CCME

2020 External Quality Review

WELLCARE OF SOUTH CAROLINA

Submitted: January 14, 2021

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the WellCare of South Carolina (WellCare) External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by WellCare since the 2019 Annual Review.

The goals of the review are to:

- Determine if WellCare is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations
- Evaluate the status of deficiencies identified during the 2019 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

The process CCME used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day virtual onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects, validation of performance measures, and validation of satisfaction surveys.

Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To access WellCare's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration:

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

WellCare's general approach to the development and disbursement of policies and procedures is evident. Lines of communication are organized to delineate the various paths of business operation within the Company. State required positions are clearly noted on the organizational chart. All WellCare employees and associates are required to report any suspected violation of the laws specific to confidentiality as required by federal or state health care program rules, the WellCare Code of Conduct, and other WellCare policies. The WellCare Corporate Compliance Program has been developed based on the regulations found in *42 CFR § 438*, and *42 CFR § 457* promotes ethical conduct in all aspects of Company operations and strives to ensure compliance with applicable federal and state laws, regulations, and standards. The Corporate Compliance Committee oversees the operations of WellCare's Compliance Program.

WellCare's Information System Capabilities Assessment (ISCA) documentation provides a good overview of systems, processes, and polices that are in place to service the SCDHHS MCO contract. Specifically, the policies and procedures aligned with *42 CFR § 438.242*, appear to be frequently reviewed and updated based upon each document's change log timestamps. WellCare put those policies and procedures to the test recently with both a third-party security audit and a successful Disaster Recovery (DR) test. Finally, it is commendable that WellCare conducts a full DR test that transfers services to a backup data center. Many organizations have desktop DR test exercises which tend to be less thorough.

Provider Services:

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

WellCare meets all requirements of *42 CFR § 438.214* for provider credentialing and recredentialing. Credentialing activities are conducted by WellCare corporate staff, and a corporate Medical Director approves clean provider files and reviews the files with the health plan during Credentialing Committee meetings. WellCare's Credentialing Committee serves as a peer-review committee, oversees credentialing and recredentialing activities, and includes providers with various specialties. The review of credentialing and recredentialing files for both independent and organizational providers confirmed the presence of all required documentation elements and evidence of appropriate queries and primary source verification of provider information. This was an improvement from the previous year's findings. Appropriate processes are in place to ensure ongoing, monthly monitoring of participating network providers.

Processes for monitoring network adequacy are documented in policy and, at least monthly, WellCare evaluates the geographic sufficiency of the network and addresses identified deficiencies as required by *42 CFR § 438.206*, *42 CFR § 438.207*, *42 CFR § 10(h)*.

WellCare ensures providers who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs are available as required by *42 CFR § 438.206(c)(2)*. A copy of WellCare's Cultural Competency Program and Plan 2020-2021 (CCP) is maintained on its website. The CCP is reviewed annually, presented to the Quality Improvement Committee (QIC), and an annual evaluation of the effectiveness of the CCP is conducted. WellCare tracks and trends any issues identified in the evaluation and implements interventions to improve the provision of services.

WellCare maintains a Provider Directory that includes all requirements outlined in the *SCDHHS Contract, Section 3.13.5* and *42 CFR § 10(h)*. Information in the web-based directory is updated from WellCare source files within 72 hours and the printed Provider Directory is revised annually.

WellCare monitors the timeliness of access to care within its provider networks via Appointment Accessibility and After-Hours telephone surveys. The 2019 Medicaid Quality Improvement Program Evaluation provides results of the Appointment Accessibility and After-Hours telephone surveys, specified which goals were met and unmet, and discussed actions taken after each round to improve findings, corrective action plans for non-compliant providers, and planned interventions for 2020.

WellCare offers training to all providers regarding the requirements of their contracts and the special needs of enrollees. All required topics are covered, including information about the grievance and appeal system, as required by *42 CFR § 438.414*. In addition to training provided by Provider Relations staff, the 2020 South Carolina Medicaid Provider Manual includes information providers will need to understand and comply with program

requirements. CCME noted discrepancies in member benefit information within the Provider Manual and when comparing the Provider Manual to the Member Handbook.

WellCare has adopted clinical practice guidelines for disease, chronic illness management, and behavioral health services for members that are consistent with national or professional standards and covered benefits, are periodically reviewed and updated, and are developed in conjunction with pertinent network specialists, as required by *42 CFR § 438.236*. WellCare staff confirmed it has now adopted Centene Corporation's clinical practice and preventive health guidelines. However, WellCare's website only displays the retired WellCare-branded guidelines.

Appropriate processes are in place to encourage and monitor continuity and coordination of care between primary care providers (PCPs) and other providers, as required by *42 CFR § 438.208*. WellCare monitors service delivery to identify and address barriers to primary and preventive care through various avenues, including Care Coordination, medical record review, etc.

WellCare conducts an annual review of contracted practitioner medical records using criteria based on contractual requirements. The annual medical record review identifies medical record documentation areas that need improvement, allows for feedback to the practitioner, and may identify areas of practice that require peer review. Despite a documented decrease in scores for the 2019 child medical records review, the 2019 Medicaid Quality Improvement Program Evaluation states, "The 2019 Medical Record Review Audit reveals improvement in Provider scores." This was confirmed to be an error during the onsite teleconference.

As part of the annual EQR process for WellCare, a Provider Access Study was performed focusing on PCPs. Calls were successfully answered 62% of the time (92 out of 148) when omitting calls answered by personal or general voicemail messaging services or call center services. When compared to last year's results of 80%, this year's study had a statistically significant decrease in successful calls at 62% (p=.0003).

Member Services:

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

WellCare has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New members receive a welcome packet that includes a Quick Start Guide with instructions for contacting Member Services, selecting a PCP, and initiating services. All members have access to information and resources in the Member Handbook, Provider Manual, on the website, and in member newsletters that can help them utilize

their benefits. The plan provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

Requirements and processes for handling member grievances and complaints are found in policies and information is provided in the Member Handbooks, Provider Manuals and the website. Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff. Grievance data is reported quarterly and ad hoc if needed to upper management and to the Utilization Management Advisory Committee.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continues to be conducted annually by a third-party vendor, SPH Analytics. The 2020 survey response rates continue to fall below the National Committee for Quality Assurance (NCQA) target response rate of 40%.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

For the Quality Improvement (QI) section, CCME reviewed the 2020 Medicaid Quality Improvement Program Description, committee structure and minutes, performance measures (PMs), performance improvement projects (PIPs), and the QI program evaluations. WellCare's 2020 Medicaid Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The 2020 Medicaid Quality Improvement Program Description is reviewed and updated at least annually.

WellCare's QI Work Plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. Some of the specific metrics in the 2020 work plan were incorrect.

The Quality Improvement Committee (QIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The 2020 Medicaid Quality Improvement Program Description, pages 24 and 25, clearly outlines the responsibilities of the QIC. The Utilization Management Advisory Committee (UMAC) oversees all clinical quality, Utilization Management (UM), and behavioral health activities. A review of the minutes showed both committees met at regular intervals and the required quorums were met for each meeting.

Annually WellCare assesses the overall effectiveness of the QI Program. WellCare provided the 2019 Medicaid Quality Improvement Program Evaluation. This evaluation addressed all aspects of the QI Program. WellCare met all the requirements included in *CFR §438.330 (a), (b) and 457.1240 (b)*.

Performance Measure Validation

WellCare uses a NCQA-certified software organization for calculation of Healthcare Effectiveness Data and Information Set (HEDIS) rates, and the validation found all requirements were met. For several hybrid measures, WellCare chose to report the measure year 2018 rate instead of the rate for measure year 2019, a substitution that is allowed by NCQA. Of the rates reported, the comparison from the previous year to the current year revealed a substantial increase (>10%) in Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Total, and Prenatal and Postpartum Care: Postpartum Care. There were several measures that showed a decline of greater than 10%. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial changes in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Statin Adherence 80% - 40-75 years (Female)	34.34%	44.55%	10.21%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	30.38%	46.01%	15.63%
Prenatal and Postpartum Care (ppc)			
Postpartum Care	61.05%	74.94%	13.89%
Substantial Decrease in Rate (>10% decrease)			
Adult BMI Assessment (aba)	89.37%	77.91%	-11.46%
Medication Management for People With Asthma (mma)			
19-50 Years - Medication Compliance 50%	55.56%	45.54%	-10.02%
Asthma Medication Ratio (amr)			
12-18 years	70.17%	56.93%	-13.24%
19-50 years	56.94%	39.73%	-17.21%
51-64 years	56.36%	38.78%	-17.58%
Total	70.33%	59.49%	-10.84%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	45.65%	31.19%	-14.46%
Total	49.30%	36.36%	-12.94%

CCME recommends WellCare evaluate interim trends in rates that show a substantial decrease to determine if this is a trend or anomaly and assess barriers to improving HEDIS rates that have declined.

The performance measure validation found that WellCare was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

Quality Withhold Measures

WellCare reported 16 Quality Clinical Withhold Measures for 2019. The 2019 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Diabetes rates generated the highest index score followed by Women's Health, and Pediatric Preventive Care.

Table 2: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	88.77	75	5	4.15
HbA1c Control (< =9)	41.85	50	4	
Eye Exam (Retinal) Performed	52.62	25	3	
Medical Attention for Nephropathy	91.23	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	93.19	90	6	4.10
Breast Cancer Screen	57.04	25	3	
Cervical Cancer Screen	57.42	25	3	
Chlamydia Screen in Women (Total)	63.46	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	63.3	25	3	3.10
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.63	25	3	
Adolescent Well-Care Visits	51.95	25	3	
Weight Assessment/Adolescents: BMI % Total	82.48	50	4	

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	38.18	10	2	2.50
Antidepressant Medication Management Effective Continuation Phase Treatment	27.58	10	2	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	36.36	<10	1	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	32.12	25	3	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	35.14	50	4	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	38.93	25	3	

Performance Improvement Project Validation

WellCare submitted two projects for validation – Improving Dilated Retinal Exam (DRE) Screening and Access to Care. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

TABLE 3: Performance Improvement Project Validation Scores

Project	2019 Validation Score	2020 Validation Score
Improving Dilated Retinal Exam (DRE) Screening	91/91=100% High Confidence in Reported Results	73/73=100% High Confidence in Reported Results
Access to Care	91/91=100% High Confidence in Reported Results	80/80= 100% High Confidence in Reported Results

For rate for the Access to Care performance improvement project (PIP) showed a slight increase. Member incentives and outreach and provider education continue to have a slight impact on improving primary care visits. These interventions will continue.

The rate for the Improving DRE Screening PIP was noted as unchanged from CY2018 to CY2019. According to WellCare, the project uses administrative rates, and the 2018 rate was reported for 2019 as allowed by NCQA. WellCare will continue the following in 2021: Member Outreach to remind members of the importance of needed DRE Screening; Utilize In-Home Assessments for DRE Screening when available; Continue support of Vision

Vendors efforts with Member automated calls and provider outreach to include efforts for DRE CPT II coding; and reward members and providers (Healthy Rewards/P4Q Program) when DRE's are completed. Progress will be monitored by the HEDIS® Comprehensive Diabetes Care (sub-measure Dilated Retinal Exams) rates obtained through the Annual Audit Review Table (ART).

Both PIPs received a score within the High Confidence Range and met the validation requirements per *42 CFR §438.330 (d) and §457.1240 (b)*.

Utilization Management:

42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

The Utilization Management (UM) Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Policies and procedures define how services are implemented and provided to members.

Appropriate reviewers conduct Service Authorization Requests using internal clinical guidelines and other established criteria. The interrater reliability (IRR) benchmark goal was incorrectly documented in the 2020 Utilization Management Program Description, 2020 Medicaid Quality Improvement Program Description, and the 2019 Quality Improvement Program Evaluation, indicating 85% instead of 90%.

WellCare has established policies defining processes for handling appeals of adverse benefit determinations. However, documentation issues were noted with pharmacy denial and appeal letter templates.

The Care Management (CM) Program Description and policies appropriately document care management processes and services provided.

Overall, the review of Utilization Management service authorization requests, appeal, and denial files provided evidence that appropriate processes are followed. Case Management files indicate care gaps are identified and addressed consistently and services are provided for various risk levels.

Delegation:

42 CFR § 438.230 and 42 CFR § 457.1233(b)

WellCare delegates several functions to other entities. For this EQR, WellCare delegates the several services through 32 delegate agreements. Policies outline the process followed for pre-delegation, annual oversight, and ongoing monitoring of delegated functions. WellCare submitted the pre-delegation monitoring and annual delegation

monitoring for most of delegates. There were several delegates where the annual monitoring was underway. WellCare indicated they expected to have the monitoring completed by December 31, 2020.

During the previous EQR, the audit tools used for oversight monitoring neither address the query of the SCDHHS List of Providers Terminated for Cause nor the Collaborative Agreement/Written Protocol for Nurse Practitioners. WellCare addressed these issues and both elements were added to the auditing tools. However, the monitoring tools used for four of the delegates either not included the query of the SCDHHS List of Providers Terminated for Cause on the audit tools or was inappropriately marked as not applicable.

State Mandated Services:

42 CFR § Part 441, Subpart B

WellCare's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program follows the Bright Futures Periodicity Schedule for required screenings and health treatments. WellCare monitors provider compliance with provision of EPSDT services and required immunizations through HEDIS requirements and medical record reviews conducted by the Quality Department. The 2019 Medicaid Quality Improvement Program Evaluation identified EPSDT performance measures below established benchmarks.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were 12 standards scored as "Partially Met" and four standards scored as "Not Met". Following the 2019 EQR, WellCare submitted a Quality Improvement Plan to address any deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on March 23, 2020. The following is a high-level summary of those deficiencies:

- Credentialing and Recredentialing policies and procedures did not adequately address how WellCare performs federal and state database checks for persons identified on the Ownership Disclosure forms with an ownership or controlling interest.
- Credentialing and recredentialing files did not include all required elements and evidence of required queries.
- Policies describing processes for written member materials did not address the requirement to use a 12-point font size for regular print and 18-point font size for large print.
- Pharmacy appeal policies contained errors and omitted several requirements for member appeals.

- Documentation issues regarding timeliness guidelines for service authorization and appeal processes were noted in the Provider Manual, Member Handbook, letter templates and WellCare's website.
- Review of appeals files reflect issues with acknowledgement and resolution timeframes, not notifying member of the appeal downgrade from expedited to standard, and incorrect appeal determination.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plan was implemented and the deficiencies corrected.

Table 4, Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2019 review. 208 out of 214 standards received a score of "Met". There were five standards scored as "Partially Met" and one standard related to the Telephone Provider Access Study that received a "Not Met" score.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2019	40	0	0	0	0	40	100%
2020	40	0	0	0	0	40	100%
Provider Services							
2019	73	2	3	0	0	78	94%
2020	72	3	1	0	0	76	95%
Member Services							
2019	29	4	0	0	0	33	88%
2020	33	0	0	0	0	33	100%
Quality Improvement							
2019	14	0	0	0	0	14	100%
2020	14	0	0	0	0	14	100%
Utilization							
2019	40	5	0	0	0	45	89%
2020	44	1	0	0	0	45	98%
Delegation							
2019	1	1	0	0	0	2	50%
2020	1	1	0	0	0	2	50%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
State Mandated Services							
2019	3	0	1	0	0	4	75%
2020	4	0	0	0	0	4	100%
Totals							
2019	**200**	**12**	**4**	**0**	**0**	**216**	**93%**
2020	**208**	**5**	**1**	**0**	**0**	**214**	**97%**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Last year, CCME also recommended WellCare move the HEDIS goal rate to the 50th percentile for HEDIS measures that have met the 25th percentile over the three-year trend and focus future PIP topic selections on reducing admissions, readmissions and ER visits for CHF and COPD. WellCare provided this response:

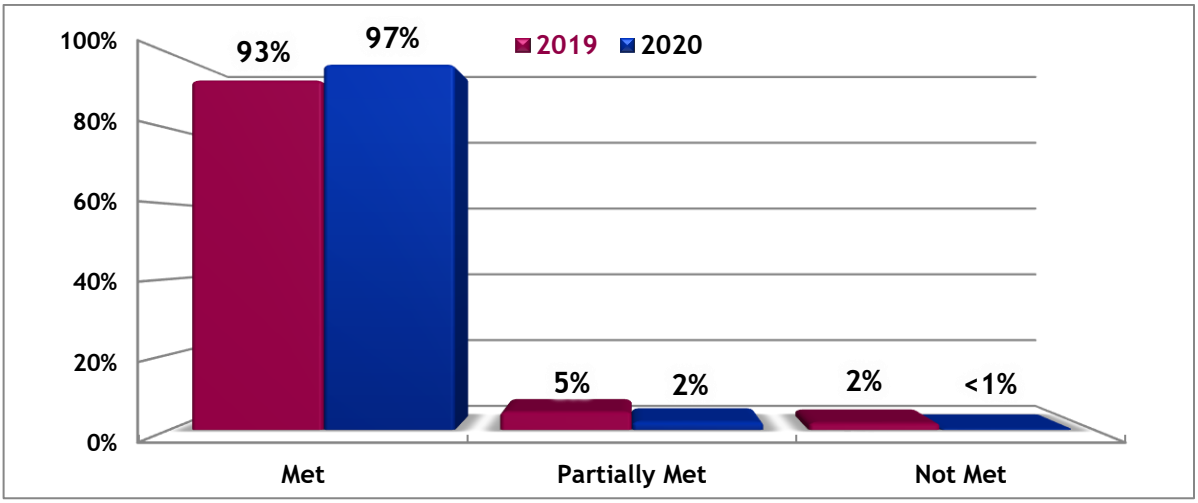
- A three-year trend of HEDIS rates found many of the rates had met or exceeded the 25th percentile goal set by WellCare. It was recommended that the goal rate be moved to the 50th percentile for those HEDIS measures that have met the 25th percentile for several years. The 2019 Annual Evaluation and the 2020 QI Work Plan reflected an increase of the goal rates regarding some of the HEDIS measures.
- Focus future PIP topic selections on reducing admissions, readmissions and emergency room (ER) visits for congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). WellCare's indicated the QI Team reviewed several forms of data to include Quality Management reports to assess the recommendation for a PIP focus on reducing admission, readmissions, and ER visits for CHF, COPD, diabetes, and hypertension. Although, there were some increased rates of non-compliance noted in the HEDIS data and some increased variances noted in disease management, other data sources did not show prevalence or increases. Based on the data, WellCare will continue to monitor all chronic disease states to include the following:
  - Ensure members are discharged with a safe discharge plan and/or case management follow-up reducing readmissions.
  - Bi-weekly outlier rounds to discuss members with complex discharges and come up with a member specific safe discharge plan.
  - Collaborative discharge planning with every Utilization Management review to ensure that any expected discharge needs are addressed.
  - Access data for the top readmit facilities and diagnosis and develop actions such as referring members in high readmit facilities and those with a high readmit diagnosis to case management.

- Refer members that are at high risk for readmission such as noncompliance and chronic illness to case management for early intervention.
- Refer readmission to the QI Department for potential quality of care and unavoidable readmission.
- Monitor HEDIS rates for areas of noncompliance to include interventions to improve compliance.
- Distribute provider gaps in care reports to encourage office visits.
- Focused member outreach on increasing compliance and awareness of benefits.

Conclusions

Overall, WellCare met the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. The 2020 Annual EQR shows that WellCare has achieved a "Met" score in 97% of the standards reviewed. As the following chart indicates, 2% of the standards were scored as "Partially Met," and <1% of the standards scored as "Not Met". The chart that follows provides a comparison of the current review results to the 2019 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

- WellCare's ISCA documentation provides a good overview of systems, processes, and polices that are in place to service the SCDHHS MCO contract. Specifically, the policies and procedures aligned with *42 CFR § 438.242*.

- WellCare conducts a full Disaster Recovery test that transfers services to a backup data center. Many organizations reviews are conducted via desktop exercises which tend to be less thorough.
- The WellCare website does not provide reporting options for Fraud Waste and Abuse (FWA) in a clearly visible way.
- Appropriate processes are in place for provider credentialing and recredentialing and WellCare met all requirements of *42 CFR § 438.214*. A review of credentialing and recredentialing files revealed a noted improvement over the previous year's findings, with all files containing all required elements and evidence of required primary source verification and queries.
- WellCare maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements and with *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230*.
- The Telephonic Provider Access Study conducted by CCME shows a statistically significant decrease in successful calls from the previous study's results.
- WellCare maintains a copy of its Cultural Competency Program and Plan (CCP) on its website and directs all network providers to review the document. Thorough information about the CCP is included in the Provider Manual; however, the manual directs the reader to a Cultural Competency Survey on WellCare's website without providing any information about the survey. CCME could not locate the survey on the website.
- Appropriate processes are in place and followed for initial and ongoing provider education. In response to restrictions from Covid-19, WellCare has adjusted its processes for provider education. A few discrepancies in member benefit information were noted within the Provider Manual and when comparing the Provider Manual to the Member Handbook.
- WellCare has adopted the Centene preventive health and clinical practice guidelines, but its website displays retired WellCare guidelines.
- Processes to ensure continuity and coordination of care between PCPs and other providers are adequate.
- An annual medical record review audit is conducted to ensure acceptable documentation in the member medical records maintained by primary care physicians.
- The performance measure validation found that WellCare was fully compliant.
- The HEDIS rates that showed a substantial increase included: Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Total, and Prenatal and Postpartum Care: Postpartum Care.

- All the performance improvement projects received validation scores in the "High Confidence Range".
- The Member materials such as resolution notices are written in a language that is easily understood.
- The file review for member grievances and appeals revealed timely acknowledgements, appropriate staff conducted the review, and resolutions were timely.
- WellCare improved documentation of the pharmacy appeal process by incorporating the process into the Member appeal policy (SC22-HS-AP-002, Member Appeals Policy).

Recommendations and Opportunities for Improvements

Areas needing corrections and recommendations include:

- The Fraud Waste and Abuse reporting options that are very well documented in the Provider Handbook, should also be provided in a clear and easily accessible way on WellCare's website.
- Revise the Provider Manual to include additional information about the Cultural Competency Survey and ensure the survey is available on the website.
- Explore new procedures or processes to update provider file information. Consider including a variable that specifies the primary location of the providers in the provider file that is uploaded to CCME for the access study.
- Revise the Provider Manual and Member Handbook to include correct, consistent information about member benefits.
- Update the website to include the preventive health and clinical practice guidelines that have been adopted and are currently in use.
- Update the Member Handbook and Provider Manual to include all services that can be obtained without a referral.
- Provide additional instructions that specify all information required for filing a written grievance.
- The results of the Adult and Child CAHPS Surveys showed a decrease in the response rate from 2019. WellCare should continue working with the survey vendor regarding methods to improve the member satisfaction response rates.
- Evaluate interim trends in performance measure rates that show a substantial decrease to determine if this is a trend or anomaly in rate decline. Assess barriers to improving HEDIS rates that have declined.
- Update the interrater reliability goal noted in program descriptions.

- Include a definition or description for the term Authorized Representative in the Member Handbook and on the website.
- Include the complete definition of the term Adverse Benefit Determination in the Definitions and Abbreviations section of the Provider Manual.
- Correct the timeframes allowed for a member to request an appeal and submit written confirmation in the pharmacy denial letter templates.
- WellCare listed CVS as a delegate for several functions including credentialing. However, the annual monitoring did not include a file review.
- Conduct a file review for all delegates responsible for credentialing and recredentialing.
- Update all auditing audit tools used for the monitoring of the credentialing and recredentialing files to include checking the SCDHHS List of Providers Terminated for Cause. Provide additional training for delegation auditors regarding the requirements for checking the SCDHHS List of Providers Terminated for Cause.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On October 19, 2020, CCME sent notification to WellCare that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow WellCare to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from WellCare on November 2, 2020 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on December 16th and 17th. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with WellCare administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between WellCare and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

WellCare's general approach to the development and disbursement of policies and procedures is evident. An internal 360 email system is used to identify policy review and approval due dates on a monthly basis for management. Lines of communication are

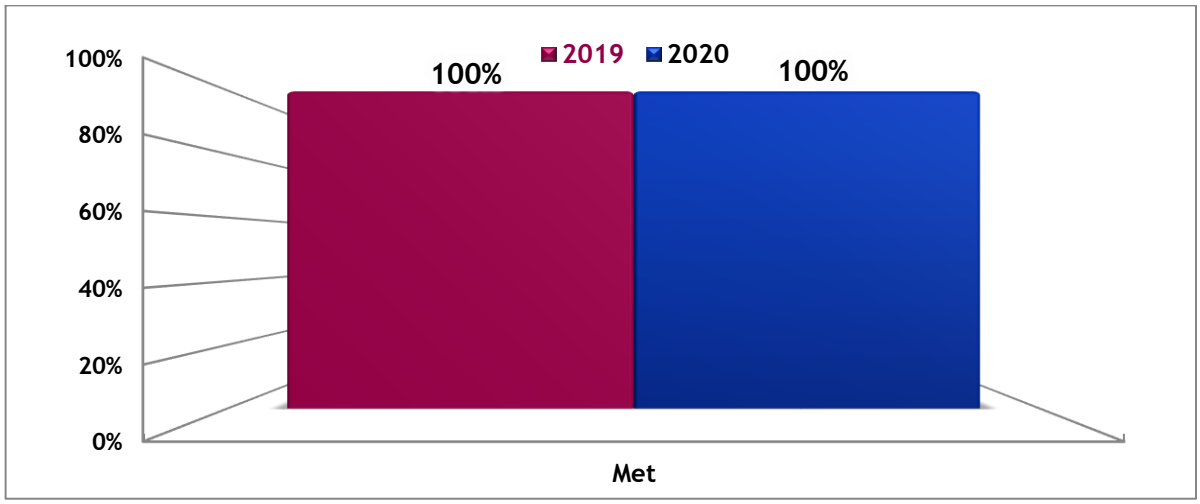
organized to delineate the various paths of business operation within the Company. State required positions are clearly noted on the organizational chart.

WellCare's ISCA documentation provides a good overview of systems, processes, and polices that are in place to service the SCDHHS MCO contract. Specifically, the policies and procedures aligned with *42 CFR § 438.242*, appear to be frequently reviewed and updated based upon each document's change log timestamps. The organization put those policies and procedures to the test recently with both a third-party security audit and a successful disaster recovery test. Finally, it is commendable that WellCare conducts a full Disaster Recovery (DR) test that transfers services to a backup data center. Many organizations reviews are conducted via desktop DR test exercises which tend to be less thorough.

The WellCare Corporate Compliance Program in compliance with *42 CFR 438.608(a)* promotes ethical conduct in all aspects of Company operations and strives to ensure compliance with applicable state and federal laws, regulations, and standards. The Corporate Compliance Committee as required by *42 CFR § 438.608(a)(1)(ii)*, oversees the operations of WellCare's Compliance Program. The Market Compliance Oversight Committee Charter indicates that the Committee meets no less than once per calendar quarter. Training specific to compliance and confidentiality is provided upon new-hire training and is required for renewal annually.

WellCare continues to meet all the requirements in the Administration section.

Figure 2: Administration Findings



Strengths

- State-specific position requirements are clearly denoted on the organizational chart.

- WellCare's ISCA documentation provides a good overview of systems, processes, and polices that are in place to service the SCDHHS MCO contract. Specifically, the policies and procedures aligned with *42 CFR § 438.242*.
- An IT security audit was recently performed with no notable exceptions found.
- WellCare conducts a full Disaster Recovery test that transfers services to a backup data center. Many organizations reviews are conducted via desktop exercises which tend to be less thorough.
- A disaster recovery testing that transfers IT operations to a backup site is used instead of a desktop recovery exercise.

Weaknesses

- The WellCare website does not provide reporting options for Fraud Waste and Abuse (FWA) in a clearly visible way.

Recommendations

- The Fraud Waste and Abuse reporting options that are very well documented in the Provider Handbook should also be provided in a clear and easily accessible way on WellCare's website, such as the homepage for use by all network stakeholders to strengthen the visibility of reporting.

B. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

The review of Provider Services encompasses credentialing and recredentialing processes and functions, adequacy of the provider network, initial and ongoing provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical records.

Provider Credentialing and Selection

WellCare meets all requirements of *42 CFR § 438.214* and *42 CFR § 457.1233(a)* for provider credentialing and recredentialing. Processes for credentialing and recredentialing practitioners and organizational providers are documented in the WellCare Health Plans, Inc. 2020 Credentialing Program Description and in related policies. Credentialing activities are conducted by WellCare corporate staff. A corporate Medical Director approves clean provider files, and the files are reviewed with the health plan during Credentialing Committee meetings. The Credentialing Committee is the principal clinical peer committee that oversees credentialing and recredentialing activities, discusses providers with potential quality of care or conduct issues, and

determines whether providers are meeting reasonable standards of care. WellCare's Credentialing Committee membership includes providers with specialties of cardiology, pediatrics, and family practice. Membership also includes a Licensed Clinical Social Worker. CCME's review of Credentialing Committee activities confirms meetings are held at least monthly, but the committee quorum was not identified in submitted documentation. Onsite discussion confirmed the quorum is 50% of voting members. The minutes confirmed the presence of a quorum for each meeting reviewed.

The review of credentialing and recredentialing files for both independent and organizational providers revealed an improvement from the previous year's findings. The files reviewed for the current EQR included all required documentation elements and evidence of appropriate queries and primary source verification of provider information. In addition, WellCare has appropriate processes in place to ensure ongoing, monthly monitoring of participating network providers, including a review of the:

- National Plan and Provider Enumeration System
- Social Security Administration's Death Master File
- Medicaid Sanction Exclusions and Reinstatement reports
- Office of Inspector General List of Excluded Individuals and Entities
- System for Award Management
- Medicare Opt-Out listings
- CMS Preclusion List
- South Carolina Excluded Provider List
- South Carolina Exclusion and Termination for Cause Listing
- Professional licensing sanctions

Availability of Services

Processes for monitoring network adequacy are documented in policy and, at least monthly, WellCare evaluates the geographic sufficiency of the network and takes action as appropriate to address any identified deficiencies, as required by *42 CFR § 438.206*, *42 CFR § 438.207*, *42 CFR § 10(h)*, *42 CFR § 457.1230(a) and 42 CFR § 457.1230(b)*. Provider Network Reports are submitted to SCDHHS at least biannually.

WellCare ensures providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs, as required by *42 CFR § 438.206(c)(2)* and *42 CFR § 457.1230(a)* and *(b)*. WellCare maintains a copy of its Cultural Competency Program and Plan (CCP) on its website and directs network providers to review the document. The CCP is reviewed annually and presented to the Quality Improvement Committee to ensure compliance with the program objectives. An annual evaluation of the effectiveness of the CCP is conducted and may include results from the Consumer Assessment of Health Plans and Systems (CAHPS) surveys and other comparative member satisfaction surveys, outcomes for cultural groups, member grievances and appeals, provider feedback, and WellCare staff surveys. WellCare tracks and trends any issues identified in the evaluation and implements interventions to improve the provision of services. The 2020 South Carolina Medicaid Provider Manual provides an overview of the Cultural Competency Program; however, page 35 includes a statement that providers may access the Cultural Competency Survey on WellCare's website but includes no other information about this survey. CCME could not locate the survey on the website.

WellCare maintains a Provider Directory that includes all requirements outlined in the *SCDHHS Contract, Section 3.13.5* and *42 CFR § 10(h)*. Information in the web-based directory is updated from WellCare source files within 72 hours and the print Provider Directory is revised annually.

Provider appointment scheduling and wait times are defined in WellCare's Provider Appointment Accessibility and After-Hours Coverage policy (SC22-OP-NI-002). Standards documented in the policy are consistent with contractual requirements. WellCare monitors the timeliness of access to care within its provider networks via Appointment Accessibility and After-Hours telephone surveys. All network providers are required to offer hours of operation that are no less than the hours of operation offered to Commercial and Fee-for-Service patients. PCPs are required to arrange for after-hour coverage. The 2019 Medicaid Quality Improvement Program Evaluation provides results of the Appointment Accessibility and After-Hours telephone surveys from October 2019 (round 1) and December 2019 (round 2). The evaluation specified which goals were met and unmet, and discussed actions taken after each round to improve findings, corrective action plans for non-compliant providers, and planned interventions for 2020.

Initial and ongoing provider education is the responsibility of Provider Relations staff. WellCare offers training to all providers regarding the requirements of their contracts and the special needs of enrollees—initial training is conducted within 30 calendar days of placing a newly contracted provider, or provider group, on active status, and ongoing training is conducted as necessary to ensure compliance with program standards and other contractual obligations. Provider trainings are provided via provider orientation, newsletters, emails, faxes, letters, on-site training, etc. All required topics are covered,

including information about the grievance and appeal system, as required by *42 CFR § 438.414* and *42 CFR § 457.1260*. In addition to training provided by Provider Relations staff, the Provider Manual includes information providers will need to understand and comply with program requirements. CCME noted discrepancies in member benefit information within the Provider Manual and when comparing the Provider Manual to the Member Handbook. These discrepancies require correction by the health plan.

In compliance with requirements of *42 CFR § 438.236* and *42 CFR § 457.1233(a),* WellCare adopts practice guidelines that are evidence-based, consider the needs of the health plan's membership, are adopted in consultation with network providers, and are routinely reviewed and updated as needed. WellCare disseminates the guidelines to providers and others via its website and in hard copy upon request. CCME discussed the guidelines with WellCare staff during the onsite teleconference, and WellCare confirmed it has retired its previously adopted clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) and has now adopted Centene's CPGs and PHGs. A review of WellCare's website, however, revealed the retired, WellCare-branded CPGs and PHGs are still displayed and not the currently adopted, Centene CPGs and PHGs. The website must be updated to display the currently adopted guidelines.

Appropriate processes are in place to encourage and monitor continuity and coordination of care between PCPs and other providers, as required by *42 CFR § 438.208* and *42 CFR § 457.1230(c)*. WellCare monitors service delivery to identify and address barriers to primary and preventive care through various avenues, including Care Coordination, medical record review, etc.

WellCare conducts an annual review of contracted practitioner medical records using criteria based on contractual requirements. The annual medical record review identifies medical record documentation areas that need improvement, allows for feedback to the practitioner, and may identify areas of practice that require peer review. Quality Improvement staff or a vendor conduct the review. A random sample of 200 records used in the most recent hybrid HEDIS season is selected for review and results are scored for each provider reviewed. Half of the records are for adult members and half are for pediatric members. Despite a documented decrease in scores for the 2019 child medical records review, pages 89 and 90 of the 2019 Medicaid Quality Improvement Program Evaluation state, "The 2019 Medical Record Review Audit reveals improvement in Provider scores." This was discussed during the onsite teleconference. WellCare responded it was an oversight and will be corrected.

Provider Access and Availability Study

42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

As part of the annual EQR process for WellCare, a Provider Access Study was performed focusing on PCPs. From a list of current providers given to CCME by WellCare, a population of 2,461 unique PCPs was found. A sample of 180 providers was randomly selected from this population for the Access Study. Attempts were made to contact the sample of providers to ask a series of questions regarding access members have with the providers.

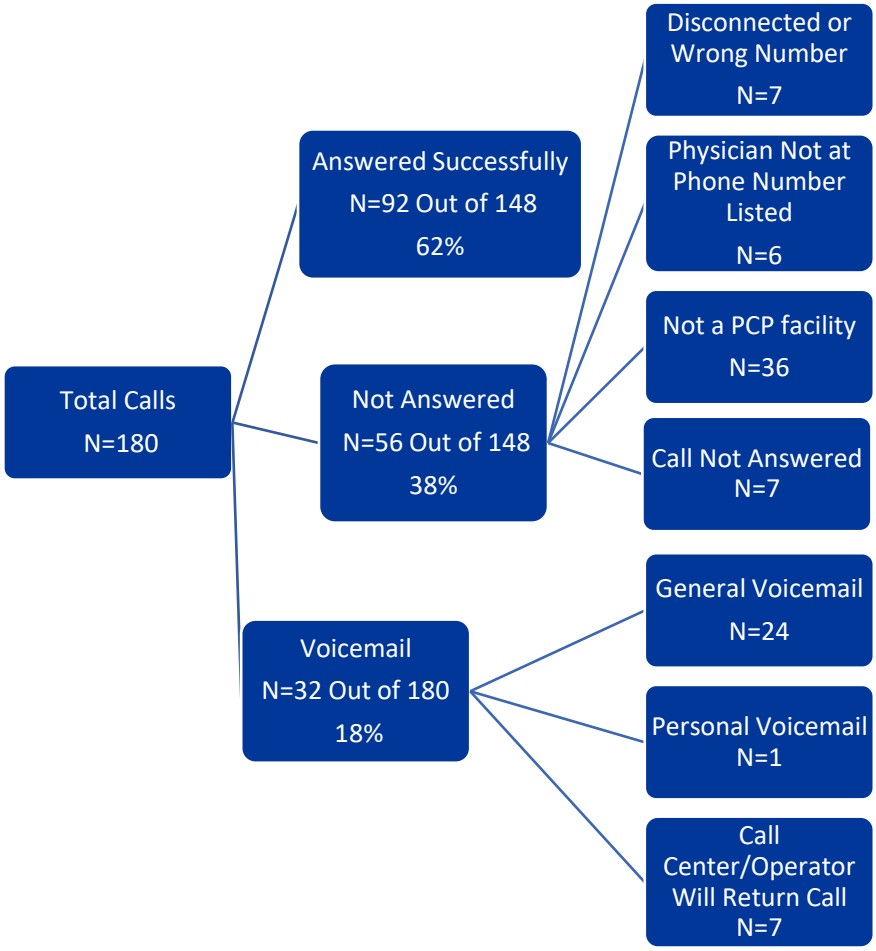
Calls were successfully answered 62% of the time (92 out of 148) when omitting calls answered by personal or general voicemail messaging services or call center services (see *Figure 3* below). When compared to last year's results of 80%, this year's study had a statistically significant decrease in successful calls at 62% (p=.0003).

Table 5: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2019 Review	240	80%	.0003
2020 Review	180	62%	

Figure 3: Telephonic Provider Access Study Results provides an overview of the results of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results

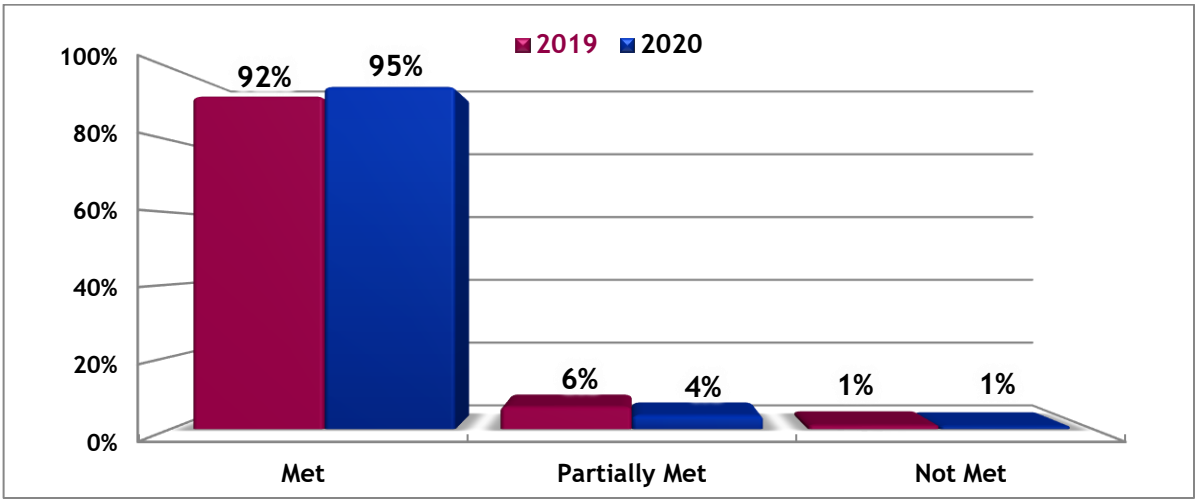


For those not answered successfully (n=56 calls), 36 (64%) were unsuccessful because the location called did not provide primary care services, such as a hospital, residency program, or urgent care facility.

Of the 92 providers that were successfully contacted, only 60 responded to the question about accepting WellCare, and of those 60, only 56 (93%) indicated they do accept WellCare. Of the 56 accepting WellCare, 38 (68%) were accepting new patients. Of the 38 accepting new patients, only 13 (34%) require a prescreen. For the 13 that require a prescreen, 11 (85%) require both a medical record review and application, one (8%) required a medical record review only, and one (8%) required an application only.

WellCare achieved "Met" scores for 95% of the Provider Services standards, as illustrated in *Figure 4: Provider Services Findings*.

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 6: Provider Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Met
	Initial Credentialing: Verification of information on the applicant, including: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Not Met	Met
	Initial Credentialing: Verification of information on the applicant, including: Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Partially Met	Met
	Recredentialing: Verification of information on the applicant, including: Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Not Met	Met

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Credentialing and Recredentialing	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Not Met	Met
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met
Provider Education	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met
Primary and Secondary Preventive Health Guidelines	The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Partially Met
Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services	The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Credentialing and recredentialing files included all required elements and documentation of required primary source verification and queries. This is a noted improvement over the file review findings for the previous EQR.

Weaknesses

- CCME could not identify the quorum for the Credentialing Committee in the materials reviewed. Onsite discussion confirmed the quorum is 50% of voting members.

- Page 35 of the 2020 South Carolina Medicaid Provider Manual includes a Cultural Competency Survey heading with the following statement: "Providers may access the Cultural Competency Survey on WellCare's website at www.wellcare.com/South-Carolina/providers/Medicaid." However, there is no other information about this survey, and CCME could not locate the survey on WellCare's website. Note: the draft Provider Manual, page 36, includes the same information.
- The Telephonic Provider Access Study conducted by CCME showed a statistically significant decline in success rate for calls made.
- Discrepancies were noted when comparing member benefits listed in the Provider Manual and the Member Handbook:
  - The 2020 Provider Manual (pages 10 and 11) includes "Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling)" along with "Panniculectomy" (when specific criteria are met) in the member benefits grid, but page 16 of the Provider Manual states these are excluded from the member benefits. Onsite discussion confirmed these procedures are covered when medically necessary. Also, these procedures are not included as covered benefits in the Member Handbook.
  - For Maternity Services, the Member Handbook, page 27 includes "Postpartum services (one home visit within 6 weeks of delivery)" but this is not included in the Provider Manual, page 12.
  - Page 12 of the Provider Manual states, "Optometrist services (for Members under age 21)" but that age limit is not specified on page 27 of the Member Handbook.
- The Provider Manual, page 45, states, "Clinical Practice Guidelines, including preventive health guidelines, are on WellCare's website…" However, this link takes the user to WellCare-branded guidelines that have been retired. The currently adopted Centene guidelines are not found on the website.
- Despite a documented decrease in scores for the 2019 child medical records review, pages 89 and 90 of the 2019 Medicaid Quality Improvement Program Evaluation state, "The 2019 Medical Record Review Audit reveals improvement in Provider scores."

Quality Improvement Plans

- Explore new procedures or processes to update provider file information. Consider including a variable that specifies the primary location of the providers in the provider file that is uploaded to CCME for the access study.
- Revise page 16 of the 2020 Provider Manual to remove the erroneous statement that gastric bypass surgery/vertical-banded gastroplasty and panniculectomy are excluded from benefit coverage. Also, include information about these procedures in the benefits grid in the Member Handbook. Update the Provider Manual to include full

information about Maternity Services benefits, as documented in the Member Handbook (page 27). Ensure the age limit for optometrist services listed on page 12 of the Provider Manual is also documented on page 27 of the Member Handbook.

- Update the WellCare website to include the Centene clinical and preventive practice guidelines that have been adopted and are currently in use.

Recommendations

- Ensure the Credentialing Committee quorum is documented in appropriate policies and/or the WellCare Health Plans, Inc. 2020 Credentialing Program Description.
- Revise the Provider Manual to include additional information about the Cultural Competency Survey, such as the purpose of the survey, who should take the survey, when and how often it should be taken, etc. Ensure the survey is located on the WellCare website as stated in the Provider Manual.
- Ensure correct information about the results of the 2019 Medical Record Review Audit are include in the 2019 Medicaid Quality Improvement Program Evaluation.

C. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

WellCare's Member Services review focused on areas such as, but not limited to: Member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures and files. WellCare has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities.

The Member Handbook provides useful information, is easily understood, and written at a sixth-grade reading level. It is available in Spanish and alternate formats including large font, audio, and Braille. The Member Handbook informs members of their rights and responsibilities, preventive health guidelines, appointment guidelines, and instructs members on how to access benefits. CCME identified that Policy SC22-OP-CS-012, Medicaid Referral and Authorization Guidelines, describes that communicable disease services, vision care services, and dental services can be obtained without a referral, however, this is not communicated in the Member Handbook or Provider Manual.

The BeWell member newsletters and health and wellness topics are accessible from the website. WellCare ensures member program materials are written in a clear and understandable manner and meet contractual requirements. Members receive the Quick Start Guide with instructions for accessing the Member Handbook and Provider Directory online.

Member Services staff are available per contract requirements via a toll-free number. The toll-free Member Services telephone number routes calls to an Interactive Voice Response menu that allow callers to reach staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Standard Time, Monday through Friday. The Nurse Call Line is available 24 hours a day.

WellCare contracts with SPH Analytics, a certified CAHPS Survey vendor to conduct both the Child and Adult Surveys. Survey results were presented to the Quality Improvement Committees and to providers. The number of completed surveys did not meet the NCQA requirement for the Adult Survey or the Child and Children with Chronic Conditions Surveys. The Child CAHPS Survey response rate was 12%; the Adult CAHPS Survey response rate was 15.8%; and the Children with Chronic Conditions CAHPS Survey response rate was 12.5%. All response rates decreased from 2019 and may impact the generalizability of the results. CCME recommends continue working with vendors to increase responses, since they are less than the NCQA target response rate of 40%.

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Requirements and processes for handling member grievances and complaints are found in policies and information is provided in the Member Handbooks, Provider Manuals and the website. Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff.

Policy SC22-OP-GR-001, Medicaid Grievance Policy, indicates grievances are reported monthly, quarterly, and annually to the upper management team. During the onsite teleconference, grievance staff explained grievance data is reported quarterly and ad hoc if needed. Review of the Utilization Management Advisory Committee (UMAC) meeting minutes and presentation slides reflect grievance data is presented and discussed.

Overall, review of Member Services reflects that WellCare ensures member rights, provides member education and information in various formats, implements a grievance system and operates a call center, according to requirements in the SCDHHS Contract and in the federal regulations.

As noted in *Figure 5: Member Services Findings*, WellCare achieved “Met” scores for 100% of the Member Services standards.

Figure 5: Member Services Findings

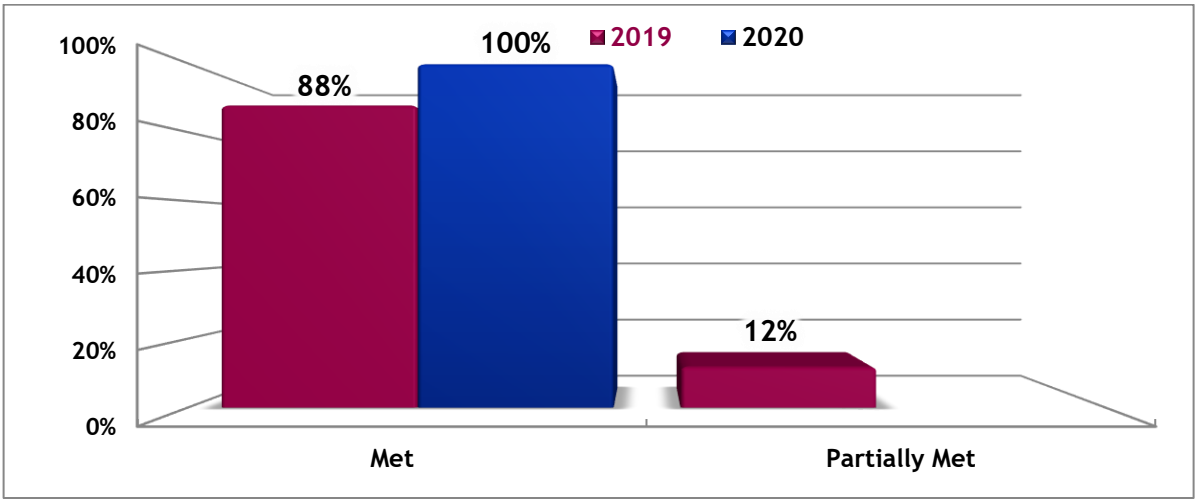


Table 7: Member Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Member MCO Program Education	Member program education materials are written in a clear and understandable manner and meet contractual requirements	Partially Met	Met
Grievances	Timeliness guidelines for resolution of a grievance	Partially Met	Met
	The MCO applies grievance policies and procedures as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- The Member Handbook lists specific examples of issues that might involve a grievance.

Weaknesses

- The following services that members can self-refer are listed in Policy SC22-OP-CS-012, Medicaid Referral and Authorization Guidelines, however they are not communicated in the Member Handbook or Provider Manual: Communicable Disease Services, Vision Care Services, and Dental Services.
- Response rates for the Child and Adult Surveys decreased.

Recommendations

- Update the Member Handbook and Provider Manual to reflect that Communicable Disease Services, Vision Care Services, and Dental Services can be obtained without a referral.
- Continue working with the survey vendor for methods to improve response rates.

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

For the QI section, CCME reviewed the 2020 Medicaid Quality Improvement Program Description, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations. WellCare's 2020 Medicaid Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.

WellCare's QI Work Plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 Work Plans included the planned activities, specific metrics, target dates for completions, responsible parties, and the goals. Some of the specific metrics in the 2020 Work Plan were incorrect. The turn-around time for measuring the resolution of a retrospective appeal request was listed on the work plan as 60 days. Policy SC22-HS-AP 002, Member Appeal Policy and policy SC22-HS-AP001, Provider Appeal Process notes the turn-around time as 30 calendar days. The goal listed for interrater reliability was 85%. However, the goal noted in procedure SC22-HS-UM-007-PR001, Interrater Reliability Procedure lists the goals as 90%. During the previous EQR, several errors were noted in the Work Plans. WellCare indicated the QI Team has been more diligent in addressing QI Work Plan deficiencies, errors, and incomplete data. The QI Director, Project Manager and Sr. QI Specialists carefully reviews the Work Plan for deficits and pursues obtaining data and making necessary corrections to reflect a complete QI Work Plan.

The Quality Improvement Committee (QIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The 2020 Medicaid Quality Improvement Program Description, page 24 and 25, clearly outlines the responsibilities of the QIC. The Utilization Management Advisory Committee oversees all clinical quality, Utilization Management, and behavioral health activities. A review of the minutes shows both committees met at regular intervals and the required quorums were met for each meeting. Last year the attendance for some of the network providers on the Utilization Management Advisory Committee was poor. WellCare's QI Department monitors provider attendance and the Chief Medical Officer addresses providers that are

deficit in attendance. The Chief Medical Officer recruited two additional physicians from two large network provider groups and will continue to actively recruit.

Annually WellCare assesses the overall effectiveness of the QI Program. WellCare provide the 2019 Medicaid Quality Improvement Program Evaluation. This evaluation addressed all aspects of the QI Program and met the requirements of *42 CFR §438.330 (e)(2) and §457.1240 (b)*.

Last year, CCME recommended that the goal rate be moved to the 50th percentile for those HEDIS measures that have met the 25th percentile for several years. The 2019 Annual Evaluation and the 2020 QI Work Plan reflected an increase of the goal rates and included interventions and comments regarding the HEDIS measures.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that WellCare was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

Table 8: HEDIS Performance Measure Results reports all relevant HEDIS performance measures for WellCare for the current review year, measure year (MY) 2019, the previous year (MY 2018), and the change from 2018 to 2019. The change in rates shown in green indicates a substantial (>10%) improvement, and the rates shown in red indicate substantial (>10%) decline.

Table 8: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	89.37%	77.91%	-11.46%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	82.48%	82.48%	--
Counseling for Nutrition	63.75%	63.75%	--
Counseling for Physical Activity	59.12%	59.12%	--
Childhood Immunization Status (cis)			
DTaP	75.18%	70.32%	-4.86%
IPV	87.83%	83.45%	-4.38%

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
MMR	88.32%	85.16%	-3.16%
HiB	83.21%	79.56%	-3.65%
Hepatitis B	89.54%	80.54%	-9.00%
VZV	88.56%	84.91%	-3.65%
Pneumococcal Conjugate	75.18%	70.56%	-4.62%
Hepatitis A	82.00%	82.97%	0.97%
Rotavirus	69.10%	67.15%	-1.95%
Influenza	40.15%	36.25%	-3.90%
Combination #2	71.78%	65.69%	-6.09%
Combination #3	68.37%	62.29%	-6.08%
Combination #4	65.69%	60.83%	-4.86%
Combination #5	58.39%	53.04%	-5.35%
Combination #6	32.85%	28.71%	-4.14%
Combination #7	56.20%	51.82%	-4.38%
Combination #8	32.36%	28.71%	-3.65%
Combination #9	29.68%	25.06%	-4.62%
Combination #10	29.20%	25.06%	-4.14%
Immunizations for Adolescents (ima)			
Meningococcal	69.34%	68.61%	-0.73%
Tdap/Td	82.48%	78.83%	-3.65%
Combination #1	68.37%	67.88%	-0.49%
Combination #2	28.95%	27.25%	-1.70%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	29.93%	27.98%	-1.95%
Lead Screening in Children (lsc)	71.53%	69.88%	-1.65%
Breast Cancer Screening (bcs)	53.89%	57.04%	3.15%
Cervical Cancer Screening (ccs)	55.53%	57.42%	1.89%
Chlamydia Screening in Women (chl)			
16-20 Years	57.84%	61.25%	3.41%
21-24 Years	68.86%	70.03%	1.17%
Total	60.55%	63.46%	2.91%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	NA	86.10%	NA
18-64	NA	73.83%	NA
65+	NA	NR*	NA
Total	81.97%	84.02%	2.05%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	23.26%	23.12%	-0.14%
Pharmacotherapy Management of COPD Exacerbation (pce)			

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Systemic Corticosteroid	63.93%	63.02%	-0.91%
Bronchodilator	74.24%	71.35%	-2.89%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	52.99%	54.05%	1.06%
5-11 Years - Medication Compliance 75%	27.86%	26.76%	-1.10%
12-18 Years - Medication Compliance 50%	49.06%	49.79%	0.73%
12-18 Years - Medication Compliance 75%	23.02%	25.32%	2.30%
19-50 Years - Medication Compliance 50%	55.56%	45.54%	-10.02%
19-50 Years - Medication Compliance 75%	26.50%	24.75%	-1.75%
51-64 Years - Medication Compliance 50%	60.00%	61.54%*	NA
51-64 Years - Medication Compliance 75%	35.00%	46.15%*	NA
Total - Medication Compliance 50%	52.43%	51.77%	-0.66%
Total - Medication Compliance 75%	26.46%	26.70%	0.24%
Asthma Medication Ratio (amr)			
5-11 Years	76.76%	71.28%	-5.48%
12-18 Years	70.17%	56.93%	-13.24%
19-50 Years	56.94%	39.73%	-17.21%
51-64 Years	56.36%	38.78%	-17.58%
Total	70.33%	59.49%	-10.84%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	48.66%	39.66%	-9.00%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	70.83%	73.68%*	NA
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	79.77%	75.92%	-3.85%
Statin Adherence 80% - 21-75 years (Male)	49.28%	51.03%	1.75%
Received Statin Therapy - 40-75 years (Female)	75.00%	78.29%	3.29%
Statin Adherence 80% - 40-75 years (Female)	34.34%	44.55%	10.21%
Received Statin Therapy - Total	77.70%	76.88%	-0.82%
Statin Adherence 80% - Total	43.04%	48.37%	5.33%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	88.77%	88.77%	--
HbA1c Poor Control (>9.0%)	41.85%	41.85%	--
HbA1c Control (<8.0%)	48.31%	48.31%	--
HbA1c Control (<7.0%)	40.63%	40.63%	--
Eye Exam (Retinal) Performed	52.62%	52.62%	--
Medical Attention for Nephropathy	91.23%	91.23%	--

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Blood Pressure Control (<140/90 mm Hg)	55.38%	55.38%	--
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	59.31%	63.48%	4.17%
Statin Adherence 80%	46.72%	47.14%	0.42%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	68.13%	NA	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	41.40%	40.92%	-0.48%
Effective Continuation Phase Treatment	25.54%	27.58%	2.04%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	36.58%	38.18%	1.60%
Continuation and Maintenance (C&M) Phase	54.42%	52.82%	-1.60%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	76.25%	68.15%	-8.10%
6-17 years - 7-Day Follow-Up	46.25%	43.70%	-2.55%
18-64 years - 30-Day Follow-Up	47.44%	56.36%	8.92%
18-64 years - 7-Day Follow-Up	25.32%	31.79%	6.47%
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
30-Day Follow-Up	53.32%	59.67%	6.35%
7-Day Follow-Up	29.59%	35.14%	5.55%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	64.56%	68.42%	3.86%
6-17 years - 7-Day Follow-Up	47.57%	47.37%	-0.20%
18-64 years - 30-Day Follow-Up	50.14%	46.34%	-3.80%
18-64 years - 7-Day Follow-Up	38.63%	34.76%	-3.87%
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
30-Day Follow-Up	55.34%	55.83%	0.49%
7-Day Follow-Up	41.86%	40.17%	-1.69%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	NA	50.00%*	NA
13-17 years - 7-Day Follow-Up	NA	0.00%*	NA
18-64 years - 30-Day Follow-Up	NA	31.47%	NA
18-64 years - 7-Day Follow-Up	NA	21.68%	NA
65+ years - 30-Day Follow-Up	NA	NA*	NA
65+ years - 7-Day Follow-Up	NA	NA*	NA

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Total - 30-Day Follow-Up	NA	32.21%	NA
Total - 7-Day Follow-Up	NA	20.81%	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
*30-Day Follow-Up: 13-17 Years**	17.65%	8.33%*	NA
*7-Day Follow-Up: 13-17 Years**	11.76%	8.33%*	NA
30-Day Follow-Up: 18+ Years	15.58%	17.42%	1.84%
7-Day Follow-Up: 18+ Years	9.97%	12.90%	2.93%
30-Day Follow-Up: Total	15.68%	17.08%	1.40%
7-Day Follow-Up: Total	10.06%	12.73%	2.67%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	70.79%	72.83%	2.04%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	68.53%	64.86%	-3.67%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	60.00%*	88.89%*	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	65.46%	67.11%	1.65%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	NA	49.15%	NA
65+ years	NA	50.00%*	NA
Total	NA	49.16%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	NA	41.82%	NA
Cholesterol Testing - 1-11 Years	NA	23.64%	NA
Blood glucose and Cholesterol Testing - 1-11 Years	NA	21.82%	NA
Blood glucose testing - 12-17 Years	NA	66.36%	NA
Cholesterol Testing - 12-17 Years	NA	37.27%	NA
Blood glucose and Cholesterol Testing - 12-17 Years	NA	37.27%	NA
Blood glucose testing - Total	NA	58.18%	NA
Cholesterol Testing - Total	NA	32.73%	NA
Blood glucose and Cholesterol Testing - Total	NA	32.12%	NA
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	89.15%	NR	NA
Digoxin	NR	NR	NA
Diuretics	89.61%	NR	NA
Total	89.35%	NR	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.04%	.91%	-0.13%

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Appropriate Treatment for Children With URI (uri)			
3months-17 Years	NR	87.90%	NA
18-64 Years	NR	68.48%	NA
65+ Years	NR	NA*	NA
Total	88.66%	85.53%	-3.13%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	NA	54.75%	NA
18-64 Years	NA	28.37%	NA
65+ Years	NA	NA*	NA
Total	30.38%	46.01%	15.63%
Use of Imaging Studies for Low Back Pain (lbp)	65.48%	70.52%	5.04%
Use of Opioids at High Dosage (hdo)	4.10%	5.24%	1.14%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	25.44%	24.04%	-1.40%
Multiple Pharmacies	8.46%	5.48%	-2.98%
Multiple Prescribers and Multiple Pharmacies	4.21%	3.40%	-0.81%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	6.71%	4.51%	-2.20%
18-64 years - >=31 Days covered	3.45%	3.68%	0.23%
65+ years - >=15 Days covered	NA*	NA*	NA
65+ years - >=31 Days covered	NA*	NA*	NA
Total - >=15 Days covered	6.71%	4.51%	-2.20%
Total - >=31 Days covered	3.45%	3.68%	0.23%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	73.07%	73.33%	0.26%
45-64 Years	84.20%	84.43%	0.23%
*65+ Years**	100.00%	NA*	NA
Total	77.01%	77.10%	0.09%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	95.53%	95.94%	0.41%
25 Months - 6 Years	83.29%	85.48%	2.19%
7-11 Years	85.98%	86.80%	0.82%
12-19 Years	84.46%	85.80%	1.34%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	36.36%*	36.84%	NA

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	9.09%*	21.05%	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	0.00%*	50.00%	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	0.00%*	0.00%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	33.70%	36.54%	2.84%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	22.83%	24.04%	1.21%
Initiation of AOD Treatment: 13-17 Years	33.33%	35.09%	1.76%
Engagement of AOD Treatment: 13-17 Years	21.21%	22.81%	1.60%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	45.77%	40.24%	-5.53%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.45%	4.97%	-3.48%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	47.48%	44.48%	-3.00%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	17.65%	20.00%	2.35%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	41.36%	38.77%	-2.59%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.84%	8.36%	-1.48%
Initiation of AOD Treatment: 18+ Years	42.88%	39.24%	-3.64%
Engagement of AOD Treatment: 18+ Years	9.77%	8.64%	-1.13%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.60%	40.13%	-5.47%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	8.46%	5.47%	-2.99%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	47.08%	44.52%	-2.56%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	17.50%	19.86%	2.36%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	40.52%	38.49%	-2.03%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	11.26%	10.31%	-0.95%
Initiation of AOD Treatment: Total	42.22%	38.93%	-3.29%
Engagement of AOD Treatment: Total	10.56%	9.70%	-0.86%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	88.16%	93.19%	5.03%
Postpartum Care	61.05%	74.94%	13.89%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	0.00%*	NA	NA
6-11 Years	60.87%*	NA	NA
1-11 Years	NA	52.94%	NA
12-17 Years	45.65%	31.19%	-14.46%

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Total	49.30%	36.36%	-12.94%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.66%	2.66%	--
1 Visit	2.39%	2.39%	--
2 Visits	3.19%	3.19%	--
3 Visits	3.46%	3.46%	--
4 Visits	9.84%	9.84%	--
5 Visits	15.16%	15.16%	--
6+ Visits	63.30%	63.30%	--
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	63.28%	65.63%	2.35%
Adolescent Well-Care Visits (awc)	51.95%	51.95%	--

Note. * indicates small denominator; NR= not reported; NA= not applicable; -- same rates reported for HEDIS 2019 and HEDIS 2020

Commercial and Medicaid plans reporting to NCQA can report the previous year's data for measures using hybrid methodology only under certain circumstances. NCQA allows a plan to report its audited HEDIS 2019 hybrid rate if the rate is better than its HEDIS 2020 hybrid rate because of low chart retrieval. There were several hybrid measures that WellCare chose to report the MY 2018 rate instead of the rate for MY 2019, as allowed by NCQA.

The comparison from the previous to the current year revealed a substantial increase (>10%) in Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Total, and Prenatal and Postpartum Care: Postpartum Care. *Table 9* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 9: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Statin Adherence 80% - 40-75 years (Female)	34.34%	44.55%	10.21%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Total	30.38%	46.01%	15.63%
Prenatal and Postpartum Care (ppc)			
Postpartum Care	61.05%	74.94%	13.89%
Substantial Decrease in Rate (>10% decrease)			
Adult BMI Assessment (aba)	89.37%	77.91%	-11.46%
Medication Management for People With Asthma (mma)			
19-50 Years - Medication Compliance 50%	55.56%	45.54%	-10.02%
Asthma Medication Ratio (amr)			
12-18 years	70.17%	56.93%	-13.24%
19-50 years	56.94%	39.73%	-17.21%
51-64 years	56.36%	38.78%	-17.58%
Total	70.33%	59.49%	-10.84%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	45.65%	31.19%	-14.46%
Total	49.30%	36.36%	-12.94%

The measures that decreased substantially (>10%) were Adult BMI Assessment, Medication Management for People with Asthma for 19-50 year-olds for 50% Medication Compliance, Asthma medication ratio for all age ranges except 5-11 year-olds, and Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics from 12-17 year-olds and Total. CCME recommends WellCare evaluate interim trends in rates that show a substantial decrease to determine if this is a trend or anomaly and assess barriers to improving HEDIS rates that have declined.

Quality Withhold Measures

As required by SCDHHS, there were 16 quality clinical withhold measures reported for 2019. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020). As per the Medicaid Playbook and Managed Care Organizations Policy and Procedure Guide, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 percentile = 1 point; 10-24 percentile = 2 points; 25-49 percentile = 3 points; 50-74 percentile = 4 points; 75-90 percentile = 5 points; >90 percentile = 6 points). Points attained for each measure are multiplied by individual measure's weights then summed to obtain quality index score. *Table 10: Quality Withhold Measures* shows the 2019 rate, percentile, point value, and index score. The Diabetes measure rates generated the highest index score, followed by Women's Health, and then Pediatric Preventive Care. The Behavioral Health index score reflected an index score of 2.50.

Table 10: Quality Withhold Measures

Measure	MY 2018 Rate	MY 2018 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	88.77	75	5	4.15
HbA1c Control (< =9)	41.85	50	4	
Eye Exam (Retinal) Performed	52.62	25	3	
Medical Attention for Nephropathy	91.23	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	93.19	90	6	4.10
Breast Cancer Screen	57.04	25	3	
Cervical Cancer Screen	57.42	25	3	
Chlamydia Screen in Women (Total)	63.46	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	63.3	25	3	3.10
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.63	25	3	
Adolescent Well-Care Visits	51.95	25	3	
Weight Assessment/Adolescents: BMI % Total	82.48	50	4	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	38.18	10	2	2.50
Antidepressant Medication Management Effective Continuation Phase Treatment	27.58	10	2	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	36.36	<10	1	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	32.12	25	3	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	35.14	50	4	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	38.93	25	3	

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was done in accordance with the CMS-developed protocol titled, *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed include the following:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

WellCare submitted two projects for validation – Improving Dilated Retinal Exam (DRE) Screening and Access to Care. *Table 11: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

TABLE 11: Performance Improvement Project Validation Scores

Project	2019 Validation Score	2020 Validation Score
Improving Dilated Retinal Exam (DRE) Screening	91/91=100% High Confidence in Reported Results	73/73=100% High Confidence in Reported Results
Access to Care	91/91=100% High Confidence in Reported Results	80/80= 100% High Confidence in Reported Results

Both PIPs received a score within the High Confidence Range and met the validation requirements per *42 CFR §438.330 (d) and §457.1240 (b)*.

For rate for the Access to Care PIP showed a slight increase. Member incentives and outreach and provider education continue to have a slight impact on improving primary care visits. These interventions will continue.

The rate for the Improving DRE Screening PIP was noted as unchanged from CY2018 to CY2019. According to WellCare, the project uses administrative rates, and the 2018 rate was reported for 2019 as allowed by NCQA. WellCare will continue the following in 2021: Member Outreach to remind members of the importance of needed DRE Screening; Utilize In-Home Assessments for DRE Screening when available; Continue support of Vision Vendors efforts with Member automated calls and provider outreach to include efforts for

DRE CPT II coding; and reward members and providers (Healthy Rewards/P4Q Program) when DRE's are completed. Progress will be monitored by the HEDIS® Comprehensive Diabetes Care (sub-measure Dilated Retinal Exams) rates obtained through the Annual Audit Review Table (ART).

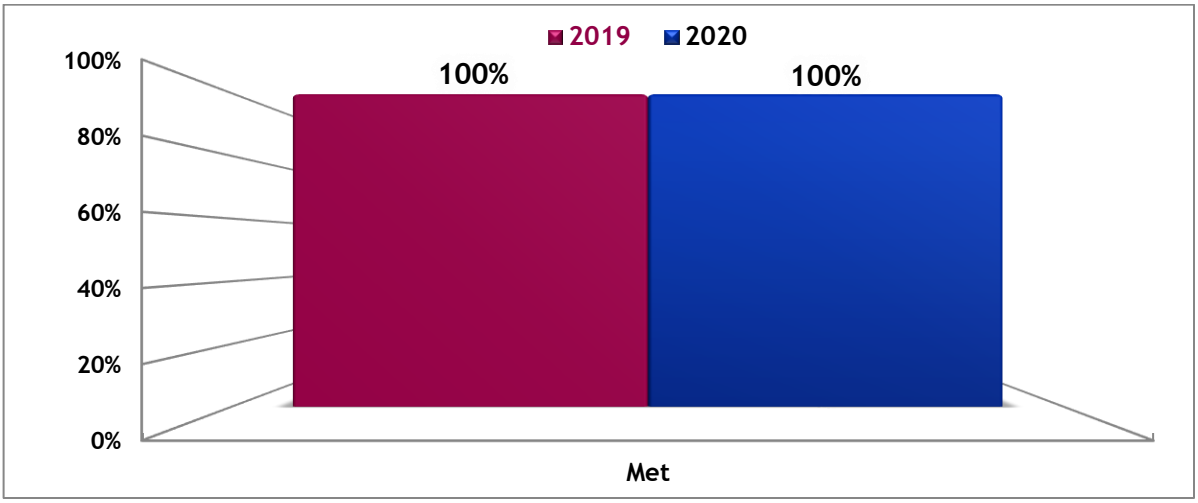
The PIP recommendations from the previous EQR included: focus future PIP topic selections on reducing admissions, readmissions and ER visits for CHF and COPD. WellCare offered this response: The QI Team reviewed several forms of data to include Quality Management reports to assess the recommendation for a PIP focus on reducing admission, readmissions and ER visits for CHF, COPD, diabetes, and HTN. Although, there were some increased rates of non-compliance noted in the HEDIS data and some increased variances noted in disease management, other sources of data did not show prevalence or increases. Based on the data, WellCare will continue to monitor all chronic disease states to include the following:

- Ensure members are discharged with a safe discharge plan and/or Case management follow-up reducing readmissions.
- Bi-weekly outlier rounds to discuss members with complex discharges and come up with a member specific safe discharge plan.
- Collaborative discharge planning with every Utilization Management review to ensure that any expected discharge needs are addressed.
- Access data for the top readmit facilities and diagnosis and develop actions such as referring members in high readmit facilities and those with a high readmit diagnosis to case management.
- Refer members that are at high risk for readmission such as noncompliance and chronic illness to case management for early intervention.
- Refer readmission to the Quality Department for potential quality of care and unavoidable readmission.
- Monitor HEDIS rates for areas of noncompliance to include interventions to improve compliance.
- Distribute Provider gaps in care reports to encourage office visits.
- Focused member outreach on increasing compliance and awareness of benefits.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

WellCare "Met" all the Standards in the QI section as noted in *Figure 6*.

Figure 6: Quality Improvement Findings



Strengths

- The performance measure validation found that WellCare was fully compliant.
- The HEDIS rates that showed a substantial increase included: Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Total, and Prenatal and Postpartum Care: Postpartum Care.
- All the PIPs received validation scores in the "High Confidence Range."

Weaknesses

- The specific metrics in the 2020 work plan regarding turn-around time for measuring the resolution of a retrospective appeal request and the interrater reliability goal was incorrect.
- The following HEDIS measure rates were determined to be areas of possible improvement for WellCare since these rates had a greater than 10% decline:
  - Adult BMI Assessment,
  - Medication Management for People with Asthma for 19-50 year-olds for 50% Medication Compliance,
  - Asthma medication ratio for all age ranges except 5-11 year-olds,
  - And Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics from 12-17 year-olds and Total.

Recommendations:

- Correct the metric used to measure the turn-around time for a retrospective appeal and the interrater reliability goal in the QI Work Plan.
- Evaluate interim trends in rates that show a substantial decrease to determine if this is a trend or anomaly in rate decline. Assess barriers to improving HEDIS rates that have declined.

E. Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

Review of WellCare's Utilization Management (UM) Program includes UM documents, medical necessity determination processes, pharmacy requirements, the Care Management Program, and a review of approval, denial, appeal, and care management files.

The Utilization Management Program Description and policies guide staff in conducting UM services for physical health, behavioral health, and pharmaceutical services for members in South Carolina. Additionally, it outlines the structure, lines of responsibility, and standards used to make Utilization Management decisions. The UM Program is evaluated at least annually to assess its strengths and effectiveness.

Appropriate Utilization Management staff review service authorization requests using InterQual and other established criteria. WellCare assesses consistency in criteria application and decision-making through annual interrater reliability testing of both physician, non-physician, and pharmacy reviewers. However, discrepancy in documentation is noted where the 2020 Utilization Management Program Description, 2020 Medicaid Quality Improvement Program Description and the 2019 Medicaid Quality Improvement Program Evaluation reflects the interrater reliability (IRR) benchmark is 85%. Policy SC22-HS-UM-007, Interrater Reliability and the corresponding Procedure, and Policy SC22-RX-019, Drug Evaluation Review (DER) Process Policy indicate the IRR benchmark is 90%.

WellCare is the pharmacy benefit manager (PBM) and is responsible for all pharmaceutical services. The plan uses the most current version of the PDL to fulfill pharmacy requirements which is accessible on the website.

Appeals

42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260

WellCare has established policies defining processes for handling appeals of adverse benefit determinations. Discussions during the onsite teleconference revealed Policy SC22-RX-012, Pharmacy Appeals has been retired and all pharmacy appeals processes are incorporated into Policy SC22-HS-AP-002, Member Appeals Policy. A few issues were noted with appeals documentation, such as the term Authorized Representative is not clearly defined in the Member Handbook or on the website and the complete definition of the term Adverse Benefit Determination was omitted from the Definitions and Abbreviations section in the Provider Manual. Additionally, the pharmacy denial letter template "SMD PA denial pharmacy", and the pharmacy acknowledgement letter template, "Pharmacy Appeals Acknowledgement", have incorrect timeframes for members to submit a written appeal notice following their oral appeal request.

CCME's review of appeal files revealed timely appeal acknowledgement, resolution, and notification of resolutions.

Overall, no major issues were identified with review of the Utilization Management Program. Minor issues were noted with appeals documentation and CCME offered recommendations to address them.

As noted in *Figure 7: Utilization Management Findings*, WellCare received "Met" scores for 98% of the standards and "Partially Met" scores for 2 % of the standards.

Figure 7: Utilization Management Findings

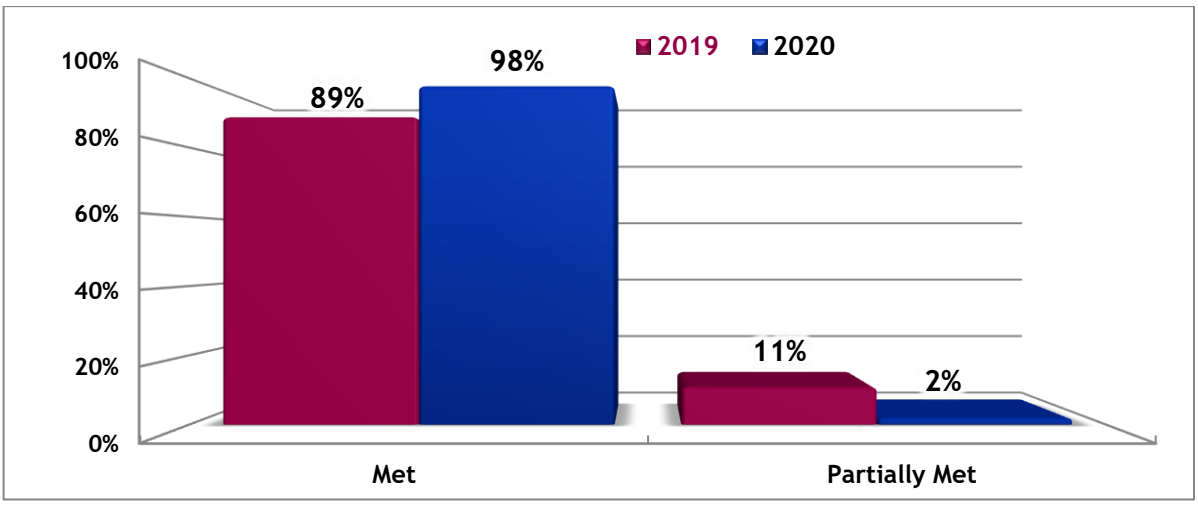


TABLE 12: Utilization Management Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met
	The procedure for filing an appeal	Met	Partially Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Met
	Other requirements as specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Written resolution notices are written in language that is easily understood.
- Incorporating all pharmacy appeals processes into Policy SC22-HS-AP-002, Member Appeals Policy, and retiring Policy SC22-RX-012, Pharmacy Appeals.

Weaknesses

- The 2020 Utilization Management Program Description, 2020 Medicaid Quality Improvement Program Description, and the 2019 Medicaid Quality Improvement Program Evaluation reflect that the IRR benchmark goal is 85% instead of 90%.
- The term Authorized Representative is not clearly defined in the Member Handbook or on the website, thus members may not fully understand their options for selecting someone to represent them if needed.
- The definition of the term Adverse Benefit Determination in the Definitions and Abbreviations section on page 125 in the Provider Manual, is not consistent with the definition on page 96. It does not include the requirements regarding residents in rural areas and regarding the denial of an enrollee's request to dispute a financial liability.
- The following documentation issues were identified with appeals letter templates:

- The pharmacy denial letter template, "SMD PA denial_pharmacy", incorrectly notes the member has 30 days to request an appeal, instead of 60 days as required by *SCDHHS Contract, Section 9.1.1.2.2.*
- The pharmacy denial letter template, "SMD PA denial_pharmacy", and the pharmacy acknowledgement letter template, "Pharmacy Appeals Acknowledgement", incorrectly indicates that written confirmation of all oral requests is required within 10 calendars instead of 30 calendar days.

Quality Improvement Plans

- Edit denial letter template, "SMD PA denial_pharmacy", to reflect that members have 60 days to request an appeal as required by *SCDHHS Contract, Section 9.1.1.2.2.*
- Edit denial letter template, "SMD PA denial_pharmacy" and acknowledgement letter template, "Pharmacy Appeals Acknowledgement", to indicate written confirmation of all oral requests must be received by WellCare within 30 calendar days from the Adverse Benefit Determination letter.

Recommendations

- Edit the benchmark IRR goal documented in the UM and QI Program Descriptions from 85% to 90% to be consistent with Policy SC22-HS-UM-007, Interrater Reliability and the corresponding Procedure, and Policy SC22-RX-019, Drug Evaluation Review (DER) Process Policy.
- To assist members in understanding their options for selecting an authorized representative, include a definition or description for the term Authorized Representative in the Member Handbook and on the website.
- Edit the Definitions and Abbreviations section of the Provider Manual to include the complete definition of the term Adverse Benefit Determination as noted in *SCDHHS Contract, Section Appendix A (A.1).*

F. Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

WellCare delegates several functions to other entities. For this EQR, WellCare delegates the following services through 32 delegate agreements.

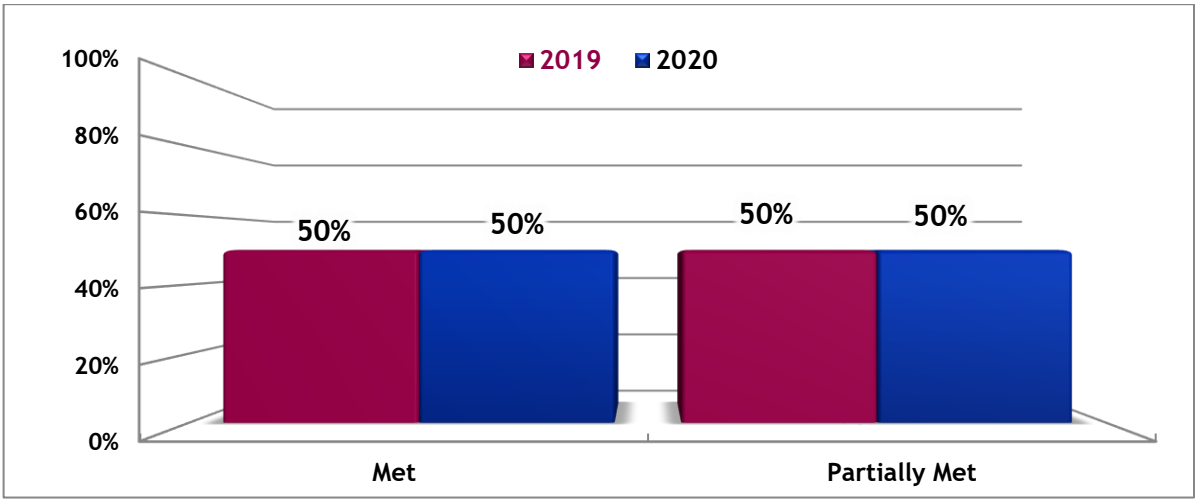
- Utilization Management
- Case Management
- Credentialing
- Nurse Advice Line
- Crisis Hotline
- Pharmacy Services
- Member and Provider Customer Services
- Vision Services

WellCare's Policy SC22-CP-AO-007, Delegation Oversight and Procedure SC22-CP-AO-007-PR-001, Delegation Oversight Procedure define the process followed for pre-delegation, annual oversight, and ongoing monitoring of delegated functions.

WellCare submitted the pre delegation monitoring and annual delegation monitoring for most of the delegates. There were several delegates where the annual monitoring was underway. WellCare indicated they expected to have the monitoring completed by December 31, 2020.

CVS as a delegate for several functions including credentialing. However, the annual monitoring did not include a file review. During the previous EQR, the audit tools used for oversight monitoring neither address the query of the SCDHHS List of Providers Terminated for Cause nor the Collaborative Agreement/Written Protocol for Nurse Practitioners. WellCare addressed these issues and both elements were added to the auditing tools. However, the monitoring tools used for four of the delegates either not included the query of the SCDHHS List of Providers Terminated for Cause on the audit tools or was inappropriately marked as not applicable. The standard related to monitoring of delegated entities received a "Partially Met" score as noted in *Figure 8: Delegation Findings*.

Figure 8: Delegation Findings



Weaknesses

- WellCare listed CVS as a delegate for several functions including credentialing. However, the annual monitoring did not include a file review.
- The audit tool used for the credentialing/recredentialing file review did not include checking the SCDHHS Provider Terminated for Cause List for the following delegates:
  - Greenville Hospital System

- OptumHealth Care Solutions
- Linka
- United Physicians

- The audit tool used for March Vision did include the check of the SCDHHS Provider Terminated for Cause list, however; that section of the tool was marked as N/A for all the files.

Quality Improvement Plans

- Conduct a file review for all delegates responsible for credentialing and recredentialing.
- Update all auditing audit tools used for the monitoring of the credentialing and recredentialing files to include checking the SCDHHS List of Providers Terminated for Cause.
- Provide additional training for delegation auditors regarding the requirements for checking the SCDHHS List of Providers Terminated for Cause.

G. State Mandated Services

42 CFR Part 441, Subpart B

WellCare continuously monitors immunization and Early and Periodic Screening Diagnostic, and Treatment (EPSDT) compliance through frequent review of HEDIS metrics and provider performance on medical record reviews. The health plan has several processes and provider engagement activities in place to educate, notify, and remind providers of needed EPSDT services. WellCare ensures core benefits and services are provided to members as required by SCDHHS Contract and *42 CFR Part 441, Subpart B*.

Following the 2019 EQR, WellCare submitted a Quality Improvement Plan to address any deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on March 23, 2020. The following is a high-level summary of those deficiencies:

- Credentialing and Recredentialing policies and procedures did not adequately address how WellCare performs federal and state database checks for persons identified on the Ownership Disclosure forms with an ownership or controlling interest.
- Credentialing and recredentialing files did not include all required elements and evidence of required queries.
- Policies describing processes for written member materials did not address the requirement to use a 12-point font size for regular print and 18-point font size for large print.

- Pharmacy appeal policies contained errors and omitted several requirements for member appeals.
- Documentation issues regarding timeliness guidelines for service authorization and appeal processes were noted in the Provider Manual, Member Handbook, letter templates and WellCare's website.
- Review of appeals files reflect issues with acknowledgement and resolution timeframes, not notifying member of the appeal downgrade from expedited to standard, and incorrect appeal determination.

A During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plan was implemented and the deficiencies corrected.

As noted in *Figure 9: State Mandated Services Findings*, WellCare received scores of "Met" for 100% of the standards.

Figure 9: State Mandated Services

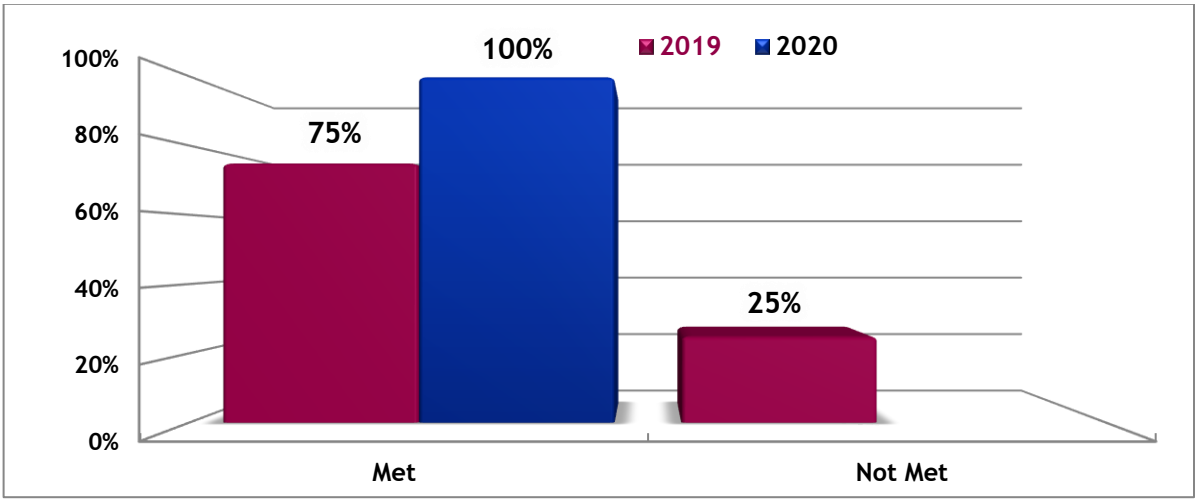


TABLE 13: State Mandated Comparative Data

Section	Standard	2019 Review	2020 Review
State-Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews.	Partially Met	Met

Strengths

- WellCare provides all benefits as contractually required and informs members how to access those benefits.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

October 19, 2020

Mr. Urcel Fields
Plan President
WellCare of South Carolina
200 Center Point, Suite 180
Columbia, SC 29210

Dear Mr. Fields:
At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2020 External Quality Review (EQR) of WellCare of South Carolina is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **December 16th and 17th**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **November 02, 2020.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2019 and 2020.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from November 2019 through October 2020. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of November 2019 through October 2020.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen;

hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;

c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of November 2019 through October 2020. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of November 2019 through October 2020, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.

2. Increasing HGBA1C PIP – latest report.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**WellCare**
Name of PIP:	**ACCESS TO CARE**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection and noted on page 2.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined on page 5.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure is focused on processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed on page 7.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection uses programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are clearly presented.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions are directly related to barriers identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	AAP rate increased slightly.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of incentive and education.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical improvement was not significant, but is calculated and documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Rate has not met target goal yet and remains below baseline.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	**80**
Project Possible Score	**80**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**WellCare**
Name of PIP:	**IMPROVING DILATED RETINAL EXAM (DRE) SCREENING- CLINICAL**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection and noted in the report.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined in report.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure is focused on processes of care and health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection uses programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are clearly presented.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions are directly related to barriers identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Rate remained the same- it did not decline or improve.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Rate is unchanged.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical improvement was not significant as rate did not change. Comparison to baseline and previous year is reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Rate has not met target goal yet.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**73**
Project Possible Score	**73**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	**WellCare**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2019**
Review Performed:	**2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2020 ***(Note: Due to COVID allowances, some reported rates for HEDIS2020 were the same as RY2019/HEDIS 2019)***

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	Methods were reported to be compliant.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Met**	Sampling was conducted according to specifications.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Met**	Replacements were conducted and found compliant.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall Assessment			Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. Audit report noted compliance for HEDIS measures.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	**WellCare**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3,324. The total completed surveys was 524 for a 15.8% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is about the same as the average response rate of 15.5%. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 **Recommendation:** Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020

CCME EQR Survey Validation Worksheet

Plan Name	**WellCare**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3,611. The total completed surveys was 435 for a 12% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is about the same as the average response rate of 12.6%. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020

CCME EQR Survey Validation Worksheet

Plan Name	**WellCare**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,629. The total completed surveys for the general population was 203 for a 12.5% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is about the same as the average response rate of 12.6%. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	WellCare of South Carolina
Collection Date:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					It is evident that policies and procedures are organized to delineate the various lines of business operation within the Company.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Bill Yurkowski serves as the interim CEO, effective thru August 1, 2021.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Chief Financial Officer (CFO);	X					Stephen Moore is the Chief Financial officer.
1.3 * Contract Account Manager;	X					Mark Ruise is the Contract Account Manager.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Brian Pogue is the Claims and Encounter Manager and is in the Florida office.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					Network Management Claims and Encounter staff are in the SC office.
1.5 Utilization Management (Coordinator, Manager, Director);	X					Kathy Buchta oversees the Utilization Management staff.
1.5.1 Pharmacy Director,	X					Nancy Youssef is the Pharmacy Director.
1.5.2 Utilization Review Staff,	X					Utilization Review staff are in the SC Office.
1.5.3 *Case Management Staff,	X					Case Management staff are in the SC Office.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Mark Dashiell directs the Quality Improvement staff.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Cecil Webb manages the Provider Services staff.
1.7.1 *Provider Services Staff,	X					Provider Services staff are in the SC office.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 *Member Services Manager;	X					Anton Brown manages the Member Services staff
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Robert London is WellCare's Medical Director
1.10 *Compliance Officer;	X					Donald Schmadel is the WellCare Compliance Officer
1.10.1 Program Integrity Coordinator;	X					Jennifer Jarke is the WellCare Program Integrity Coordinator
1.10.2 Compliance /Program Integrity Staff;	X					Compliance and Program Integrity staff are located at the SC office.
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					Legal staff are led by Jan Alonzo
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Sims is the Board-Certified Psychologist for WellCare.
1.14 Post-payment Review Staff.	X					Post-payment Review staff are in the Florida and South Carolina offices.
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO processes provider claims in an accurate and timely fashion.	X					WellCare's internal benchmark for clean claim's processing mirror that of the state's contract: 90% of all clean claims processed within 30, and 99% of all clean claims processed within 90. The statistics reported by SC WellCare show the organization exceeds the MCO contract requirements by achieving 99% of clean claims processed within 30 days.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					WellCare and its contracted partners have configured their systems according to the *42 CFR § 438.242* regulations to be capable of conducting electronic transactions in the HIPAA standard EDI format (e.g. 837 EDI 5010). systems are also configured to scan paper claims and handle them in the same HIPAA standard EDI format as native electronic claims.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					WellCare's documentation states that it collects 834 eligibility files on a daily and monthly basis. When the 834 eligibility files are received the MCO immediately begins processing them. Enrollees are assigned a unique subscriber identification number that allows them to be tracked within product lines. WellCare assigns an enrollee a new unique ID if they change product lines.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					To generate HEDIS or HEDIS-like reports, WellCare's system collects data from its internal systems and stores it in a dedicated reporting data warehouse. WellCare verifies reports by comparing data trends and historical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						benchmarks, and the organization audits the reporting process on a monthly basis.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					The documentation provided by WellCare indicates the appropriate measures have been taken to secure the organization physically and logically. The organization uses environmentally controlled data centers to host its IT resources to optimize uptime and limit physical access.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					WellCare provided ISCA documentation that indicates it has the policies, procedures, and processes in place to operate in a secure manner and manage system access. The MCO provided the results of a recent third-party security audit which did not find any exceptions.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					WellCare has an IT Disaster Recovery (DR) plan in place to recovery the critical information systems and data in the case of an incident that interrupts operations. The DR plan has been in place for several years, and the document's revision history indicates that it is reviewed and revised regularly. Finally, in March of 2020, a DR test was performed to ensure the DR plan was functional. The test results indicate a successful recovery with no exceptions noted.
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The WellCare Corporate Compliance Program promotes ethical conduct in all aspects of Company operations and strives to ensure compliance with applicable state and federal laws and standards to include *42 CFR § 438* and *42 CFR § 457*.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Business Ethics and Code of Conduct along with related policies applies to all Centene Corporation employees and subsidiaries. The Company conducts ethical business both in letter and in spirit and in compliance with applicable laws.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						Policy C13-SIU-FWA-001-SC South Carolina - Fraud Waste and Abuse Policy defines the responsibilities of the Compliance Officer to include responsible for program integrity activities required under *42 CFR § 438.608*. The Business Ethics and Code of Conduct outlines various roles and responsibilities of the Compliance Officer.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The Corporate Compliance Committee oversees the operations of WellCare's Compliance Program. The primary purpose of the Committee is to develop and implement an effective corporate ethics and compliance program for all

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						WellCare lines of business. The Market Compliance Oversight Committee Charter indicates that the Committee meets no less than once per calendar quarter.
2.5 Compliance training and education;						Policy C2-TR-002 Corporate Compliance Training outlines that Compliance training is discussed in new hire orientations. Goals are included in Focal Point evaluations in adherence to state and federally mandated guidelines. The Corporate Compliance Program includes certification to the Code of Conduct, general compliance training, mandatory courses on fraud, waste and abuse, and training on HIPAA privacy and security.
2.6 Lines of communication;						Centene has established policies and procedures for reporting circumstances in which violations occur or are suspected specific to the Code of Conduct, fraud, waste, and abuse, laws, or regulations. Employees are asked to reach out with questions to one's immediate supervisor as a first step, higher level management as a second step, then the local Compliance Officer, the Chief Compliance Officer (CCO), and/or make a call to the Ethics and Compliance Helpline.
2.7 Enforcement and accessibility;						If an investigation, regulatory audit, or monitoring process confirms the existence of a compliance issue, the WellCare Corporate Compliance Plan indicates that the Compliance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Department works to promptly resolve the issue and take necessary corrective action, including timely and appropriate disciplinary action.
2.8 Internal monitoring and auditing;						Audits and routine monitoring are conducted periodically of business operations to measure and assess WellCare's compliance with its internal controls and with applicable federal and state laws, regulations, and guidance.
2.9 Response to offenses and corrective action;						Staff from the Compliance Department have the responsibility for the oversight of regulatory compliance performance. This includes risk assessment, compliance policy development, education, investigations of alleged violations, oversight and response to incidents of non-compliance, and auditing.
2.10 Data mining, analysis, and reporting;						General Dynamics STARSSolutions, an antifraud software is used as a data analytic tool to augment our investigative staff. Healthcare Fraud Prevention Partnership, which is designed to advance the detection and prevention of health care fraud, waste and abuse is used to share data across the industry and between public and private sectors and collaborating on anti-fraud methodologies. Onsite: SIU Manager internal and external data mining system. HFPP is a partnership, CMS, law enforcement, best practices, case discussions, fraud, department of insurance, National Healthcare antifraud, meets for conferences quarterly.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Exclusion status monitoring.						WellCare will not knowingly hire, retain or otherwise conduct business with an Associate, contractor, provider, sales representative or agent who: -Is excluded, debarred, suspended or otherwise made ineligible from participating in federal or state funded programs; or -Has 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.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The WellCare Market Compliance Oversight Committee meets quarterly and as needed.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The Member Handbook meets the standard for the provision of multiple reporting options for fraud, waste, and abuse (FWA). The WellCare website does not provide reporting options for FWA in a clearly visible way. *Recommendation: The Fraud Waste Abuse reporting options that are very well documented in the Provider Handbook should also be provided in a clear and easily accessible way on WellCare's website, such as the homepage for use by all network stakeholders to strengthen the visibility of reporting.*
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Policy C13-CP-020 Corporate Compliance Internal Investigation and Policy C13-SIU-FWA-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						001-SC on Fraud Waste and Abuse describes that the Special Investigations Unit reports to the Vice President. Corporate Compliance Investigations are reported to the Chief Compliance Officer. The SIU maintains written policies and procedures and adheres to standards of conduct that articulate WellCare's commitment to comply with all applicable federal and state standards.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					In compliance with *42 CFR § 438.224, t*he Business Ethics and Code of Conduct, Policy SC22-OP-CS-002, Medicaid Disclosure and Confidentiality, and Policy C13-CP-003-PR-001 Reporting Compliance Issues to the Compliance Program – Confidentiality and Non-Retaliation Procedure, meet the requirements of *42 CFR § 438.224. These documents address the* requirements regarding privacy and confidentiality of each person's health information.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Process for credentialing and recredentialing practitioners and organizational providers are documented in Policy SC22 OP-CR-001, Credentialing and Recredentialing, Policy SC22-OP-CR-009, Assessment of Organizational Providers, and the WellCare Health Plans, Inc. 2020 Credentialing Program Description. Credentialing activities are conducted by WellCare corporate staff.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					A corporate Medical Director approves clean provider files and reviews the files with the health plan during Credentialing Committee meetings. The Credentialing Committee is the principal clinical peer committee that oversees credentialing and recredentialing activity. Current committee members have specialties of Cardiology, Pediatrics, Family Practice, and a Licensed Clinical Social Worker.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Credentialing Committee also acts as a peer review committee, discussing cases with potential quality of care or conduct issues and whether providers are meeting reasonable standards of care. CCME could not identify the quorum for the Credentialing Committee in the materials reviewed. Onsite discussion confirmed the quorum is 50% of voting members. A review of Credentialing Committee meetings for the past year confirmed the presence of a quorum at each meeting. *Recommendation: Ensure the Credentialing Committee quorum is documented in appropriate policies and/or the Credentialing Program Description.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						Credentialing files included all required components.
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Policy SC22 OP-CR-001, Credentialing and Recredentialing, Policy SC22-OP-CR-009, Assessment of Organizational Providers and WellCare Health Plans, Inc. 2019 Credentialing Program Description explain how WellCare credentials and recredentials practitioners and organizational providers. For both nurse practitioner recredentialing files reviewed, there were no full collaborative agreements (or protocols) included. This was discussed during the onsite and the full collaborative agreement was provided for both.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					Several recredentialing files were noted with no CLIA Certificate or Certificate of Waiver, although the providers' applications indicate laboratory services were provided or no response was entered for this section. During onsite discussion, WellCare staff explained their process for contacting the provider's office for clarification in this situation. Supporting documentation was provided for all files in question.
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					WellCare ensures provider quality monitoring and quality review information is incorporated into the credentialing peer review process. The Credentialing Department submits a list of providers due for recredentialing to the Plan Quality Improvement Analyst (QIA) quarterly. The QIA checks the database for confirmed quality issues and trends, grievances, and corrective provider education. If a quality issue is found, a quality profile is provided to Credentialing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider-specific quality of care complaints and adverse event information are reviewed by the Quality Department. If there is a confirmed quality of care issue identified, it is referred through the Medical Director to the Credentialing Committee for peer review. If the Credentialing Committee denies continued participation, the physician is entitled to access the Hearing and Appellate Review process (also known as the Provider Dispute Resolution Peer Review Process).
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					Policy SC22 OP-CR-009, SC - Assessment of Organizational Providers defines the credentialing/recredentialing guidelines for organizational providers. CCME's review of organizational credentialing and recredentialing files confirmed the files contained all required components. Several files were missing documentation on the initial review, but the missing items were discussed during the onsite and provided to CCME for all files in question.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Policy SC22-OP-CR-046, Ongoing Monitoring of Providers, states WellCare conducts ongoing monitoring of the participating network providers on a monthly basis, including a review of the National Plan and Provider Enumeration System (NPPES); Social Security Administration's Death

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Master File (DMF); Medicaid Sanction Exclusions and Reinstatement reports; Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); System for Award Management (SAM); Medicare Opt-Out listings; CMS Preclusion List; South Carolina Excluded Provider List; South Carolina Exclusion and Termination for Cause Listing; and professional licensing sanctions.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy SC22 OP-NI-001, GeoAccess Reporting, defines the requirement for access to a PCP as 90% of the Managed Care eligible population in the county with access to at least one PCP within 30 miles and within 45 minutes or less driving time. The policy states OB/GYN, FQHC, and RHC providers acting as PCPs are included in the PCP section of the Geocoding report. At least monthly, WellCare evaluates the geographic sufficiency of the network and takes action as appropriate. Provider Network Reports are submitted to SCDHHS at least biannually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2019 Medicaid Quality Improvement Program Evaluation indicates for both Q2 and Q4 of 2019, 100% of members had access to PCPs within the required time/distance standards.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy SC22 OP-NI-001, GeoAccess Reporting, defines the requirement for access to specialists as 90% of the Managed Care eligible population in the county with access to the required specialist within 50 miles and within 70 minutes or less driving time. The policy also defines the requirement for access to hospitals as 90% of the Managed Care eligible population in the county with access to a hospital within 50 miles and within 70 minutes or less driving time. The 2019 Medicaid Quality Improvement Program Evaluation indicates for both Q2 and Q4 of 2019, 100% of members had access to cardiologists and gastroenterologists within the required time/distance standards. Goals were also met for oncologists and pulmonologists, with percentages of members with the required access of 99.98% and 98% respectively. 100% of members had the required access to an acute inpatient hospital.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy SC22-GOV-PD-005, Cultural Competency, states WellCare maintains a copy of its Cultural Competency Program and Plan (CCP) on its website and directs all network providers to review the document. WellCare will provide a hard copy of the CCP at no cost upon request. The CCP is reviewed annually and presented to the Quality Improvement Committee to ensure compliance with the program objectives. An evaluation of the effectiveness of the CCP is conducted annually and may include results from the CAHPS surveys and other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances and appeals, provider feedback, and WellCare staff surveys. WellCare tracks and trends any issues identified in the evaluation and implements interventions to improve the provision of services. CCME confirmed the WellCare Cultural Competency Program and Plan 2020-2021 is located on WellCare's website. The 2020 South Carolina Medicaid Provider Manual provides an overview of the Cultural Competency Plan. Page 35 of the manual includes a Cultural Competency Survey heading. Under this heading is the following statement: "Providers may access the Cultural Competency Survey on WellCare's website at

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						www.wellcare.com/South-Carolina/providers/Medicaid." However, there is no other information about this survey and CCME could not locate the survey on WellCare's website. This was discussed with WellCare staff during the onsite. They stated additional information would be provided but none was received. Note: the draft Provider Manual, page 36, includes the same information. *Recommendation: Revise the Provider Manual to include additional information about the Cultural Competency Survey, such as the purpose of the survey, who should take the survey, when and how often it should be taken, etc. Ensure the survey is located on the WellCare website, as stated in the Provider Manual.*
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					WellCare's Provider Directory is available on the website and in print format upon request. CCME's review of Provider Directory entries confirms most required components are included; however, the reviewer could not identify that the Provider Directory indicates providers who have completed cultural competency training. WellCare staff responded that this is indicated in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the online Provider Directory by an icon and this was confirmed. The provider information in the web-based directory is updated from WellCare source files within 72 hours. Onsite discussion confirmed the print Provider Directory is revised annually.
3.Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy SC22-OP-NI-002, Provider Appointment Accessibility and After-Hours Coverage defines appointment scheduling and wait times. Standards documented in the policy are consistent with contractual requirements. WellCare monitors the timeliness of access to care within its provider networks via Appointment Accessibility and After-Hours telephone surveys. WellCare requires all network providers to offer hours of operation that are no less than the hours of operation offered to Commercial and Fee-for-Service patients and requires PCPs to arrange for after-hour coverage. When standards are not met, WellCare takes corrective action, as appropriate. The 2019 Medicaid Quality Improvement Program Evaluation provides results of the Appointment

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Accessibility and After-Hours telephone surveys from October 2019 (round 1) and December 2019 (round 2). The evaluation specified which goals were met and unmet, and discussed actions taken after each round to improve findings, corrective action plans for non-compliant providers, and planned interventions for 2020.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			As part of the annual EQR process for WellCare, a Provider Access Study was performed focusing on primary care providers. From a list of current providers given to CCME by WellCare, a population of 2,461 unique PCPs was found. A sample of 180 providers was randomly selected from this population for the Access Study. Attempts were made to contact the sample of providers to ask a series of questions regarding access members have with the providers. Successfully answered calls equaled 62% (92 out of 148) when omitting calls answered by personal or general voicemail messaging services or call center services. When compared to last year's results of 80%, this year's study had a statistically significant decrease in successful calls at 62% (p=.0003). For those not answered successfully (n=56 calls), 36 (64%) were unsuccessful because the location called was not a primary care outpatient facility,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						such as a hospital, residency program, or urgent care facility). Of the 92 providers that were successful contacted, only 60 responded to the question about accepting WellCare, and of those 60, only 56 (93%) indicated they accept WellCare. Of the 56 accepting WellCare, 38 (68%) were accepting new patients. Of the 38 accepting new patients, only 13 (34%) require a prescreen. For the 13 that require a prescreen, 11 (85%) require both a medical record review and application, 1 (8%) required a medical record review only, and 1 (8%) required an application only. *Quality Improvement Plan: Explore new procedures or processes to update provider file information. Consider including a variable that specifies the primary location of the providers in the provider file that is uploaded to CCME for the access study.*
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy SC22-HS-PR-001, Provider Training and Education Policy states Provider Relations staff are responsible for initial provider orientation and ongoing training. WellCare offers training to all providers and their staff regarding the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements of their contracts and the special needs of enrollees—initial training is conducted within 30 calendar days of placing a newly contracted provider, or provider group, on active status, and ongoing training is conducted as necessary to ensure compliance with program standards and other contractual obligations. Provider trainings are provided via provider orientation, newsletters, emails, faxes, letters, on-site training, etc. For initial orientation, a Provider In-Service Checklist that outlines all topics to be covered is used. Topics discussed during initial orientation include the managed care program and services, WellCare policies and procedures, the Compliance Program, caring for members with special needs, and a review of the Provider Manual. Providers are informed of their responsibility to train their staff on the various aspects of WellCare's Compliance Program, including improper payments, prohibition of bribes, kickbacks, and illegal inducements, physician self-referral, ineligible persons, the Health Insurance Portability and Accountability Act (HIPAA), fraud, waste, and abuse (FWA), and the Federal False Claims Act.
2. Initial provider education includes:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					Billing processes and guidelines are detailed in the Provider Manual and the website.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				Discrepancies were noted when comparing member benefits listed in the Provider Manual and the Member Handbook: •The 2020 Provider Manual (pages 10 and 11) includes "Gastric Bypass Surgery/Vertical-Banded Gastroplasty (Gastric Stapling)" along with "Panniculectomy" (when specific criteria are met) in the member benefits grid, but page 16 of the Provider Manual states these are excluded from the member benefits. Onsite discussion confirmed these procedures are covered when medically necessary. Also, these procedures are not included as covered benefits in the Member Handbook. •For Maternity Services, the Member Handbook, page 27 includes "Postpartum services (one home visit within 6 weeks of delivery)" but this is not included in the Provider Manual, page 12. ○Page 12 of the Provider Manual states, "Optometrist services (for Members under age 21)" but that age limit is not specified on page 27 of the Member Handbook. *Quality Improvement Plan: Revise page 16 of the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						2020 Provider Manual to remove the erroneous statement that gastric bypass surgery/vertical-banded gastroplasty and panniculectomy are excluded from benefit coverage. Also, include information about these procedures in the benefits grid in the Member Handbook. Update the Provider Manual to include full information about Maternity Services benefits, as documented in the Member Handbook (page 27). Ensure the age limit for optometrist services listed on page 12 of the Provider Manual is also documented on page 27 of the Member Handbook.
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					The Provider Manual includes PCP access standards and discusses the requirement that PCP's must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week.
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					Medical record documentation standards are addressed in the Provider Manual. The manual also includes information about medical record confidentiality and retention.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Provider and member grievance and appeal procedures;	X					The Provider Manual includes information about the provider dispute resolution peer review process as well as member and provider appeals.
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					The Provider Manual includes detailed information about the Preferred Drug List (PDL), additions and exceptions to the PDL, pharmacy coverage limitations, member copayments, use of generic medications, the prior authorization process, etc. It also includes information about the Pharmacy Lock-In Program.
2.10 Reassignment of a member to another PCP;	X					The Provider Manual gives specific information about requirements and processes for a provider terminating a member, including the requirement to submit adequate documentation to support the request and the requirement to continue to provide care for the member until receipt of written notification from WellCare that the transfer has occurred.
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					The Provider Training and Education Policy (SC22 HS-PR-001) states WellCare conducts ongoing training for providers to ensure compliance with program standards and other contractual obligations. Ongoing training is performed at a mutually agreed upon site by all parties involved. Methods of training include group orientations, seminars, one-on-ones, webinars, phone calls,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						emails, etc. Records of ongoing training are retained.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC22-HS-QI-009, Provider Clinical Practice Guidelines and Preventive Health Guidelines indicates WellCare develops and adopts Preventive Health Guidelines (PHGs) to improve member health by screening for acute and potentially chronic illnesses. The guidelines are reviewed at least annually and revised, as necessary. However, when checking the submitted PHGs submitted in the desk materials, all indicate they were retired in May 2020. This was discussed during the onsite teleconference and WellCare confirmed it has now adopted the Centene PHGs. A list of the Centene PHGs was included in the desk materials.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.		X				The Provider Manual, page 45, states, "Clinical Practice Guidelines, including preventive health guidelines, are on WellCare's website…" However, this link takes the user to WellCare-branded guidelines that have been retired, as noted in the standard above. *Quality Improvement Plan: Update the website*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to include the guidelines that have been adopted and are currently in use.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy SC22-HS-QI-009, Provider Clinical Practice Guidelines and Preventive Health Guidelines, indicates WellCare develops and adopts Clinical Practice Guidelines (CPGs) for both physical and behavioral health topics to provide staff and practitioners with procedures, resources, and tools to assist in member care. The CPGs are based on medical evidence, are relevant to the population served, and are reviewed annually. However, when checking the submitted preventive health guidelines, almost all indicate they were retired in May 2020. This was discussed during the onsite teleconference and WellCare confirmed it has now adopted the Centene CPGs. A list of the Centene CPGs was included in the desk materials.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.		X				The Provider Manual, page 45, states, "Clinical Practice Guidelines, including preventive health guidelines, are on WellCare's website…" However, this link takes the user to WellCare-branded guidelines that have been retired, as noted in the standard above. *Quality Improvement Plan: Update the website to include the guidelines that have been adopted and are currently in use.*
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy SC22-HS-UM-019, Care Coordination Continuity and Transition of Care Policy, states all members' healthcare should be directed and coordinated by or through the PCP, and that WellCare implements appropriate continuity of care and service efforts to ensure members receive the appropriate care and services to which they are entitled. According to Procedure SC22-HS-UM-019-PR-001, Care Coordination Continuity and Transition of Care Procedure, WellCare expects the PCP to act as the member's gatekeeper by coordinating services with WellCare, issuing referrals to specialists, and coordinating treatments, evaluations, and procedures with specialists and WellCare. WellCare provides continuity of care activities to ensure appropriate personnel, including the PCP, are kept informed of the member's needs, changes, progress or problems. WellCare monitors service delivery to identify and address barriers to primary and preventive care, through various avenues, including Care Coordination, medical record review, etc.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy SC22-HS-QI-005, Medical Record Review, describes standards for acceptable medical record documentation and the process for annual medical record review.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Policy SC22-HS-QI-005, Medical Record Review, lists the elements included in the review of practitioner medical records. The medical record documentation standards are also included in WellCare's Provider Manual.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					WellCare conducts an annual review of contracted practitioner medical records using criteria based on contractual requirements. The annual medical record review identifies medical record documentation areas that need improvement, allows for feedback to the practitioner, and may identify areas of practice that require peer review. Quality Improvement staff or a vendor conduct the review. A random sample of 200 records used in the most recent hybrid HEDIS season is selected for review and results are scored for each provider reviewed. Half of the records are for adult members and half are for pediatric members. WellCare requires network provider to maintain at least an 80% score. Results are provided to practitioners who score below 80%, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						additional records may be selected for review. If the score from the initial review and/or composite score from the initial and additional review sample are below 80% overall, a corrective action plan (CAP) is issued. Results of all reviews are considered during recredentialing and recontracting. For the 2019 adult medical records review, 100% of the providers passed, with an average final score of 97.9%. This represents an improvement of 0.9% over the 2018 score. For the 2019 child medical records review, 100% of the providers passed, with an average final score of 92.8%. This represents 3.2% decrease from 2018. Despite this noted decrease in scores for the 2019 child medical records review, pages 89 and 90 of the 2019 Medicaid Quality Improvement Program Evaluation state, "The 2019 Medical Record Review Audit reveals improvement in Provider scores." This was discussed during the onsite teleconference and WellCare responded that this was an oversight and will be corrected. *Recommendation: Ensure correct information about the results of the 2019 Medical Record*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Review Audit are include in the 2019 Medicaid Quality Improvement Program Evaluation.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					WellCare's Provider Manual informs practitioners of various QI Program activities, including monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS measures, medical record audits, etc. It informs practitioners that they are contractually required to comply with the QI Program. Specific information that member medical records must be accessible for review and audit as well as the record retention timeframe is also included. These requirements are specified in the WellCare Participating Provider Agreement.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Member rights and responsibilities are described in Policy SC22-OP-CS-023, Medicaid Customer Service Disclosure of Rights and Responsibilities. Instructions for accessing or obtaining a copy of member rights and responsibilities are published annually in member newsletters, posted on the website, and included in the Member Handbook.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in the Member Handbook, Provider Manual, and on the website according to requirements in *SCDHHS Contract, Section 3.16.*
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy SC22-MMO-002 Medicaid Post-Enrollment Member Materials Policy explains members will receive a Quick Start Guide within 5 days and ID Card within 15 days of WellCare receiving enrollee notification from the state. During the onsite teleconference, WellCare staff confirmed members receive a welcome packet that includes

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Quick Start Guide, Notice of Privacy Practice, Over-the-counter (OTC) Booklet, and the Healthy Rewards Booklet. Procedure SC22-OP-CS-009, Medicaid New Enrollee Welcome Calls, describes new enrollees receive calls from Eliza, a third-party vendor, who obtains and verifies enrollee information and obtains a health history utilizing a preapproved script. See specific comments for Standards 1.1 to 1.22.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						Copayments and limits of coverage are listed in the Member Handbook and a Co-pay Chart is accessible on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Emergency care, post-stabilization care and urgent care are correctly defined in the Member Handbook. Members are informed that in addition to their PCP, the Nurse Advice Line is available 24 hours a day, seven days a week. Information is also provided on the website.
1.7 Policies and procedures for accessing specialty care;						Policy SC22-OP-CS-012, Medicaid Referral and Authorization Guidelines describes the primary provider is responsible for referrals for specialty care and indicates members can self-refer for Communicable Disease Services, Family Planning, Vision Care Services, and Dental Services. During the onsite teleconference CCME discussed, except for family planning services, the Member Handbook and Provider Manual do not specify that Communicable Disease Services, Vision Care Services, and Dental Services can be obtained without a referral. *Recommendation: Update the Member Handbook and Provider Manual to reflect that Communicable Disease Services, Vision Care*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services, and Dental Services can be obtained without a referral.
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List (PDL) and find participating pharmacies or contact Customer Services to obtain this information. Members may get an emergency supply of medicine that will cover them for 72 hours while a prior authorization request is pending.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						WellCare notifies members in writing of significant changes to the program no later than 30 calendar days prior to implementation, as described in Policy SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy and noted in the Member Handbook. Updates to the PDL and the Member Handbook are found on the member website and are appropriately dated to indicate the effective dates of change.
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The Member Handbook and the website give instructions for managing PCP selections and scheduling appointments. Members can call Member Services for assistance or log into their secured online account.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedures for disenrolling from the MCO;						Disenrollment information and instructions provided in the Member Handbook meets SCDHHS Contract requirements.
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						A description of the Provider Directory is found in the Member Handbook along with instructions to access the Provider Directory on the website. Members can contact Member Services to obtain information about providers such as schooling, qualifications and languages spoken, and to request a Provider Directory.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						The Member Handbook has sample pictures of the WellCare/Healthy Connections ID Card and describes the importance for members to present it at time of service.
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						Adult members, 18 years and older, can obtain information for the three different types of Advance Directives from the Member Handbook, Member Services or their provider: living wills, healthcare surrogates, and anatomical donations. The Provider Manual explains that each adult member should receive information on living wills and Advance Directives.
1.21 Information on how to report suspected fraud or abuse;						Fraud and Abuse is correctly defined in the Member Handbook and the website. Instructions are provided for how members can anonymously report FWA to WellCare, SCDHHS and to South Carolina's Division of Program Integrity.
1.22 Additional information as required by the contract and/or federal regulation;						The Member Handbook Change Control Log is posted on the website and clearly indicates when updates were made.
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Policy SC22-MMO-002 Medicaid Post-Enrollment Member Materials Policy indicates WellCare will inform members of their right to request a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						printed copy of the Member Handbook and the Provider Directory. Additionally, this information is noted on the website.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					WellCare notifies members by mail of significant changes in benefits, 30 days prior to the effective date as described in Policy SC22-PD-002, Covered Service Policy and in the Member Handbook. Member Services will send written notice of provider terminations within 15 days after receiving notification, as indicated in Policy SC22-OP-EN-007, Member Notification of Specialist Termination.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy SC22-SM-004, Medicaid Written Marketing Review and Policy SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy, describes and outlines the processes WellCare uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. Additionally, materials include tag lines in large print explaining the availability of written translation or oral interpretation services if needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					Policy SC22-OP-CS-004, Twenty-Four Hour Coverage Policy, describes the process for 24-hour member access. The toll-free telephone number for Member Services and the 24-Hour Nurse Advice Line are located on the member's ID card, in the Member Handbook, and on the WellCare website. Additionally, this information is in education materials such as the member newsletter. The Member Services Call Center is staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of the normal business hours, the Interactive Voice Response system instructs callers to call 911 or go to the nearest emergency room for life-threatening emergencies. Callers are given the option to leave a message to which a response is provided the next business day. The TTY number for the Member Services Call Center and the 24-hour Behavioral Crisis Hotline are published in the Member Handbook.
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Policy SC22-OP-EN-003, Provider Auto Assignment, and Policy SC22-OP-CS-006, Change of Primary Care Physician describes the process for members to be assigned to a PCP. Members can select one PCP for all members of the family

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or choose different PCPs according to their needs. New members who have not selected a PCP by the 10th day of the month after enrollment will be contacted by a Customer Service Representative and assisted with selecting a PCP. WellCare will assign a PCP if the member has not selected one within the required timeframe.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC22-OP-EN-005, Disenrollment, defines the process for member -initiated disenrollment requests, and involuntary disenrollment initiated by WellCare or SCDHHS. WellCare must submit to SCDHHS detailed written requests for member disenrollment.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members can access the website or Member Handbook for information on preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services. Digital versions of the "Be Well" member newsletter are easily accessible on the website. The newsletters are easy to navigate and contain information on many health topics, covering risk factors and wellness promotion, which varies with each edition.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					WellCare ensures EPSDT services for members through the month of their 21st birthday as described in Policies SC22-HS-QI-002. They describe processes and methods for notification, tracking, and follow-up of the EPSDT program and addresses barriers of low utilization by creating interventions to encourage members to use the services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					The 2019 Quality Improvement Program Evaluation describes how WellCare uses outreach calls, text messaging, Community Outreach events, and the website to inform members about health risk factors and to encourage healthy behaviors. Discussions during the onsite-teleconference revealed community health events did not occur due to COVID-19 precautions and restrictions.
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					Policy SC22-HS-QI-022, Maternity Education & Reward Program and The Member Handbook informs members about the Maternity Education & Reward Program. Additionally, WellCare tracks timeliness of prenatal care through HEDIS monitoring of pregnant members. Pregnant members are identified through a variety of means such as welcome calls, eligibility files, prenatal risk assessments, self-referrals, health risk assessments, physician referrals, inter-departmental

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						referrals/coordination, and nurse advice line referrals.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					WellCare used an NCQA-certified vendor, SPH Analytics, to complete the CAHPS surveys for Adult, Child, and Child CCC. The Adult survey yielded a response rate of 15.8% with 524 valid surveys completed. This is a decrease from last year's response rate of 21.0%. For the Child survey, a response rate of 12.0% was yielded with 435 valid surveys completed, which is lower than the previous response rate of 12.6%. The response rate for the Child-CCC survey is 12.5% with 203 valid surveys completed. This is a decrease from last year's response rate of 15.9%. *Recommendations: Continue to implement and develop methods to increase awareness and importance of the survey to members and work with survey vendor for methods to improve response rates.*
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					SPH Analytics summarizes and details results from the Adult and Child Surveys, and WellCare analyzes the vendor's reports.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					WellCare's 2020 CAHPS Assessment gives evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The 2020 CAHPS Survey results were reported to providers via the SCAID 2020 Q4 Provider Newsletter.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The QIC was presented with the CAHPS 2020 results for Child, Adult, and the CCC surveys as noted in minutes from October 2020. Analysis of data is provided in CAHPS Assessment 2020.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC22-OP-CS-021, Medicaid Customer Service Intake of Member Grievances and Policy SC22-OP-GR-001, Medicaid Grievance Policy, describes WellCare's processes for receiving,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						processing, and responding to member requests for informal and formal complaints and grievances. Additionally, grievance information is provided in the Member Handbook, Provider Manual and on the website.
1.1 The definition of a grievance and who may file a grievance;	X					The definition of a grievance is correctly defined in Policy SC22-OP-GR-001, Medicaid Grievance Policy, the Member Handbook, and the Provider Manual. The documents appropriately indicate that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf.
1.2 Procedures for filing and handling a grievance;	X					Requirements for filing a grievance are documented in Policy SC22-OP-GR-001, Medicaid Grievance Policy, in the Member Handbook, in the Provider Manual, and on WellCare's website. WellCare provides instructions, including mailing address and phone numbers, for grievances to be filed either orally or written and will acknowledge the grievance in writing within five business days.
1.3 Timeliness guidelines for resolution of a grievance;	X					Policy SC22-OP-GR-001, Medicaid Grievance Policy, the Member Handbook, and the Provider Manual indicate grievances are resolved within 90 calendar days of receipt. Additional information is provided on the website, grievance acknowledgement letter and grievance extension letter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Requirements for maintaining the grievance log and retention timeframes are documented in Policy SC22-OP-GR-001, Medicaid Grievance Policy.
2. The MCO applies grievance policies and procedures as formulated.	X					Grievance files reflect timely acknowledgements, determinations, and notification. Grievance resolution notices contain appropriate language, includes all contractually required components and directly address member's concerns. Grievance staff conducted appropriate email follow-ups with other departments when checking on the grievance status.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC22-OP-GR-001, Medicaid Grievance Policy, indicates grievances are reported monthly, quarterly, and annually to the upper management team. During the onsite teleconference, grievance staff explained grievance data is reported quarterly and ad hoc if needed. Review of the Utilization Management Advisory Committee (UMAC) meeting minutes and presentation slides reflect grievance data is presented and discussed, and review of QIC minutes indicate approval of the corresponding UMAC meeting minutes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The 2020 Medicaid Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The 2020 Medicaid Quality Improvement Program Description is reviewed and updated at least annually.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Service utilization is included as part of the scope of work.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					WellCare's QI Work Plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 Work Plans included the planned activities, specific metrics, target dates for completions, responsible parties, and the goals. Some of the specific metrics were incorrect. The turn-around time for measuring the resolution of a retrospective appeal request was listed on the work plan as 60 days. Policy SC22-HS-AP 002, Member Appeal Policy and policy SC22-HS-AP001, Provider Appeal Process notes the turn-around time as 30 calendar days. The goals listed for the interrater reliability was 85%. However, the goal noted in Procedure SC22-HS-UM-007-PR001, Interrater Reliability Procedure lists the goals as 90%. *Recommendation: Correct the metric used to measure the turn-around time for a retrospective appeal and the interrater reliability goal in the QI work plan.*
IV B. Quality Improvement Committee						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The 2020 Medicaid Quality Improvement Program Description, page 24 and 25, clearly outlines the responsibilities of the QIC. The Utilization Management Advisory Committee oversees all clinical QI, UM, and behavioral health activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					QIC members include heath plan senior leaders and department directors. The Utilization Management Advisory Committee is chaired by the Chief Medical Officer. Voting members of the committee include practicing primary care practitioners and specialists.
3. The QI Committee meets at regular quarterly intervals.	X					The QIC and Utilization Management Advisory Committee meet at least quarterly. A review of the minutes shows both committees met at regular intervals. The required quorums were met for each meeting.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					The performance measure validation found that WellCare was fully compliant with all HEDIS measures. The HEDIS rates that showed a substantial increase included: Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Total, and Prenatal and Postpartum Care: Postpartum Care. The following HEDIS measure rates were determined to be areas of possible improvement for WellCare since these rates had a greater than 10% decline: •Adult BMI Assessment, •Medication Management for People with Asthma for 19-50 year-olds for 50% Medication Compliance, •Asthma medication ratio for all age ranges except 5-11 year-olds, •And Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics from 12-17 year-olds and Total. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Recommendation: Evaluate interim trends in rates that show a substantial decrease to determine if this is a trend or anomaly in rate decline. Assess barriers to improving HEDIS rates that have declined*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					WellCare submitted two projects for validation – Improving Dilated Retinal Exam (DRE) Screening and Access to Care.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Both PIPs received a score within the High Confidence Range and met the validation requirements. For the Access to Care PIP, incentives and education continue to have a slight impact on improving primary care visits. The rate for the Improving DRE Screening PIP was noted as unchanged from CY2018 to CY2019. According to WellCare, the project uses administrative rates, and the 2018 rate was reported for 2019 as allowed by NCQA. Details of the validation of the performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Per policy SC22-HS-QI-011, Quality Improvement Program and Provider Involvement, WellCare requires its providers to contractually agree to participate in quality improvement projects and medical record review activities.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, WellCare assesses the overall effectiveness of the QI Program. WellCare provide the 2019 Medicaid Quality Improvement Program Evaluation. This evaluation addressed all aspects of the QI Program.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management Program Description outlines the goals, scope, and staff roles for physical health, behavioral health, and pharmaceutical services for members in South Carolina. Policies, such as SC22 HS-UM-011, Application of Criteria are in place to guide staff on Utilization Management requirements and processes. See specific comments for Standards 1.1 to 1.7:
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness requirements are correctly documented in the Utilization Management Program Description, Procedure SC22-HS-UM-025-PR-001, Service Authorization Decisions, the Provider Manual, and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member Handbook. The 2019 QI Program Evaluation explains WellCare completed Standard prior authorization requests within 14 days more than 98% of the time. The service authorizations table on page 59 in the Provider Manual was edited to be consistent with the concurrent review timeframes in Policy SC22-HS-UM-023, Inpatient Concurrent Review as noted from the 2019 EQR.
1.5 consideration of new technology;	X					WellCare has established criteria and guidelines to determine medical necessity for procedures or technologies for both medical and behavioral health services.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Preferred Provider Program outlines the process and criteria for providers to be included in the program. WellCare has a Preferred Provider Workgroup that consists of select members from the leadership team who assess and monitor criteria for participation in the program.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The roles of the Utilization Management Medical Director and the Behavioral Health Medical Director are outlined in the 2020 Utilization Management Program Description. Responsibilities include, but not limited to Identifying and implementing evidence-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						based practice guidelines, timely medical advice, participating in plan committees, and conducting Level II reviews.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The Utilization Management Program is reviewed, evaluated and updated annually and presented to the Utilization Management Medical Advisory Committee and the Quality Improvement Committee (QIC) for approval. The committees include plan Medical Directors as well as community based participating physicians who are voting members. The 2019 Utilization Management Program Evaluation is incorporated within the overall 2019 Medicaid Quality Improvement Program Evaluation and was approved on June 8 and June 30, 2020 by the respective committees.
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy SC22-HS-UM-011, Application of Criteria and the Utilization Management Program Description list nationally recognized clinical support tools and evidence-based criteria used for determining medical necessity for physical health, behavioral health, durable medical equipment, and devices. Milliman Care Guidelines® (MCG) is WellCare's primary decision support tool. Additionally, Behavioral Health Utilization Management uses the American Society for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Addictions Medicine (ASAM) criteria. Individual circumstances and the local delivery system are considered when determining medical necessity.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Utilization Management approval files reflect reviewer staff apply approved criteria and processes, as described in Policy SC22-HS-UM-011, Application of Criteria and the Utilization Management Program Description to determine service authorization requests. files reflect use of appropriate criteria, consideration of individual member's needs, and requests to obtain additional information when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions, and the Provider Manual. Additionally, the criteria for obtaining this service is available in the Member Handbook. The required forms for hysterectomies, sterilizations, and abortions are available in the Provider Manual and on the provider section of the website.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy SC22-HS-UM-01, Application of Criteria describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. Files reflect reviewers use appropriate criteria, demonstrate consideration of individual member's needs, and obtain additional information when needed to render a determination.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy SC22-HS-UM-007-PR-001 Interrater Reliability Procedure and the Utilization Management Program Description describes WellCare's process for assessing consistency in applying clinical criteria. The Population Health Clinical Operations (PHCO) - Learning and Development team conducts IRR annually for Utilization Management and appeals clinical reviewers, for medical and Behavioral Health services areas. Associates must achieve a passing score of 90% or greater and remediation is provided for those not passing. Additionally, Policy SC22-RX-008, Quality Assurance in the Pharmacy Department, and Policy SC22-RX-019, DER Process Policy, describes that WellCare's Pharmacy Quality Assurance (QA) Team performs monthly QA Reviews for pharmacy coverage determinations using case reviews and IRR testing requiring a passing score of 90%. Discussions during the onsite teleconference revealed, after remediation for select few, all BH and medical review staff passed the 2019 IRR testing. High turnover in pharmacy staff contributed to the low IRR score of 62%. Pharmacy management staff explained interventions has been established to address it and improvements are noted. Policy SC22-HS-UM-007, Interrater Reliability, the corresponding Procedure, and Policy SC22-RX-019, Drug Evaluation Review (DER) Process Policy indicates

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the IRR benchmark is 90%. However, discrepancy in documentation is noted where the 2020 Utilization Management Program Description, 2020 QI Program Description and the 2019 Medicaid Quality Improvement Program Evaluation reflect the IRR benchmark is 85%. During the onsite teleconference, WellCare staff confirmed the passing score is 90% and the only change in the IRR process was utilizing MCG criteria instead of InterQual criteria. *Recommendation: Edit the benchmark IRR goal documented in the UM and QI Program Descriptions from 85% to 90% to be consistent with Policy SC22-HS-UM-007, Interrater Reliability, the corresponding Procedure, and Policy SC22-RX-019, Drug Evaluation Review (DER) Process Policy.*
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					WellCare provides the pharmacy benefit for its members. Pharmacy benefit processes and guidelines are correctly documented in policies such as, Policy SC22-RX-019, Drug Evaluation Review (DER) Process Policy, Policy C22-RX-011, Medicaid Preferred Drug List, and SC22-RX-015, Pharmacy Transition. WellCare honors existing prescriptions needing a Prior Authorization (PA) under the new plan's formulary for a period of no less than ninety (90) days. Policy SC22-RX-005, South Carolina - Pharmacy Lock-In Program, describes restrictions and requirements of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						program. Members and providers are encouraged to use approved medications from the PDL. CCME identified changes to the PDL are posted on the website at least 30 days prior to implementation, evidence from P&T meeting held on September 9, 2020 and changes effective on October 26, 2020. Standard and expedited pharmacy prior authorization requests are completed within twenty-four (24) hours as required *SCDHHS Contract, Section 4.2.21.3.1.* The Pharmacy and Therapeutics (P&T) Committee consists of physicians, pharmacists, and other health professionals selected from within and outside of the plan. The committee meets quarterly and reports to the Utilization Management Advisory Committee and is primarily responsible for approving pharmacy policies and criteria. Per the *SCDHHS MCO P&P Guide, Section 4.2.21*, medication for Hepatitis C (HCV) are carved out to fee-for-service effective July 1, 2015. Onsite discussions revealed Hepatitis C medications are carved back into health plan benefits effective July 2020. The 2020 Medicaid Quality Improvement Program Description describes Hepatitis C medication adherence is part of the Health Coaching Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					SC22-RX-003, South Carolina - Emergency Medication Overrides Policy indicates a 72-hour supply of medication will be approved while a prior authorization request is pending.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					SC22-HS-UM-028, Emergency and Post-Stabilization Services, the Provider Manual, and the Member Handbook addresses emergency medical services and post-stabilization services and requirements. WellCare covers emergency and post-stabilization services without prior authorization for medical and behavioral health conditions.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Licensed staff are trained to perform physical and behavioral health clinical reviews as described in the Utilization Management Program Description and policies such as SC22-HS-UM-025, Service Authorization Decisions and UM.008S, Clinical Criteria.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for UM approval files are consistent with the SC22-HS-UM-025-PR-001, Service Authorization Decisions Procedure, Policy SC22-RX-019, Drug Evaluation Review (DER) Process Policy, and SCDHHS Contract requirements.
11. Denials						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Denial files reflect attempts from the reviewer to obtain additional clinical information when needed to render a determination of medical necessity.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Adverse Benefit Determinations reflect decisions are made by an appropriate physician specialist as outlined in Policy UM.017S, Notice of Adverse Determinations. Reviewer specialty noted during the file review consisted of but not limited to Psychiatry, emergency medicine, family medicine, and pediatrics.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Policy SC22-HS-UM-025, Service Authorization Decisions Policy outlines the process for handling adverse benefit determinations. Review of denial files met timeliness requirements for acknowledgment and notifying the provider. The Adverse Benefit Determination notice to the member and provider includes contractually required information, such as specific information about the action taken, the member's right to file an appeal with the WellCare, and to request a State Fair Hearing.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC22-HS-AP-002, Member Appeals Policy outlines the appeals processes for medical and pharmacy services. Instructions are provided in the Provider Manual, Member Handbook, and the member tab on the website. Discussions during the onsite teleconference revealed Policy SC22-RX-012, Pharmacy Appeals has been retired and all pharmacy appeals processes are incorporated into Policy SC22-HS-AP-002, Member Appeals Policy.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definitions of an Adverse Benefit Determination and an appeal and who may file an appeal are described in Policy SC22-HS-AP-002, Member Appeals Policy, the Provider Manual, the Member Handbook and the website. These documents appropriately indicate that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf. However, the term Authorized Representative is not clearly defined in the Member Handbook or on the website, and members may not fully understand their options for selecting someone to represent them if needed. Page 96 in the Provider Manual has the complete requirements of the term Adverse Benefit Determination however, the definition on page 125 in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Definitions and Abbreviations section, omitted the following two SCDHHS Contract requirements: •the denial for a resident of a rural area with only one MCO to obtain services outside the network. •the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. *Recommendation: To assist members in understanding their options for selecting a representative, include a definition or description for the term Authorized Representative in the Member Handbook and on the website. Edit the Definitions and Abbreviations section of the Provider Manual to include the complete definition of the term Adverse Benefit Determination as noted in SC DHHS Contract Section Appendix A (A.1)*
1.2 The procedure for filing an appeal;		X				Requirements for filing a medical and pharmacy appeal are documented in Policy SC22-HS-AP-002, Member Appeals Policy, the Provider Manual, and on WellCare's website. Additionally, instructions are included with the respective Adverse Benefit Determination notice and appeal acknowledgement letters. CCME identified the following documentation issues with appeals: •The pharmacy denial letter template, "SMD PA denial_pharmacy", incorrectly notes the member has

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						30 days to request an appeal, instead of 60 days as required by *SCDHHS Contract, Section 9.1.1.2.2.* •SC22-HS-AP-002, Member Appeals Policy states, "Written confirmation of all oral requests must be received by the Plan within the 30 calendar days for the resolution of the appeal or the appeal may be denied by the Plan." However, the pharmacy denial letter template, "SMD PA denial_pharmacy", and the pharmacy acknowledgement letter template, "Pharmacy Appeals Acknowledgement", indicates response is required within 10 calendars. *Quality Improvement Plan: Edit the denial letter template, "SMD PA denial_pharmacy", to reflect that a member has 60 days to request an appeal as required by SCDHHS Contract, Section 9.1.1.2.2. Edit the denial letter template, "SMD PA denial_pharmacy" and acknowledgement letter template, "Pharmacy Appeals Acknowledgement", to indicate written confirmation of all oral requests must be received within the 30 calendar days from the Adverse Benefit Determination letter.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
not previously reviewed the case;						
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Standard appeals for medical, BH and pharmaceutical services are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt a noted in Policy SC22-HS-AP-002, Member Appeals Policy, Timeframe requirements for resolution and notification are correctly documented.
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy SC22-HS-AP-002 Member Appeals Policy, and appeal letter templates, such as Pharmacy Appeal Denial and SC_Mbr_DenialMN_ Committee_040319, addresses all requirements for appeal resolution notices as required in *SCDHHS Contract, Section. 9.1.6.2.2 to 9.1.6.3.1.3.*
1.7 Other requirements as specified in the contract.	X					Requirements for continuation of benefits are documented in Policy SC22-HS-AP-002 Member Appeals Policy, the Provider Manual, the Member Handbook and letter templates. CCME identified the timely filing requirement for continuation of benefits in the Member Handbook and on the WellCare website have been corrected from the 2019 QIP.
2. The MCO applies the appeal policies and procedures as formulated.	X					Determinations were issued by appropriate reviewers, and acknowledgments and resolutions were completed timely.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC22-HS-AP-002, Member Appeals Policy, explains all member appeals are reported monthly, quarterly, and annually to the upper management team. During the onsite teleconference, staff explained appeals data is reported quarterly and ad hoc if needed. Review of Utilization Management Advisory Committee meeting minutes and presentation slides reflect appeals data is presented and discussed, however; review of QIC minutes indicate approval of the corresponding UMAC meeting minutes only. As recommended from the 2019 EQR Policy SC22-HS-AP-002, Member Appeals Policy specifies the committees to which appeals data is reported. Policy SC22-RX-012, Pharmacy Appeals has been retired and the recommendation does not apply.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					WellCare's Case Management and Care Coordination Programs are described in Policy SC22-HS-CM-001, Care Management Program Description Process and the 2020 Care Management Program Description. The Disease Management (DM) Program is incorporated within the Care Management Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from case management.	X					The Care Management Program Description describe methods for identifying and referring eligible members into case management. In addition to such avenues as claims data, laboratory and health risk assessment results, and internal and external referrals, at-risk members are identified through population assessment and analysis. WellCare utilizes LACE, proprietary algorithm that runs daily to capture risk based on length of stay, acuity, co-morbidities, and ER usage, as stated in the 2019 QI Program Evaluation.
3. The MCO provides care management activities based on the member's risk stratification.	X					WellCare uses a proprietary ID Strat model to identify and stratify members for management. to stratify identified members into low, moderate, or high-risk categories and approach to member engagement is based on the risk category. WellCare's approach to member engagement, based on the member's risk level, as outlined in the Care Management Program Description and the 2020 Medicaid Quality Improvement Program Description.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Policy SC22-HS-CM-017, Care Management Transition to Other Care Process states, "The appropriate personnel, the Sr. Manager of CM, will serve as the Transition Coordinator." At the virtual onsite WellCare confirmed Kate Buchta, VP Medical Management serves as the Transition Coordinator.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The Care Management Program is evaluated at least annually, key performance metrics are monitored and evaluated for effectiveness and reported UMAC and QIC. SPH Analytics (SPH) was selected by WellCare to conduct its 2019 Care Management Satisfaction Survey. The Care Management member satisfaction survey goal of 95% was met.
7. Care management and coordination activities are conducted as required.	X					Case Management files indicate care management activities are conducted as required and Care Managers follow policies to conduct the appropriate level of service. HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed. Unable to contact (UTC) letters and education materials are appropriately utilized. Staff demonstrate consistent continuity of care by

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						faxing updated care plans to the PCP or specialist. Care Needs Assessment (CNA) were completed timely. Referral information and Acuity Levels are consistently noted. There was evidence of care coordination and continuity of care, such as mailing education materials, assisting with scheduling appointments and transportation, sending both the member and provider copies of the agreed upon care plan.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					WellCare analyzed and monitored data and offered recommendations in committee meetings and in the program evaluation based on findings for several services about utilization.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					WellCare delegates several functions to other entities. For this EQR, WellCare delegates the following services through 32 delegate agreements: •Utilization Management •Case Management •Credentialing •Nurse Advice Line •Crisis Hotline •Pharmacy Services •Member and Provider Customer Services •Vision Services
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				WellCare's Policy SC22-CP-AO-007, Delegation Oversight and Procedure SC22-CP-AO-007-PR-001, Delegation Oversight Procedure define the process followed for pre-delegation, annual oversight, and ongoing monitoring of delegated functions. WellCare submitted the pre delegation monitoring and annual delegation monitoring for most of the delegates. There were several delegates where the annual monitoring was underway. WellCare indicated

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						they expected to have the monitoring completed by December 31, 2020. The following issues were identified with the monitoring: •WellCare listed CVS as a delegate for several functions including credentialing. However, the annual monitoring did not include a file review. •The audit tool used for the credentialing/recredentialing file review did not include checking the SCDHHS List of Providers Terminated for Cause for the following delegates: Greenville Hospital System OptumHealth Care Solutions Linka United Physicians •March Vision - The audit tool did include the check of the SCDHHS List of Providers Terminated for Cause, however; that section of the tool was marked as N/A for all the files. *Quality Improvement Plan: Conduct a file review for all credentialing delegates. Update the audit tools used for the monitoring of the credentialing and recredentialing files to include checking the SCDHHS List of Providers Terminated for Cause. Provide additional training for delegation auditors regarding the requirements for checking the SCDHHS List of Providers Terminated for Cause.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					WellCare ensures pediatric and adolescent immunization requirements are monitored as described in Policy SC22-HS-QI-012, Early Periodic Screening Diagnosis and Treatment. Additionally, vaccine codes are conveniently listed in the Provider Manual. The 2019 Quality Improvement Program Evaluation details how child and adolescent immunizations are tracked, monitored, and evaluated for improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					Provider compliance with rendering EPSDT services is monitored via medical record reviews as noted in Policy SC22-HS-QI-005, Medical Record Review. In addition to Policy SC22-HS-QI-012, Early Periodic Screening Diagnosis and Treatment, the EPSDT Tool Kit, list several methods used to inform and remind providers of impending or missed EPSDT services.
2. Core benefits provided by the MCO include all those specified by the contract.	X					WellCare ensures all contractually required benefits are provided.
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					Following the 2019 EQR, WellCare submitted a Quality Improvement Plan to address any deficiencies identified. During the current EQR, CCME assessed the degree to which the health plan implemented the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						actions to address those identified deficiencies. All identified deficiencies were appropriately addressed.