical procedure on the wrong patient
- d. Performance of a wrong surgical procedure
- e. Performance of a wrong-site surgical procedure
- f. Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- g. Surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk as disclose the patient
- h. Performance of a procedure to remove unplanned foreign objects remaining from a surgical procedure

On an annual basis, no later than April 1st, the LHRM submits to AHCA the *Annual Report of Incidents* for the preceding calendar year via the online reporting system for AHCA's Risk Management & Patient Safety Program. That includes, in addition to all Code 15 reportable, the following:

- a. Permanent Disfigurement
- b. Fracture or dislocation of bones or joints
- c. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility
- d. Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent
- e. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior the adverse incident

If an incident is determined, by the LHRM, that it is not adverse and not reportable to the Agency for Health Care Administration and a PQOC issue is determined to represent a deviation in the standard of care it is referred to the Market Medical Director, for further investigation and a determination for the need for Peer Review via the Credentialing Committee.

Under the direction of the Medical Director, the Credentialing Committee reviews both trended system-wide and provider-specific data on a regular basis. Due to the confidential nature of these investigations and the potential impact to both the member and provider, all elements of case review, analysis and presentation will be completed in a confidential manner. Final disposition of provider-specific peer case review may include continued tracking/trending, provider or practitioner education/counseling, participation sanction, network suspension or termination. Any peer review finding of quality deficiency that results in network sanction, suspension or termination will be reported to the National Practitioner Data Bank (NPDB), the Composite State Board of Medical Examiners (CSBME) and as needed to governing agencies, such as the CMS and the Florida DMS within the CHFS.

PQOC's are codified to enable efficient tracking and trending of data over time. In addition, summary statistics are prepared which detail the final disposition of the case by level of severity. Incidents are segmented by differentiation between a "substantiated" or "unsubstantiated" and "adverse" or "non adverse" finding, depending on whether there is evidence of a deviation from the standard of care and classification in one of six categories:

- a. Death or Serious Disability
- b. Delay or Omission of Care
- c. Medication Issue
- d. Patient Safety
- e. Post-Op Complications
- f. Procedural Issue

Trended system-wide statistics are reviewed for consideration of further member and network education, in the attempt to reduce the occurrence of future quality of care issues.

2. Investigate and Report Findings from Member Complaints Regarding the Quality of Practitioner Office Sites

Member complaints into the Plan regarding physical accessibility, physical appearance, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping of practitioner office sites are received by the Grievance department and forwarded to the Provider Relations department for review and investigation. Once received, the appropriate Provider Relations Representative conducts a site visit at the practitioner office site to fully assess the member complaint. Results of the site visit are entered into the Site Inspection Evaluation tool and practitioners falling below Plan standards must implement a corrective action

plan within 30 days. The effectiveness of the corrective action plan is evaluated at least every six months until deficiencies are corrected.

3. Identify Instances of Polypharmacy

Pharmacy data is analyzed to identify members who are dispensed an excessive number of medications. These reports are used to identify instances of duplicate and/or contraindicated medication therapy. Customer Service Department generates a monthly report that identifies those Members who contacted Customer Service last month to make a PCP change and who also made a contact 3 or more times in the last 6 month span to change their PCP and this report is correlated with the Polypharmacy report to identify those member's displaying drug seeking behaviors. When found, the Plan communicates findings with individual member's primary care providers (PCP) and customer service department in an effort to eliminate duplicate and contraindicated therapy, minimize drug seeking behaviors and improve patient safety.

4. Medication Recalls

It is the policy of WellCare for its Pharmacy Department to notify members who have received a medication affected by a Class 1 and/or a Class 2 retail level recall as well as its authorized prescribers. WellCare's Pharmacy Department shall also notify affected members and authorized prescribers of market withdrawals.

1. Formulary Services shall receive an alert from one of the following regarding a drug recall or planned market withdrawal:
 - a. The FDA via email (fda@service.govdelivery.com)
 - b. Facts and Comparisons news items (online.factsandcomparisons.com)
 - c. Pharmaceutical company communications to healthcare professionals
2. Formulary Services shall review the alert to determine if the recall is relevant to WellCare's membership. Wholesale-only drug recalls and withdrawals and withdrawals unrelated to safety issues do not require notification of providers or members.
3. Formulary Services shall identify and notify members that have received the recalled or withdrawn medication in the ninety (90) days prior to the date the notification were discovered.
4. Formulary Services shall notify authorized prescribers of product recalls and market withdrawals, which include voluntary withdrawals by the manufacturer and those under an FDA requirement.
 - a. For market withdrawals, authorized prescribers shall be notified via facsimile.
5. For Class 1 Recalls, members and authorized prescribers shall be notified within ten (10) calendar days of the date which WellCare discovers the recall.
6. For Class 2 Recalls, members and authorized prescribers shall be notified within thirty (30) calendar days of the date which WellCare discovers the recall when affected members can be identified from batch and lot numbers.

5. Member Education Regarding Risk Management/Patient Safety

Improving member knowledge and awareness of patient safety is a key component of the Patient Safety Plan. It is important for members to be aware of and understand the impact patient safety has to the quality of their overall clinical health care. The following member education initiatives are conducted to increase member knowledge of patient safety:

- Develop and distribute a patient tip sheets that includes important questions and discussion items during a provider office visit such as; what to ask before surgery, drug interactions, and shared decision-making.

6. Provider Education Regarding Risk Management/Patient Safety

Providers are important pieces to ensuring members receive safe clinical practices and services. Provider collaboration is key to improve knowledge of safe practices. The following provider education initiatives are conducted to improve the delivery of safe clinical practice and services:

- Distribute the Plan's medical record documentation standards to providers.
- Develop, distribute, and conduct provider training regarding improving medical record legibility and using electronic medical records to be compliant with medical record documentation standards.
- Distribute clinical practices guidelines that promote best practices when treating chronic conditions.
- Develop and distribute the first annual Patient Safety Tip Sheet.

Implementation of the Plan requires interdepartmental collaboration. Associates from Appeals, Grievance, Credentialing, Utilization Management, Pharmacy Operations, Customer Service and Quality Improvement are regularly involved in the monitoring of patient safety. Analysis of patient safety data compiled from all departments is the responsibility of WellCare's Risk Management requirements within the Quality Improvement Department, where the LHRM along with registered nurse staff under the direction of a Florida-licensed Medical Director, review both the issue and related medical record information as needed to arrive at findings. Should peer review be required, the peer review body of the Credentials Committee is engaged.

XVII. Objectives for Serving Culturally and Linguistically Diverse Members

WellCare Corporate recognizes the diversity and specific cultural needs of its members and has identified measures to meet the cultural needs of its membership population. Actions implemented to facilitate cultural and linguistic needs include:

- Staff and network practitioners and providers are encouraged to deliver culturally competent services.
- Language assistance services are available through a language translation line and bilingual staff at no cost to those members with limited English proficiency.
- Bilingual staff are hired and retained.
- Member-related materials, including conflict and grievance resolution instructions, are available in languages of commonly encountered membership groups
- The cultural, ethnic, racial and linguistic needs of members are assessed and identified opportunities to improve provider network composition are pursued.
- Strategies are implemented to recruit and retain a diverse provider network that meets the cultural needs of the membership.
- Complaints, grievances, and appeals are reviewed and analyzed for issues identified by members or other community stakeholders related to the design of activities and initiatives to meet the cultural needs of the population.

WellCare Corporate makes cultural competency training available via WellCare University for all staff members. The training program identifies methods utilized to ensure the members' preferences, needs, and values are addressed in a manner that is free from discrimination.

XVIII. Members with Complex and Special Needs

WellCare identifies supports and engage our most vulnerable members at any point in their health care continuum to assist them in achieve an improved health status. WellCare provides services in a member-centric fashion. WellCare's objectives for serving members with complex and special needs are but not limited to:

- Complete an annual population assessment to identify the needs of the population and subpopulations so that Case Management processes and resources can be updated to address member needs. Promotion of preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in members.
- Conduct comprehensive assessments that identify member needs and barriers to care.
- Coordinating transitions of care for members with complex and special needs to assist navigating the complex healthcare system and accessing provider, public and private community based resources.

- Improve access to primary and specialty care ensuring that members with complex health conditions receive appropriate services.
- Consult with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers, behavioral health professionals, etc.
- Ensure that members socio-economic barriers are addressed

XIX. Regulatory Compliance

The Plan maintains compliance with contractual requirements and regulatory standards. Applicable state agencies and CMS have the right to view all documents relating to quality assessment and improvement activities to the extent permitted by applicable law and regulation.

XX. Annual Review and Update of the Quality Improvement Work Plan

The Quality Improvement Senior Director is responsible for updating the QI Work Plan.

XXI. Annual Quality Improvement and Utilization Management Program Evaluations

The Quality Improvement and Utilization Management Program Descriptions and Work Plans determine the program structure and activities for a period of one calendar year. At least annually, the QI and UM Departments facilitate a formal evaluation of the effectiveness of the QI and UM Programs, analyzing outcomes realized from Work Plan activities and data trends.

The Annual Evaluation addresses the overall effectiveness of the QI and UM Programs and includes without limitation, the following:

- Summary description of the QI and UM Programs;
- Major accomplishments, including an assessment of progress made in influencing network-wide safe clinical practices;
- Measures trended over time including, without limitation:
 - i. HEDIS[®] data
 - ii. CAHPS[®] data
 - iii. Enterprise and Plan specific data;
- Analysis and evaluation of outcomes including an assessment of the extent to which QI and UM activities were completed and goals met;
- Identification and analysis of issues or barriers to achieving goals and limitations of the data or measure;
- Recommended interventions/actions to demonstrate improvements for the upcoming year;
- Evaluation of the adequacy of resources, training, scope and content of the QI and UM Programs;
- Provider and member participation in the QI and UM Programs;
- Quantifiable improvements in care and service.

The QI and UM Annual Evaluations are developed with participation and support from all applicable parties and are presented to the UMAC, QMAC, QIC and the Board for final approval and recommendations.

XXII. Ethics

WellCare Corporate, its associates and directors are responsible for complying with all applicable laws, regulations, WellCare Corporate policies, and WellCare Corporate's high standards of business ethics. The Plan operates according to the new WellCare Corporate compliance program, titled *iCare* and the WellCare *Code of Conduct and Business Ethics (the Code)*. *iCare* stand for Integrity Compliance Accountability Responsibility and Engagement. The *iCare* compliance program helps ensure that WellCare Corporate complies with all of the laws and regulations that govern our business. The *iCare* program includes additional compliance tools and information to ensure that associates have the resources and support the need for WellCare Corporate to be compliant. All associates must complete the *iCare* training program and acknowledge completion annually.

The Code enunciates the basic principles governing our business activities and relationships. It is based on the laws, rules, and regulations that apply to our work. *The Code* identifies the basic principles that guide all of our activities: good judgment, personal honesty and sound business ethics.

XXIII. Confidentiality

All QI Program documents, including but not limited to, meeting minutes of the committees and results of the review of medical records and clinical studies are subject to WellCare Corporate's policies and procedures for handling confidential information.

XXIV. Approval

Approved by the Utilization Management Medical Advisory Committee on: March 12, 2015

Approved by the Quality Improvement Committee on: March 24, 2015

Approved by the Board of Directors on: TBD