CCME

2019 External Quality Review

WELLCARE OF SOUTH CAROLINA

Submitted: January 16, 2020

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 2019 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 WellCare of South Carolina (WellCare) demonstrated since the 2018 annual EQR.

Review goals include the following:

- Determine if WellCare is following service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies found during the 2018 annual EQR and any ongoing quality improvements made to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate that contracted health care services are being delivered and of good quality

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

Overall Findings

The 2019 annual EQR shows that WellCare has achieved "Met" scores for 93% of the standards reviewed. As the following chart shows, 5% of the standards were scored as "Partially Met" and 2% of the standards were scored as "Not Met." The chart that follows provides a comparison of WellCare's current review results to the 2018 EQR results.

Figure 1: Annual EQR Comparative Results

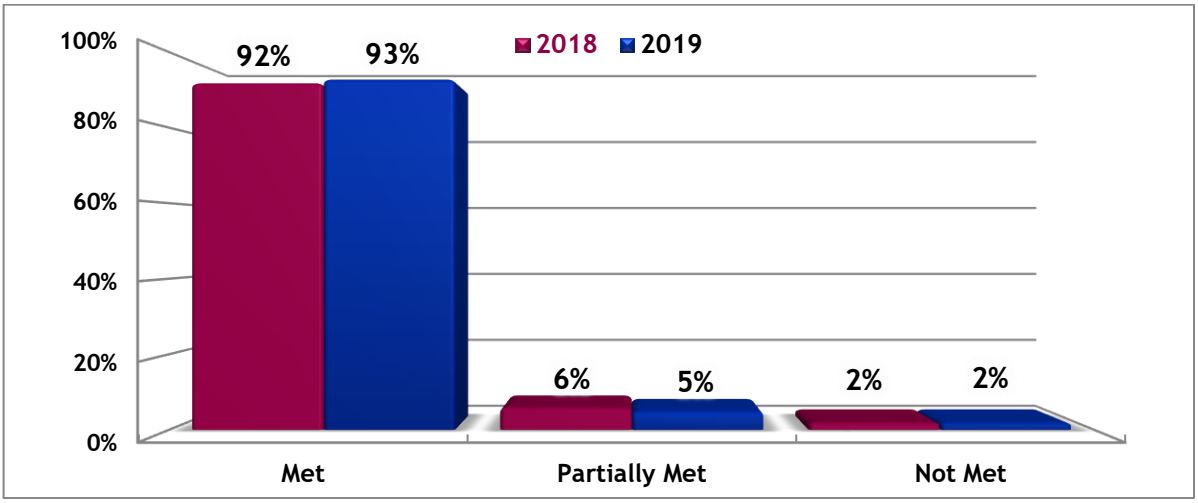


Table 1: Scoring Overview, provides a snapshot of the findings of the current annual review compared to the findings of the 2018 EQR.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2018	38	2	0	0	0	40
2019	40	0	0	0	0	40
Provider Services						
2018	70	4	4	0	0	78
2019	73	2	3	0	0	78
Member Services						
2018	29	4	0	0	0	33
2019	29	4	0	0	0	33
Quality Improvement						
2018	15	0	0	0	0	15
2019	14	0	0	0	0	14
Utilization						
2018	43	2	0	0	0	45

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
2019	40	5	0	0	0	45
Delegation						
2018	1	1	0	0	0	2
2019	1	1	0	0	0	2
State Mandated Services						
2018	3	0	1	0	0	4
2019	3	0	1	0	0	4

Administration:

WellCare is a subsidiary of WellCare Health Plans, Inc. The corporate offices are in Tampa, Florida. All contractually required positions are filled. One Clinical HEDIS Practice Advisor position is vacant, and WellCare is actively working to fill this position.

WellCare's processes for policy maintenance and annual review and revision are suitable. Policies are organized by department or functional area within the organization. Each policy's business owner is responsible for reviewing and revising the policy. Policy revisions are reviewed by Regulatory Affairs staff and ultimately approved by Corporate Compliance staff. Health plan staff are informed of new policies and policy revisions via email communication. Staff can access policies via a local intranet site.

WellCare places a priority on data security and systems availability. The health plan demonstrates a focus on Health Insurance Portability and Accountability Act compliance and protecting information with best practice access controls. Disaster recovery efforts included testing of actual recovery routines rather than desktop simulations.

The *WellCare Corporate Compliance Program* (Compliance Plan), *Code of Conduct and Business Ethics* (Code of Conduct), policies, procedures, and other documentation define WellCare's expectations and processes to ensure compliance with laws and regulations and to guard against fraud, waste, and abuse. Compliance training is required at the time of hire and annually for all associates, officers, and directors. WellCare provides, or monitors the online completion of, compliance training to agents, contractors, and first tier, downstream, and related entities. WellCare staff can use an established Compliance Hotline and web portal to report compliance program violations. The web portal is hosted by an independent third-party vendor to ensure anonymity for those reporting violations.

The Pharmacy Lock-In Program Policy (SC22-RX-005) describes requirements and processes for the contractually required statewide Pharmacy Lock-In Program. CCME recommends revising this policy to include processes for the provider lock-in component of the program which was implemented in July 2019.

Provider Services:

WellCare's Credentialing Committee is the clinical peer review committee that oversees credentialing and recredentialing activity. This committee has final authority to approve or disapprove provider applications and delegated authority to the Medical Director to approve clean files. The Credentialing Committee is also the peer review committee for potential quality-of-care issues. The Senior Medical Director chairs the Credentialing Committee. Other voting members include four network providers whose specialties include cardiology, hematology/oncology, family medicine, pediatrics, and a licensed clinical social worker. The committee meets at least once per month, not less than nine times per year, and records minutes for each meeting. A review of a sample of meeting minutes shows the committee met monthly and that a quorum of voting members was present for each meeting.

CCME reviewed a sample of credentialing and recredentialing files and found that none of the of the credentialing or recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried as required by the *SCDHHS Contract, Section 11.2.10*. CCME identified this issue during the 2018 EQR and the corrections were not made. There were other issues noted with Clinical Laboratory Improvement Amendment (CLIA) and Ownership Disclosure forms.

WellCare defines standards for geographic distribution of providers and provider access and availability expectations in policy. WellCare meets its established goals for access to primary care providers (PCPs); however, access requirements for Status 1 Specialists were not met for neurology (nine counties), pulmonary medicine (three counties), and urology (two counties). WellCare continues its attempts to recruit providers in these categories and has developed relationships with non-participating providers to provide services to WellCare members on an as-needed basis.

WellCare's *Cultural Competency Program and Plan 2019-2020* describes actions to ensure services and materials are provided in a culturally competent way to members, including those with limited English proficiency. The written plan is maintained on WellCare's website. The *2019 South Carolina Medicaid Provider Manual* (Provider Manual) includes a detailed description of the Cultural Competency Program, including information about oral and written translation services and technology which can be coordinated through the Member Services Department. WellCare staff are educated about cultural

competency and sensitivity through the Compliance Training Program at the time of hire and annually.

As part of the annual EQR process for WellCare, CCME conducted a Telephonic Provider Access Study that focused on PCPs. WellCare provided CCME with a list of current providers. From this list, CCME identified a population of 2,312 unique PCPs. CCME then randomly selected a sample of 240 providers from this population for the study. CCME attempted to contact these providers to ask a series of questions about access members have to the providers.

Calls were successfully answered 80% of the time (158 of 197) when omitting calls answered by personal or general voicemail messaging services (see *Table 2: Telephonic Provider Access Study Answer Rate Comparison*).

Table 2: Telephonic Provider Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2018 Review	286	68%	<.001
2019 Review	240	80%	

When compared to last year's results of 68%, this year's study had a statistically significant increase in successful calls (p=<.001).

Member Services:

WellCare's policies and procedures define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New enrollees receive a *Quick Start Guide* with instructions to access or request a *South Carolina Member Handbook* (Member Handbook) and the *Provider Directory*. However, there is no documentation that members are notified of their right to request a copy of the *Provider Directory* annually. All members have access to information and resources that can help them understand and use their benefits via the Member Handbook, Provider Manual, on the website, and in member newsletters. Onsite discussions revealed WellCare used 12-point font in regular print and 18-point font in large print member materials. However, documentation of this is missing. The health plan provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

WellCare continues to use a third-party vendor to conduct annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The 2019 survey response rates are still less than the National Committee for Quality Assurance's target response rate of 40%. CCME provided recommendations for these issues.

WellCare's processes for receiving, reviewing, and resolving grievances are documented in policy, the Member Handbook, Provider Manual, and on its website. Documentation issues included outdated terminology and lack of documentation that members have a right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe. Findings of CCME's review of 20 grievance files included untimely acknowledgement letters and one inappropriate resolution to a grievance about the member being billed for physician fees for an emergency room visit. WellCare took no further action to prevent the member from being billed for the emergency services.

WellCare tracks, trends, and analyzes grievance data to identify outstanding issues and adverse trends. Grievance data is routinely reported to health plan management, the Customer Service Quality Improvement Workgroup, Utilization Medical Advisory Committee (UMAC), and QI Committee.

Quality Improvement:

WellCare's Quality Improvement (QI) Program operates under a plan of continuous improvement. The *2019 Medicaid Quality Improvement Program Description* (QI Program Description) describes the program's structure, accountabilities, scope, goals, and available resources. WellCare reviews and updates the program description at least annually.

The primary committee responsible for QI activities is the Quality Improvement Committee (QIC). Key QIC responsibilities are discussed in the QI Program Description. The UMAC oversees all clinical QI, utilization management, and behavioral health activities. QIC members include heath plan senior leaders and department directors. Practicing network providers specializing in oncology, cardiology, family medicine, behavioral medicine, and pediatrics are included on the UMAC. Attendance for some UMAC network providers was poor. Four of the nine providers did not attend any meetings or only attended one meeting.

WellCare evaluated the QI Program and summarized the results of the evaluation in the *2018 Medicaid Quality Improvement Program Evaluation*. Most of the program's objectives were met. WellCare analyzed areas not meeting the goals and developed interventions to improve performance.

Performance Measures and Performance Improvement Projects

The performance measures and performance improvement projects met the CMS validation requirements. *Table 3: HEDIS Measures with Substantial Changes in Rates* highlights the Healthcare Effectiveness Data Information Set (HEDIS®) measures with substantial increases or decreases in rate from 2016 to 2017. The comparison from the previous to the current year revealed a strong increase (>10%) in a few rates, including Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy - 21-75 years (Male), Comprehensive Diabetes Care, specifically the Eye Exam (Retinal), and Metabolic Monitoring for Children ages 6 to 11 years old. A previously initiated performance improvement project to address improving retinal eye exams likely impacted the rate. The measure that decreased substantially (>10%) was Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase. The rate decreased just over 13%.

Table 3: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2017	Measure Year 2018	Change from 2017 to 2018
Substantial Increase in Rate (>10% improvement)			
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	68.29%	79.77%	11.48%
Comprehensive Diabetes Care (cdc)			
Eye Exam (Retinal) Performed	41.36%	52.62%	11.26%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
6-11 Years	6.78%	30.00%	23.22%
Substantial Decrease in Rate (>10% decrease)			
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	49.86%	36.58%	-13.28%

WellCare provided a three-year trend of HEDIS rates in the *2018 Medicaid Quality Improvement Program Evaluation*. Many of the rates met or exceeded the 25th percentile goal over the three-year trend. CCME recommends moving the goal rate to the 50th percentile for those that have met the 25th percentile for several years.

Quality Withhold Measures

WellCare reported 12 quality clinical withhold measures for 2018. The Behavioral Health measures are considered Bonus Only for MY 2018 (RY 2019). As per the *Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the 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 the individual measure's weight, which is then summed to obtain the quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 4: Quality Withhold Measures*. The Women's Health measure rates generated the highest index score, followed by Diabetes and Pediatric Preventive Care. The Behavioral Health Index Score was not provided.

Table 4: Quality Withhold Measures

Measure	2018 Rate	2018 Percentile	Point Value	Index Score
Diabetes				
Hemoglobin A1c (HbA1c) Testing	85.00%	25	3.00	3.60
HbA1c Control (>9)	51.83%	25	3.00	
Eye Exam (Retinal) Performed	50.83%	25	3.00	
Medical Attention for Nephropathy	94.00%	90	6.00	
Women's Health				
Timeliness of Prenatal Care	93.03%	90	6.00	4.10
Breast Cancer Screen	54.42%	25	3.00	
Cervical Cancer Screen	59.04%	25	3.00	
Chlamydia Screen in Women (Total)	57.43%	50	4.00	
Pediatric Preventive Care				
6+ Well-Child Visits in First 15 months of Life	66.00%	25	3.00	2.40
Well Child Visits in 3rd,4th,5th&6th Years of Life	59.50%	<10	1.00	
Adolescent Well-Care Visits	54.00%	25	3.00	

Measure	2018 Rate	2018 Percentile	Point Value	Index Score
Weight Assessment/Adolescents: BMI % Total	87.39%	75	5.00	
Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication- Initiation Phase	26.84%	10	2.0	Not Reported
Antidepressant Medication Management- Continuation Phase Treatment	51.02%	50	4.0	
Metabolic Monitoring for Children and Adolescents on Antipsychotics-Total	21.58%	<10	1.0	
Initiation and Engagement of AOD Abuse or Dependence Treatment-Initiation Total	45.00%	50	4.0	

WellCare submitted three projects, including Improving Dilated Retinal Exam Screening, Access to Care, and Improving Hemoglobin A1C Testing. The Dilated Retinal Exam Screening performance improvement project (PIP) has a rate improvement from the baseline over 10% and the Improving Hemoglobin A1C has sustained a rate above the goal rate. The Access to Care PIP improved only slightly. The incentives and education appear to be having a small impact.

All PIPs received a score within the "High Confidence" range. *Table 5: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 5: Performance Improvement Project Validation Scores

Project	2018 Validation Score	2019 Validation Score
Improving Dilated Retinal Exam (DRE) Screening	78/78=100% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Access to Care	84/85=99% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Improving Hemoglobin A1C Testing	90/91=99% High Confidence in Reported Results	96/96=100% High Confidence in Reported Results

Some of WellCare's Quality Management reports showed trends such as increased inpatient admissions for asthma, coronary artery disease, congestive heart failure (CHF),

chronic obstructive pulmonary disease (COPD), diabetes and hypertension (HTN). Emergency Room (ER) visits decreased for asthma; but increased for CHF, COPD, diabetes and HTN. Thirty-day readmissions increased for CHF and COPD. CCME recommends that future PIP topic selections focus on reducing admissions, readmissions, and ER visits for these specific diseases.

Utilization Management:

CCME's assessment of utilization management (UM) includes reviews of program descriptions and evaluations, policies, the Member Handbook, the Provider Manual, and approval, denial, appeal, and care management files, and WellCare's website.

The *Utilization Management Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Qualified reviewers evaluate medical necessity of service authorization requests using Milliman Care Guidelines and InterQual Criteria or other established criteria.

The *Care Management Program Description* and policies correctly document care management processes and services provided. Care management files show that WellCare detects and consistently addresses care gaps and provides services for various risk levels.

WellCare policy documents processes and requirements for receiving, reviewing, and resolving member appeals. Issues with documentation include an outdated reference to a form, omitted or incorrect timeframes, missing documentation of member rights related to appeal processes, incomplete information about appeal resolution notice contents and requirements for mailing appeal resolution notices, and incorrect information about continuation of benefits.

Appeal file review findings include untimely appeal acknowledgement and resolution, failure to notify the member of the denial of an expedited appeal review, and an appropriate appeal resolution.

WellCare monitors appeals data to detect opportunities for improvement and reports appeal data to appropriate committees.

Delegation:

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

WellCare performed annual delegation monitoring for all entities that handle credentialing and recredentialing. 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 submitted documentation of annual oversight of non-credentialing delegates. The documentation showed WellCare tracks metrics specific to the delegated services. Desk material documentation did not include monthly monitoring of delegates that provide call center functions (Teleperformance, The Results Companies). However, during the onsite visit WellCare staff stated it holds bi-weekly monitoring calls with the call center delegates. WellCare staff also provided documentation (monthly dashboards) they use for ongoing monitoring.

State Mandated Services:

Provider compliance with provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through Medical Record Reviews conducted by nurse reviewers. WellCare provides all core benefits specified by the *SCDHHS Contract*.

An issue identified in the previous EQR, related to the contractual requirement to query the SCDHHS List of Providers Terminated for Cause when credentialing or recredentialing a provider, has not been corrected.

METHODOLOGY

CCME's process was based on CMS-developed protocols for the EQR of a Medicaid MCO/Prepaid Inpatient Health Plan and focused on the three federally mandated EQR activities: compliance determination, validation of performance measures, and validation of performance improvement projects.

On October 21, 2019, CCME notified 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 about 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 4, 2019 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 an examination of credentialing, recredentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on December 17th and 18th at WellCare's office in Columbia, SC. 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's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized in the following subsections and are based on the regulations found in title 42 of *CFR*, part 438, and the Contract requirements between WellCare and SCDHHS. CCME notes strengths, weaknesses, and provides recommendations where applicable. CCME classified areas of review as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," which are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

The Administration review of WellCare focuses on policies and procedures, staffing, information systems, program integrity, compliance, and confidentiality.

WellCare is a subsidiary of WellCare Health Plans, Inc. The corporate offices are in Tampa, Florida. Urcel Fields is the health plan President and Bill Yurkowski is the Market Vice President. CCME's review of the Organizational Chart along with onsite discussion confirmed all required positions are filled. One Clinical HEDIS Practice Advisor position is vacant, and WellCare is actively working to fill this position.

Policies are organized by department or functional area within the organization. Each policy is assigned a business owner, responsible for annual policy review and revision. Regulatory Affairs staff review new and revised policies, and Corporate Compliance staff give final approvals. Staff are informed of new policies and policy revisions via a monthly email notification and can access policies through an intranet site linked to Compliance 360, a platform used for policy maintenance.

CCME's review of WellCare's Information Systems Capabilities Assessment (ISCA) documentation shows that data security and systems availability are important WellCare priorities. WellCare's policies demonstrate a focus on Health Insurance Portability and Accountability Act (HIPAA) compliance and protecting information with best practice access controls. WellCare's disaster recovery efforts are commendable since actual recovery routines were tested, rather than desktop simulations.

The *WellCare Corporate Compliance Program* (Compliance Plan) and *Code of Conduct and Business Ethics* (Code of Conduct), along with policies, procedures, and other documentation, define WellCare's expectations for compliance with laws and regulations, processes for guarding against fraud, waste, and abuse, and employee conduct. The Code of Conduct applies to all employees and members of corporate and subsidiary Boards of Directors. In addition to the Code of Conduct, the *WellCare Associate Handbook* provides more detail about business ethics and expectations for proper business conduct. Compliance training is required at the time of hire and annually for all associates, officers, and directors. WellCare also provides Compliance training to agents, contractors, and first tier, downstream, and related entities. WellCare maintains a Compliance Hotline and web portal that allow around-the-clock reporting of Compliance Program violations. The web portal is hosted by an independent third-party vendor, ensuring anonymity for those reporting violations.

The Pharmacy Lock-In Program Policy (SC22-RX-005) describes requirements and processes for the contractually required statewide Pharmacy Lock-In Program. CCME recommends revising this policy to include processes for the provider lock-in component of the program which was implemented in July 2019.

As illustrated in *Figure 2: Administration Findings*, WellCare achieved "Met" scores for 100% of the Administration standards.

Figure 2: Administration Findings

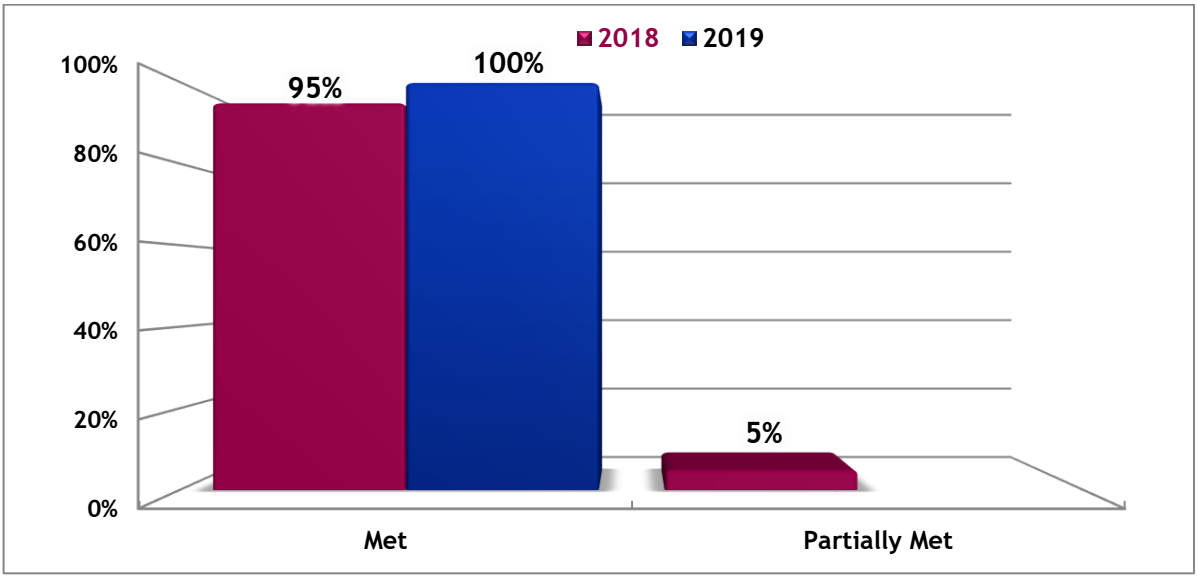


Table 6: Administration Comparative Data

Section	Standard	2018 Review	2019 Review
Compliance/ Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including: Exclusion status monitoring	Partially Met	Met
	The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- WellCare is a member of the Healthcare Fraud Prevention Partnership, which advances the detection and prevention of health care fraud, waste, and abuse by sharing data across the industry, between public and private sectors. The partnership also promotes collaboration on anti-fraud methodologies.
- WellCare's data security policies are aligned with best practices. Information security policies address HIPAA, protected health information, acceptable system use, and risk management. Access to systems and data requires successful authentication to the Microsoft Active Directory. A recent security assessment did not find any critical vulnerabilities.

- WellCare's disaster recovery efforts are commendable since there were actual recovery routines tested, rather than desktop simulations.

Weaknesses

- The *Market Compliance Oversight Committee Charter* states a simple majority of the entire committee constitutes a quorum. It is unclear whether establishment of a quorum is based on both voting members and ad hoc members or on voting members only. Onsite discussion confirmed the established quorum is 50% of the voting members of the committee.
- The Pharmacy Lock-In Program Policy (SC22-RX-005) notes that members can be locked-in to a specific provider but does not explain this process. Designed to increase care coordination, this process was implemented in July 2019.
- The version of Policy SC22-RX-005 found in the Compliance Plan, *Appendix D18* is outdated. It contains track changes and was most recently approved in 2017.
- Policy C13-CP-006, Corporate Compliance Training Policy states staff must complete designated Compliance training within 30 days of becoming a member of the workforce, unless a different due date is identified. However, onsite discussion confirmed new employees receive confidentiality and HIPAA training on the first day of employment.

Recommendations

- Clarify the *Market Compliance Oversight Committee Charter* to show a simple majority of voting members constitutes a quorum.
- Revise the Pharmacy Lock-In Program Policy (SC22-RX-005) to explain the processes and requirements for restricting members in the Pharmacy Lock-in Program to a specific provider.
- Revise the Compliance Plan, *Appendix D18* to include the current version of Policy SC22-RX-005.
- Revise Policy C13-CP-006, Corporate Compliance Training Policy to include a statement that new staff receive training on confidentiality on the first day of employment.

B. Provider Services

The Provider Services review includes credentialing and recredentialing, network adequacy, accessibility, provider education, clinical practice guidelines, and continuity of care.

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 practitioners and organizational providers are credentialed and recredentialed. Policy SC22 OP-CR-001, Credentialing and Re-credentialing provided with the desk materials did not address whether WellCare is performing federal and state database checks for persons identified on Ownership Disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2*. CCME identified this issue during the 2018 EQR. WellCare addressed this issue in their Quality Improvement Plan; however, the changes to the policy were not implemented. When discussed during the onsite, CCME learned that the wrong policy was uploaded. WellCare provided the corrected policy that included the changes.

Also, Policy SC22-OP-CR-024, Medicaid Eligibility Federal and State Sanctions and Opt Out details various queries required at credentialing and recredentialing. However, it omits querying the Social Security Death Master File as required by *SCDHHS Contract, Section 11.2.10* and *Managed Care Organizations Policy and Procedure Guide, Section 11.2*. CCME also identified this issue during the 2018 EQR. WellCare addressed this issue in their Quality Improvement Plan; however, the changes to the policy were not implemented. During the onsite WellCare discovered CCME was given the wrong policy. A red-line version was provided that included the query of the Social Security Death Master File.

Policy SC22-OP-CR-009, Assessment of Organizational Providers, includes obtaining the ownership disclosure information. However, this policy omits performing federal and state database checks for persons identified on Ownership Disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2*.

WellCare's Credentialing Committee is the clinical peer review committee that oversees credentialing and recredentialing. This committee has final authority to approve or disapprove provider applications. The committee has delegated the authority to approve clean files to the Medical Director. In addition to its credentialing functions, the Credentialing Committee is the peer review committee for potential quality of care issues. The Senior Medical Director chairs the Credentialing Committee. Other voting members include four network providers whose specialties include cardiology, hematology/oncology, family medicine, pediatrics, and a licensed clinical social worker. The committee meets at least monthly, or not less than nine times per year. Minutes are recorded for each meeting. A review of a sample of meeting minutes showed the committee met monthly, and a quorum of voting members was present for each meeting.

CCME reviewed a sample of credentialing and recredentialing files, and found the following issues:

- None of the credentialing or recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried as required by the *SCDHHS Contract, 11.2.10*. CCME identified this issue during the 2018 EQR.
- Three credentialing files did not address the Clinical Laboratory Improvement Amendment (CLIA). The applications used for credentialing did not address if laboratory services would be provided at the practice location nor was the provider queried about laboratory services.
- Six recredentialing files contained the WellCare Ownership Disclosure form instead of the required SCDHHS 1514 form.
- Three credentialing files and three recredentialing files contained old or outdated Ownership Disclosure forms.
- One nurse practitioner recredentialing file contained an outdated collaborative agreement. The agreement was dated 2/9/16 and the recredentialing file was approved on 4/10/19. Also, the supervising physicians that signed the agreement in 2016 were not this practitioner's current supervising physicians.
- One recredentialing file did not contain a copy of the facility's Department of Health and Environmental Control (DHEC) License.

WellCare defines standards for geographic distribution of providers and provider access and availability expectations in policy. WellCare's provider geographic distribution goals follow contractual requirements. The *2018 Medicaid Quality Improvement Program Evaluation* showed WellCare meets its established goals for access to primary care providers (PCPs). However, the program evaluation and additional documentation showed access requirements for Status 1 Specialists were not met for the following:

- Neurology (nine counties)
- Pulmonary Medicine (three counties)
- Urology (two counties)

WellCare continues its attempts to recruit providers in these categories and has established relationships with non-participating providers to provide services to WellCare members as needed. WellCare reported that a barrier to recruiting providers into WellCare's network is that the providers in these rural areas are at maximum capacity for their member panels.

WellCare has contracted with a vendor to conduct Appointment Accessibility and After-Hours telephone surveys. WellCare reviews and validates the results received from the vendor to monitor timeliness of access to care for network providers. The 2018 survey results revealed appointment access standards were not met for several categories. Actions taken by WellCare to address the areas of non-compliance were documented.

Policy SC22-GOV-PD-005, Cultural Competency gives an overview of WellCare's activities to ensure services and materials are provided in a culturally competent manner to members, including those with limited English proficiency. WellCare maintains a copy of the *Cultural Competency Program and Plan 2019-2020* on its website and informs providers of its availability. In addition,

WellCare's Provider Manual includes a detailed description of the Cultural Competency Program, including information about oral and written translation services and technology. The manual instructs providers to coordinate needed translation services through the Member Services Department. WellCare staff are educated on cultural competency and sensitivity through the Compliance Training Program at the time of hire and annually.

Policies define how the Provider Relations Department conducts provider orientation and ongoing trainings for providers and their staff. The Provider Orientation presentation is comprehensive and covers required topics. CCME learned that ongoing trainings and updates are provided using several methods such as letters/faxes, Provider Newsletters, and regional provider summits. The training section on the provider portal has a variety of optional and required self-learning modules.

Provider Access and Availability Study

As part of the annual EQR process for WellCare, CCME conducted a Telephonic Provider Access Study that focused on PCPs. WellCare gave CCME a list of current providers. From this list, CCME identified a population of 2,312 unique PCPs. CCME then randomly selected a sample of 240 providers from this population and attempted to contact these providers to ask a series of questions about access members have with them.

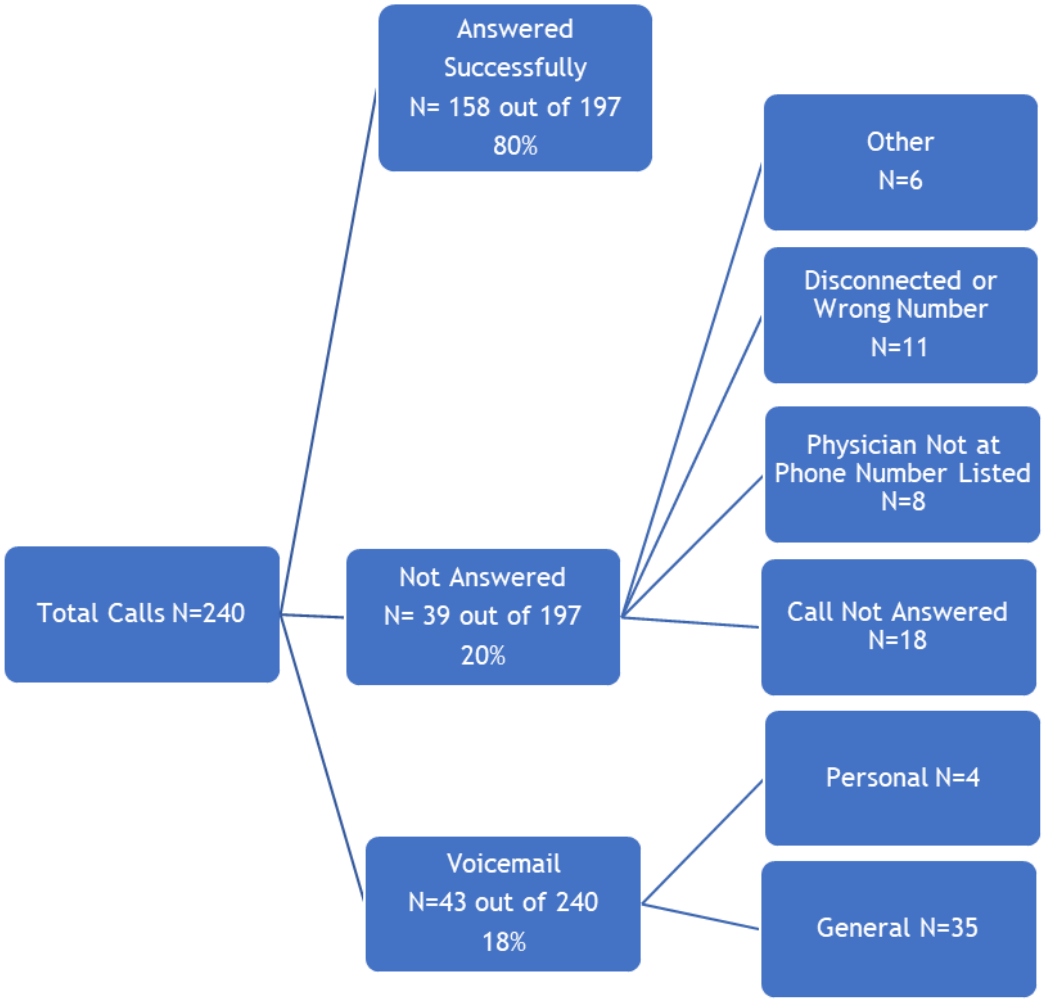
Calls were successfully answered 80% of the time (158 of 197) when omitting calls answered by personal or general voicemail messaging services (see *Table 7: Telephonic Provider Access Study Answer Rate Comparison*).

Table 7: Telephonic Provider Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2018 Review	286	68%	<.001
2019 Review	240	80%	

When compared to last year's results of 68%, this year's study had a statistically significant increase in successful calls (p=<.001). *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 calls not answered successfully (n=39), 18 (46%) were unsuccessful because the call was never answered.

Seventy-eight (78) providers responded to a question about accepting WellCare, and of the 78, 69 (88%) providers confirmed they accept WellCare.

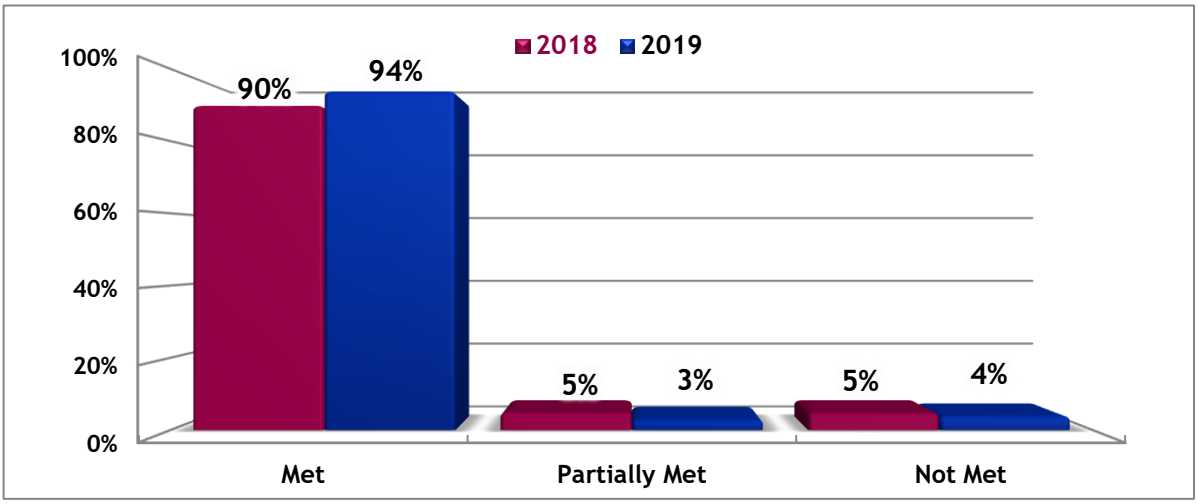
Sixty-seven (67) providers responded to the question about accepting new patients. Of the 67, 22 (33%) indicated they do not accept new patients and 45 (67%) indicated they do accept new patients.

Only 22 providers responded to the question about a screening process for new patients. Of the 22, 17 (77%) indicated an application or prescreen was necessary. The breakdown

of responses is as follows: eight (47%) required ID and insurance card; four (23%) required medical record review; one (6%) required both application and medical record review; three (18%) required application only; and one (6%) required a referral.

As illustrated in *Figure 4: Provider Services Findings*, WellCare received "Met" scores for 94% of the standards in the Provider Services section of the review.

Figure 4: Provider Services Findings



Percents may not total 100% due to rounding.

Table 8: Provider Services Comparative Data

Section	Standard	2018 Review	2019 Review
Credentialing and Recredentialing	Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Partially Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Not Met	Met
Adequacy of the Provider Network	Members have a primary care physician located within a 30-mile radius of their residence	Partially Met	Met
Provider Education	The MCO formulates and acts within policies and procedures related to initial education of providers	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Minutes are recorded for each Credentialing Committee meeting and a quorum of voting members was present for each meeting.
- Provider education resources are available on both the secured and non-secured areas of the provider website.

Weaknesses

- Policy SC22-OP-CR-009, Assessment of Organizational Providers, includes obtaining the ownership disclosure information. However, this policy does not address performing federal and state database checks for persons identified on Ownership Disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2*.
- None of the credentialing and recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried.
- Three credentialing files did not address the CLIA. The applications used for credentialing neither addressed whether laboratory services would be provided at the practice location nor were the providers queried about laboratory services.
- Three credentialing files and three recredentialing files contained old or outdated Ownership Disclosure forms.
- Six recredentialing files contained the WellCare Ownership Disclosure form instead of the required SCDHHS 1514 form.
- One nurse practitioner recredentialing file contained an outdated collaborative agreement. The agreement was dated 2/9/16 and the recredentialing file was approved on 4/10/19. Also, the supervising physicians that signed the agreement in 2016 were not this practitioner's current supervising physicians.
- One recredentialing file did not contain a copy of the facility's DHEC License.
- Page three of Policy SC22 OP-NI-001 states, “The geocoded solution includes only required Providers (i.e. those with a status of 1 in the Table below). All PCP’s are to be reported in a single combined report and all specialists are to be included in separate reports for each specialty.” However, there is no table included in the policy.
- Policy SC22 OP-NI-001, GeoAccess Reporting defines access standards for hospitals but contains an error: 90% of the Managed Care eligible population in the county must have access to a hospital within 50 miles and within seventy (75) minutes or less driving time. Onsite discussion confirmed the correct standard is 75 minutes.

- The 2019 SC Medicaid Q2 Work Plan (Network Adequacy) does not include all Status 1 providers for monitoring (example: Neurology and Urology).
- The printed *Provider Directory* does not define all icons used in the directory in the key.
- Policy SC22-OP-NI-002 defines the appointment timeframe for routine PCP visits as four weeks, but the results documented in the *2018 Medicaid Quality Improvement Program Evaluation* show the survey measures compliance to a timeframe of four to six weeks. Onsite discussion confirmed the four to six week timeframe is correct.

Quality Improvement Plans

- Update Policy SC22-OP-CR-009, Assessment of Organizational Providers to include the process WellCare uses for performing federal and state database checks for persons identified on the Ownership Disclosure form with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2.*
- Implement a plan to ensure the SCDHHS List of Providers Terminated for Cause is queried for all providers during the credentialing and recredentialing process and that proof of the query is contained in the file.
- Ensure that a copy of the CLIA Certificate is obtained during the credentialing process. If laboratory services are not addressed in the credentialing application, query the provider to determine if a CLIA is needed.
- Ensure the required SCDHHS 1514 Ownership Disclosure form is used.

Recommendations

- Obtain an updated collaborative agreement for nurse practitioners during the recredentialing process.
- Ensure a copy of the DHEC License is obtained for all applicable organizational providers.
- Ownership Disclosure forms must be current.
- Include the table of Status 1 Providers in Policy SC22 OP-NI-001 or remove the reference to the table on page three.
- Correct the typographical error in the hospital access standard in Policy SC22 OP-NI-001, GeoAccess Reporting.
- Include all Status 1 providers on the Quality Improvement Work Plan to ensure bi-annual monitoring of network adequacy.
- Ensure all icons used in the *Provider Directory* are explained in the directory key.

- Revise Policy SC22-OP-NI-002 to reflect the correct timeframe WellCare uses to measure provider compliance for routine PCP appointments.

C. Member Services

The Member Services review included policies and procedures, member rights, member informational materials, grievances, and the member satisfaction survey.

WellCare's Member Handbook is thorough, easily understood, and meets the sixth-grade reading comprehension level as required by SCDHHS. However, the font sizes used in regular print and large print materials are not documented.

WellCare's website has quick links and resources for members to access information such as the Member Handbook and Provider Directory. Members receive the *Quick Start Guide* with instructions for accessing the Member Handbook and *Provider Directory* online. However, there is no documentation that members are notified of their right to request a copy of the *Provider Directory* annually. Following enrollment, members receive an orientation phone call from Eliza, an outside vendor, to review benefit information.

The Member Handbook informs members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions on how to access benefits. Additionally, the handbook provides information on obtaining Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The handbook is available in Spanish and alternate formats including large font, audio, and Braille.

Member Services staff are available per contract requirements via a toll-free number. The toll-free Member Services telephone number routes calls to Interactive Voice Response menus 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.

WellCare contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems (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 National Committee for Quality Assurance (NCQA) requirement for the Adult Survey or the Child and Children with Chronic Conditions Surveys. The Child CAHPS Survey response rate was 17%; the Adult CAHPS Survey response rate was 21%; and the Children with Chronic Conditions CAHPS Survey response rate was 15.9%. All response rates decreased from the 2018 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%.

WellCare's processes for receiving, reviewing, and resolving grievances are documented in policy, the Member Handbook, Provider Manual, and on its website. Issues noted in documentation of grievance processes and requirements included outdated terminology and lack of documentation that members have a right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe. CCME's review of 20 grievance files found that the grievance resolutions were timely, and the grievances were properly referred for review as potential quality of care issues. However, in the 20 files reviewed, three acknowledgement letters did not follow the five business-day timeframe for acknowledgement documented in WellCare's policy. One file had an inappropriate resolution to a grievance about the member being billed for physician fees for an emergency room visit. The health plan took no further action to prevent the member from being billed for the emergency services.

WellCare tracks, trends, and analyzes grievance data to identify outstanding issues and adverse trends. Grievance data is routinely reported to health plan management, the Customer Service Quality Improvement Workgroup, Utilization Medical Advisory Committee, and Quality Improvement Committee.

As noted in *Figure 5: Member Services Findings*, WellCare achieved "Met" scores for 88% of the Member Services standards. The "Partially Met" score of 12% is related to member education and grievances.

Figure 5: Member Services Findings

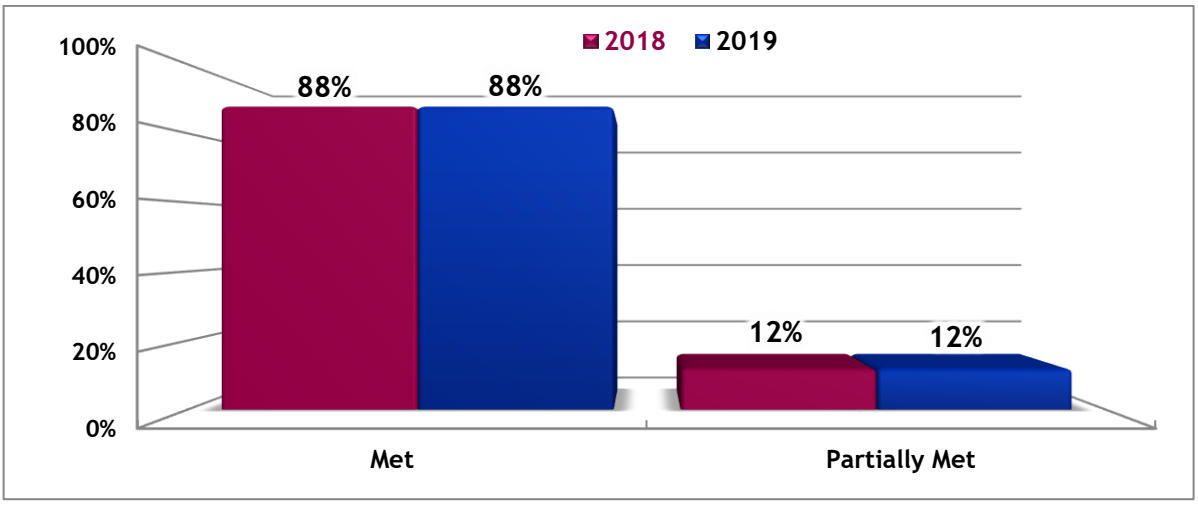


Table 9: Member Services Comparative Data

Section	Standard	2018 Review	2019 Review
Member MCO Program Education	Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met	Partially Met
Grievances	Timeliness guidelines for resolution of a grievance	Met	Partially Met
	The MCO applies grievance policies and procedures as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- The *Preferred Drug List Update* clearly indicates Pharmacy and Therapeutics Committee (P&T) meeting dates, date of the change, and description of the change.

Weaknesses

- The Member Handbook *Change Control Log* posted on the website does not have the date of the last revision.
- CCME could not identify how members are notified of their right to request a copy of the *Provider Directory* annually.
- Neither Policy SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy nor Policy SC22-SM-004, Medicaid Written Marketing Review and Approval address the requirement to use 12-point font size for regular print and 18-point font size for large printed member materials.
- Page one of Policy SC22-OP-CS-021, Medicaid Customer Service Intake of Member Grievances uses outdated terminology to define the term "grievance." It states a grievance is "an expression of dissatisfaction about any matter other than an action." The correct terminology is "adverse benefit determination" instead of "action." Refer to *42 CFR §438.400 (b)* and the *SCDHHS Contract, Section 9.1 (a)*.
- Policy SC22-OP-GR-001, Medicaid Grievance Policy, the Member Handbook, the Provider Manual, and the *Grievance Notice of Extension* letter template do not address the member's right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe. Refer to the *SCDHHS Contract, Section 9.1.6.1.5 through 9.1.6.1.5.2* and *42 CFR § 438.408 (c) (2) (ii)*.

- Issues noted in grievance files include:
  - Three of the 20 files were noted with untimely acknowledgement letters.
  - One file had an inappropriate resolution to a grievance about the member being billed for physician fees for an emergency room visit. The resolution letter to the member indicated that because this facility is not in the WellCare network, WellCare is limited in its ability to get the facility to stop billing the member. There was no further action taken by WellCare to prevent the member being billed for the emergency services. The *SCDHHS Contract, Sections 4.2.11.1.1, 4.2.11.1.2,* and *4.2.11.1.4* states the MCO shall cover and pay for emergency services, provide emergency services without prior authorization, and promptly pay for emergency services regardless of whether the provider has a contract with the MCO, consistent with *42 CFR § 438.114(c)(1)(i).*

Quality Improvement Plans

- Include revision dates on the Member Handbook *Change Control Log* required by the *SCDHHS Contract, Section 3.13.2.16.*
- Edit policies SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy and SC22-SM-004, Medicaid Written Marketing Review and Approval Process to include the requirement to use 12-point font size for regular print and 18-point font size for large printed member materials as per the *SCDHHS Contract, Sections 3.15.1.3* and *3.15.2.8.*
- Revise Policy SC22-OP-GR-001, the Member Handbook, the Provider Manual, and the *Grievance Notice of Extension* letter template to address the requirement that the member must be notified of their right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe.
- Ensure grievance acknowledgement letters are sent within five business-days of receipt of the grievance, as stated in Policy SC22-OP-GR-001.
- Ensure appropriate actions are taken to address incorrect member billing for emergency services by non-participating providers.
- Update the definition of a grievance in Policy SC22-OP-CS-021, Medicaid Customer Service Intake of Member Grievances.

Recommendations

- Ensure members are clearly informed of their right to request a copy of the Member Handbook and *Provider Directory* at least once each calendar year, as required in the *SCDHHS Contract, Section 3.13.2.18.*

D. Quality Improvement

WellCare's Quality Improvement (QI) Program operates under a plan of continuous improvement. The *2019 Medicaid Quality Improvement Program Description* (QI Program Description) describes the program's structure, accountability, scope, goals, and available resources. The program description is reviewed and updated at least annually.

Annually, WellCare develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2018 and 2019 QI Work Plans. Both work plans were labeled as 2017. However, the dates associated with each QI activity reflected the correct date. Also, the cover page labeled as "Work Plan Evaluation Statement" incorrectly states "WellCare quality improvement activities and performance measures will be reviewed, evaluated, and revised annually as outlined in the 2016 Quality Improvement Program Description."

The primary committee responsible for QI activities is the Quality Improvement Committee (QIC). The QI Program Description includes the primary responsibilities of the QIC. The Utilization Management Advisory Committee (UMAC) oversees all clinical QI, utilization management, and behavioral health activities. QIC members include heath plan senior leaders and department directors. Practicing network providers specializing in oncology, cardiology, family medicine, behavioral medicine, and pediatrics are included on the UMAC. The attendance for some of the network providers on the UMAC was poor. Four of the nine providers did not attend any meetings or only attended one meeting.

WellCare evaluated the QI Program and summarized the results of this evaluation in the *2018 Medicaid Quality Improvement Program Evaluation*. Most of the program's objectives were met. WellCare analyzed areas not meeting the goals and developed the needed interventions to improve performance.

Performance Measure Validation

CCME conducted a validation review of the Healthcare Effectiveness Information Set (HEDIS®) measures following Centers for Medicare & Medicaid Services protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

WellCare uses Inovalon, a certified software organization, for calculation of HEDIS rates. CCME found the measures met all requirements. The measure year (MY) 2017 rate, the MY 2018 rate, and the change in rates are presented in *Table 10: HEDIS Performance Measure Data*. The rates shown in green indicate a substantial (>10%) improvement and the rates shown in red indicate a substantial (>10%) decline.

Table 10: HEDIS Performance Measure Data

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	86.46%	89.37%	2.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	72.99%	82.48%	9.49%
Counseling for Nutrition	59.61%	63.75%	4.14%
Counseling for Physical Activity	50.85%	59.12%	8.27%
Childhood Immunization Status (cis)			
DTaP	69.83%	75.18%	5.35%
IPV	86.13%	87.83%	1.70%
MMR	88.08%	88.32%	0.24%
HiB	81.02%	83.21%	2.19%
Hepatitis B	87.10%	89.54%	2.44%
VZV	87.35%	88.56%	1.21%
Pneumococcal Conjugate	72.51%	75.18%	2.67%
Hepatitis A	83.70%	82.00%	-1.70%
Rotavirus	70.07%	69.10%	-0.97%
Influenza	37.23%	40.15%	2.92%
Combination #2	67.64%	71.78%	4.14%
Combination #3	65.21%	68.37%	3.16%
Combination #4	63.75%	65.69%	1.94%
Combination #5	56.93%	58.39%	1.46%
Combination #6	32.36%	32.85%	0.49%
Combination #7	55.47%	56.20%	0.73%
Combination #8	31.87%	32.36%	0.49%
Combination #9	28.71%	29.68%	0.97%
Combination #10	28.22%	29.20%	0.98%
Immunizations for Adolescents (ima)			
Meningococcal	63.50%	69.34%	5.84%
Tdap/Td	78.59%	82.48%	3.89%
Combination #1	62.53%	68.37%	5.84%
Combination #2	23.36%	28.95%	5.59%

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
Human Papillomavirus Vaccine for Female Adolescents (hpv)	24.82%	29.93%	5.11%
Lead Screening in Children (lsc)	66.27%	71.53%	5.26%
Breast Cancer Screening (bcs)	53.68%	53.89%	0.21%
Cervical Cancer Screening (ccs)	55.04%	55.53%	0.49%
Chlamydia Screening in Women (chl)			
16-20 Years	58.09%	57.84%	-0.25%
21-24 Years	66.06%	68.86%	2.80%
Total	60.36%	60.55%	0.19%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	82.93%	81.97%	-0.96%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.07%	23.26%	-6.81%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	61.51%	63.93%	2.42%
Bronchodilator	77.82%	74.24%	-3.58%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	56.61%	52.99%	-3.62%
5-11 Years - Medication Compliance 75%	25.86%	27.86%	2.00%
12-18 Years - Medication Compliance 50%	47.26%	49.06%	1.80%
12-18 Years - Medication Compliance 75%	22.89%	23.02%	0.13%
19-50 Years - Medication Compliance 50%	48.39%	55.56%	7.17%
19-50 Years - Medication Compliance 75%	24.73%	26.50%	1.77%
51-64 Years - Medication Compliance 50%	53.13%	60.00%	6.87%
51-64 Years - Medication Compliance 75%	37.50%	35.00%	-2.50%
Total - Medication Compliance 50%	52.52%	52.43%	-0.09%
Total - Medication Compliance 75%	25.37%	26.46%	1.09%
Asthma Medication Ratio (amr)			
5-11 Years	75.33%	76.76%	1.43%
12-18 Years	61.40%	70.17%	8.77%
19-50 Years	47.86%	56.94%	9.08%
51-64 Years	60.47%	56.36%	-4.11%
Total	66.19%	70.33%	4.14%
Effectiveness of Care: Cardiovascular Conditions			

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
Controlling High Blood Pressure (cbp)	46.72%	48.66%	1.94%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	62.50%	70.83%	8.33%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	68.29%	79.77%	11.48%
Statin Adherence 80% - 21-75 years (Male)	44.05%	49.28%	5.23%
Received Statin Therapy - 40-75 years (Female)	73.04%	75.00%	1.96%
Statin Adherence 80% - 40-75 years (Female)	32.14%	34.34%	2.20%
Received Statin Therapy - Total	70.59%	77.70%	7.11%
Statin Adherence 80% - Total	38.10%	43.04%	4.94%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	88.08%	88.77%	0.69%
HbA1c Poor Control (>9.0%)	46.96%	41.85%	-5.11%
HbA1c Control (<8.0%)	44.04%	48.31%	4.27%
HbA1c Control (<7.0%)	NA	40.63%	NA
Eye Exam (Retinal) Performed	41.36%	52.62%	11.26%
Medical Attention for Nephropathy	92.70%	91.23%	-1.47%
Blood Pressure Control (<140/90 mm Hg)	55.23%	55.38%	0.15%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	59.03%	59.31%	0.28%
Statin Adherence 80%	38.82%	46.72%	7.90%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	71.88%	68.13%	-3.75%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	40.06%	41.40%	1.34%
Effective Continuation Phase Treatment	26.42%	25.54%	-0.88%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	49.86%	36.58%	-13.28%
Continuation and Maintenance (C&M) Phase	62.88%	54.42%	-8.46%

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	76.25%	NA
6-17 years - 7-Day Follow-Up	NR	46.25%	NA
18-64 years - 30-Day Follow-Up	NR	47.44%	NA
18-64 years - 7-Day Follow-Up	NR	25.32%	NA
65+ years - 30-Day Follow-Up	NR	NA*	NA
65+ years - 7-Day Follow-Up	NR	NA*	NA
30-Day Follow-Up	58.41%	53.32%	-5.09%
7-Day Follow-Up	35.58%	29.59%	-5.99%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	64.56%	NA
6-17 years - 7-Day Follow-Up	NR	47.57%	NA
18-64 years - 30-Day Follow-Up	NR	50.14%	NA
18-64 years - 7-Day Follow-Up	NR	38.63%	NA
65+ years - 30-Day Follow-Up	NR	NA*	NA
65+ years - 7-Day Follow-Up	NR	NA*	NA
30-Day Follow-Up	50.90%	55.34%	4.44%
7-Day Follow-Up	37.11%	41.86%	4.75%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
*30-Day Follow-Up: 13-17 Years**	4.00%	17.65%	13.65%*
*7-Day Follow-Up: 13-17 Years**	4.00%	11.76%	7.76%*
30-Day Follow-Up: 18+ Years	14.53%	15.58%	1.05%
7-Day Follow-Up: 18+ Years	10.06%	9.97%	-0.09%
30-Day Follow-Up: Total	13.84%	15.68%	1.84%
7-Day Follow-Up: Total	9.66%	10.06%	0.40%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	72.07%	70.79%	-1.28%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	65.84%	68.53%	2.69%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	75.00%*	60.00%*	-15.00%*
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	63.65%	65.46%	1.81%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	0.00%	NA*	NA
6-11 Years	6.78%	30.00%	23.22%

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
12-17 Years	23.33%	21.65%	-1.68%
Total	16.67%	24.49%	7.82%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.47%	89.15%	0.68%
Digoxin	NR	NR	NA
Diuretics	88.35%	89.61%	1.26%
Total	88.42%	89.35%	0.93%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.32%	1.04%	-0.28%
Appropriate Treatment for Children With URI (uri)	87.45%	88.66%	1.21%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	31.71%	30.38%	-1.33%
Use of Imaging Studies for Low Back Pain (lbp)	64.76%	65.48%	0.72%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
*1-5 Years**	NA	NA	NA
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	1.61%	1.39%	-0.22%
Total	0.97%	0.89%	-0.08%
Use of Opioids at High Dosage (uod)	50.46	4.10%	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	264.51	25.44%	NA
Multiple Pharmacies	74.05	8.46%	NA
Multiple Prescribers and Multiple Pharmacies	40.23	4.21%	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	6.71%	NA
18-64 years - >=31 Days covered	NR	3.45%	NA
65+ years - >=15 Days covered	NR	NA*	NA
65+ years - >=31 Days covered	NR	NA*	NA
Total - >=15 Days covered	NR	6.71%	NA
Total - >=31 Days covered	NR	3.45%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	72.70%	73.07%	0.37%

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
45-64 Years	84.32%	84.20%	-0.12%
*65+ Years**	66.67%	100.00%	33.33%*
Total	76.69%	77.01%	0.32%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	95.23%	95.53%	0.30%
25 Months - 6 Years	82.31%	83.29%	0.98%
7-11 Years	88.64%	85.98%	-2.66%
12-19 Years	85.81%	84.46%	-1.35%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	14.29%	36.36%*	22.07%*
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	7.14%*	9.09%*	1.95%*
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NR	0.00%*	NA*
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NR	0.00%*	NA*
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	32.65%	33.70%	1.05%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	21.43%	22.83%	1.40%
Initiation of AOD Treatment: 13-17 Years	30.84%	33.33%	2.49%
Engagement of AOD Treatment: 13-17 Years	19.63%	21.21%	1.58%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	44.50%	45.77%	1.27%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	10.53%	8.45%	-2.08%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	54.37%	47.48%	-6.89%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	14.56%	17.65%	3.09%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	44.64%	41.36%	-3.28%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	10.97%	9.84%	-1.13%
Initiation of AOD Treatment: 18+ Years	44.22%	42.88%	-1.34%
Engagement of AOD Treatment: 18+ Years	11.13%	9.77%	-1.36%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	43.85%	45.60%	1.75%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	10.46%	8.46%	-2.00%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	54.37%	47.08%	-7.29%

Measure/Data Element	Measure Year 2017	Measure Year 2018	Percentage Point Difference
Opioid abuse or dependence: Engagement of AOD Treatment: Total	14.56%	17.50%	2.94%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	43.34%	40.52%	-2.82%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	12.10%	11.26%	-0.84%
Initiation of AOD Treatment: Total	43.28%	42.22%	-1.06%
Engagement of AOD Treatment: Total	11.73%	10.56%	-1.17%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	89.76%	88.16%	-1.60%
Postpartum Care	64.96%	61.05%	-3.91%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	100.00%	0.00%*	NA*
6-11 Years	45.16%	60.87%*	15.71%*
12-17 Years	52.94%	45.65%	-7.29%
Total	50.60%	49.30%	-1.30%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.26%	2.66%	0.40%
1 Visit	2.01%	2.39%	0.38%
2 Visits	2.76%	3.19%	0.43%
3 Visits	6.03%	3.46%	-2.57%
4 Visits	7.04%	9.84%	2.80%
5 Visits	14.32%	15.16%	0.84%
6+ Visits	65.58%	63.30%	-2.28%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	57.86%	63.28%	5.42%
Adolescent Well-Care Visits (awc)	53.04%	51.95%	-1.09%

**= small denominator; NR = Not Reportable; NA= Not Applicable due to missing data*

The comparison from the previous to the current year revealed a strong increase (>10%) in a few rates including Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy - 21-75 years (Male), Comprehensive Diabetes Care, specifically the Eye Exam (Retinal), and Metabolic Monitoring for Children ages 6 to 11 years old. A performance improvement project (PIP) was initiated previously to address improving retinal eye exams which likely impacted the rate. The measure that decreased substantially (>10%) was Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase. The rate decreased just over 13%. *Table 11: HEDIS Measures with*

Substantial Changes in Rates highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 11: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2017	Measure Year 2018	Change from 2017 to 2018
Substantial Increase in Rate (>10% improvement)			
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	68.29%	79.77%	11.48%
Comprehensive Diabetes Care (cdc)			
Eye Exam (Retinal) Performed	41.36%	52.62%	11.26%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
6-11 Years	6.78%	30.00%	23.22%
Substantial Decrease in Rate (>10% decrease)			
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	49.86%	36.58%	-13.28%

WellCare provided a three-year trend of HEDIS rates in the *2018 Medicaid Quality Improvement Program Evaluation*. Many of the rates had met or exceeded the 25th percentile goal over the three-year trend. CCME recommends moving the goal rate to 50th percentile for those that have met the 25th percentile for several years.

Quality Withhold Measures

WellCare reported 12 quality clinical withhold measures for 2018. The Behavioral Health measures are considered Bonus Only for MY 2018 (RY 2019). As per the *Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the 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 the individual measure's weight then summed to obtain quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 12: Quality Withhold Measures*. The Women's Health measure rates generated the highest index score, followed by Diabetes, and Pediatric Preventive Care. The Behavioral Health Index Score was not provided.

Table 12: Quality Withhold Measures

Measure	2018 Rate	2018 Percentile	Point Value	Index Score
Diabetes				
Hemoglobin A1c (HbA1c) Testing	85.00%	25	3.00	3.60
HbA1c Control (>9)	51.83%	25	3.00	
Eye Exam (Retinal) Performed	50.83%	25	3.00	
Medical Attention for Nephropathy	94.00%	90	6.00	
Women's Health				
Timeliness of Prenatal Care	93.03%	90	6.00	4.10
Breast Cancer Screen	54.42%	25	3.00	
Cervical Cancer Screen	59.04%	25	3.00	
Chlamydia Screen in Women (Total)	57.43%	50	4.00	
Pediatric Preventive Care				
6+ Well-Child Visits in First 15 months of Life	66.00%	25	3.00	2.40
Well Child Visits in 3rd,4th,5th&6th Years of Life	59.50%	<10	1.00	
Adolescent Well-Care Visits	54.00%	25	3.00	
Weight Assessment/Adolescents: BMI % Total	87.39%	75	5.00	
Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication- Initiation Phase	26.84%	10	2.0	Not Reported
Antidepressant Medication Management- Continuation Phase Treatment	51.02%	50	4.0	
Metabolic Monitoring for Children and Adolescents on Antipsychotics-Total	21.58%	<10	1.0	
Initiation and Engagement of AOD Abuse or Dependence Treatment-Initiation Total	45.00%	50	4.0	

Performance Improvement Project Validation

The validation of the performance improvement projects was done following the Centers for Medicare & Medicaid Services developed protocol entitled, *EQR Protocol 3:*

Validating Performance Improvement Projects Version 2.0, September 2012. 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 three projects. They included Improving Dilated Retinal Exam Screening, Access to Care, and Improving Hemoglobin A1C Testing. The Dilated Retinal Exam Screening PIP had a rate improvement from the baseline over 10% and the Improving Hemoglobin A1C has sustained a rate above the goal rate. The Access to Care PIP improved only slightly. The incentives and education appear to be having a small impact.

All PIPs received a score within the "High Confidence" range. *Table 13: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 13: Performance Improvement Project Validation Scores

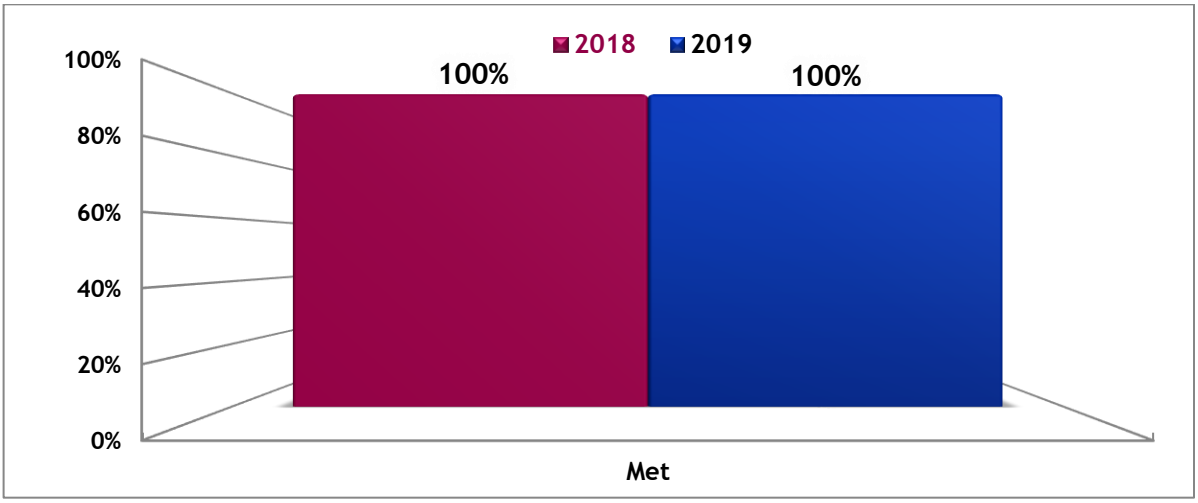
Project	2018 Validation Score	2019 Validation Score
Improving Dilated Retinal Exam (DRE) Screening	78/78=100% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Access to Care	84/85=99% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Improving Hemoglobin A1C Testing	90/91=99% High Confidence in Reported Results	96/96=100% High Confidence in Reported Results

Some of WellCare's Quality Management reports showed trends such as increased inpatient admissions for asthma, coronary artery disease, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and hypertension (HTN). Emergency Room visits decreased for asthma; however, they increased for CHF, COPD, diabetes, and HTN. Thirty-day readmissions increased for CHF and COPD. CCME recommends that future PIP topic selections focus on reducing admissions, readmissions, and ER visits for these specific diseases.

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

All Standards in the QI section received a "Met" score. *Figure 6: Quality Improvement Findings* gives an overview of the scores in 2018 compared to the current review scores.

Figure 6: Quality Improvement Findings



Strengths

- All PIPs received a validation score in the "High Confidence" range.
- WellCare provided a three-year trend of HEDIS rates in the *2018 Medicaid Quality Improvement Program Evaluation*. Many of the rates met or exceeded the 25th percentile goal over the three-year trend.

Weaknesses

- The 2018 and 2019 work plans were labeled as the 2017 work plan. Also, the cover page labeled as "Work Plan Evaluation Statement" incorrectly states "WellCare quality improvement activities and performance measures will be reviewed, evaluated, and revised annually as outlined in the 2016 Quality Improvement Program Description."
- Some network providers on the UMAC had poor attendance. Four of the nine providers did not attend any meetings or only attended one meeting.

Recommendations:

- Update the 2019 QI Work Plan and correct the errors identified.
- Recruit additional network providers to serve on the UMAC.

- Move the HEDIS goal rate to 50th percentile for those measures that have met the 25th percentile over the three-year trend noted in the 2018 Medicaid Quality Improvement Program Evaluation.
- Focus future PIP topic selections on reducing admissions, readmissions and ER visits for CHF and COPD.

E. Utilization Management

CCME's assessment for utilization management (UM) includes reviews of program descriptions and evaluations, policies, the Member Handbook, the Provider Manual, the website, and approval, denial, appeal, and care management files.

The *UM Program Description* and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina.

Service authorization requests are conducted by appropriate reviewers using Milliman Care Guidelines (MCG), InterQual Criteria, and other established criteria. Onsite discussions confirmed WellCare added MCG in 2019; however, Policy SC22-HS-UM-011, Application of Criteria does not include InterQual.

WellCare assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing of physician, non-physician reviewers and pharmacy staff. Onsite discussions confirmed the IRR benchmark for pharmacy reviewers is 80% and 85% for other reviewers.

Review of approval and denial files reflect timely and consistent decision-making, with the exception of one denial file that was outside of the required timeframe.

WellCare uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels. Care Management files indicate activities are conducted as required and Care Managers follow policies to conduct the correct level of care coordination. WellCare consistently addresses HIPAA verification, identifying care-gaps, and social determinants of health.

Processes and requirements for receiving, reviewing, and resolving member appeals are documented in WellCare policy. CCME's review of these policies and other documentation of appeals processes and requirements revealed issues. These include, but are not limited to, the following:

- An outdated reference to a form
- Omitted or incorrect timeframes

- Lack of documentation of member rights related to appeal processes
- Incomplete information about appeal resolution notice contents and requirements for mailing appeal resolution notices
- Incorrect information about continuation of benefits

Appeal file review findings include untimely appeal resolution, untimely appeal acknowledgement, failure to notify the member of denial of an expedited appeal review, and an inappropriate resolution of an appeal. WellCare monitors appeals data to identify opportunities for improvement and reports appeal data to appropriate committees; however, the two appeal policies (Policy SC22-HS-AP-002, Member Appeals Policy and Policy SC22-RX-012, Pharmacy Appeals) neither address monitoring nor reporting of appeals internally to quality committees for the purposes of identifying opportunities for improvement.

Figure 7: Utilization Management Findings shows that 89% of the standards in the Utilization Management section received a "Met" score. This represents a decrease of seven percentage points from the 2018 review. Scores of "Partially Met" are related to appeals.

Figure 7: Utilization Management Findings

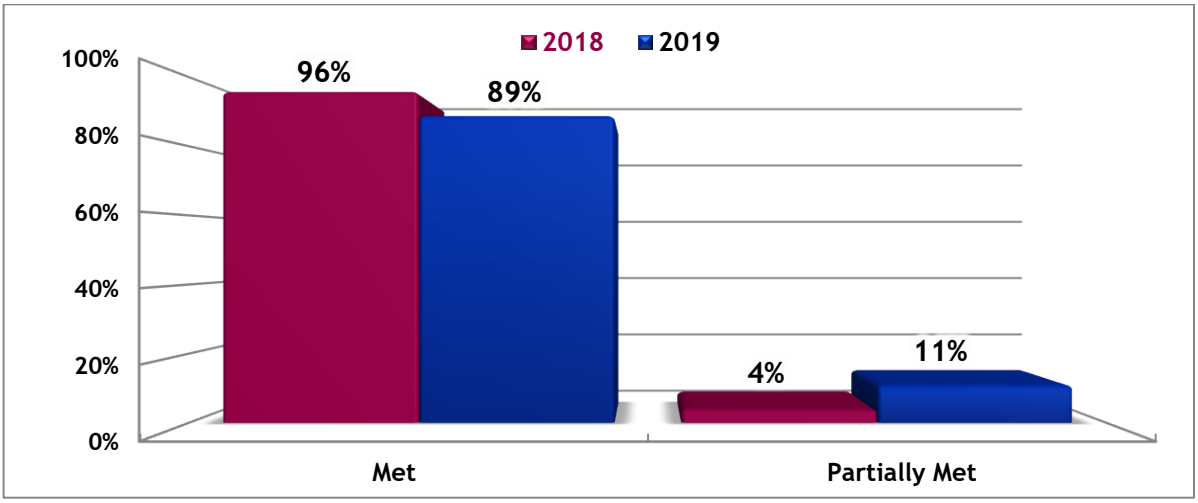


TABLE 14: Utilization Management Comparative Data

Section	Standard	2018 Review	2019 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	Met	Partially Met
	Written notice of the appeal resolution as required by the contract	Met	Partially Met
	Other requirements as specified in the contract	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Initial Care Management assessments are completed timely.
- Care gaps are consistently assessed.

Weaknesses

- Incorrect and inconsistent documentation is noted for concurrent review timeframes. The table on page 56 in the Provider Manual incorrectly lists the determination timeframe for concurrent reviews as 24 hours and extensions up to 72 hours, which is not consistent with Policy SC22-HS-UM-023, Inpatient Concurrent Review. The *SCDHHS Contract, Sections 8.6.1.3* and *8.6.1.4.* requires determinations within 72 hours and extensions up to 14 days.
- Use of InterQual Criteria for service authorizations is not documented in Policy SC22-HS-UM-011, Application of Criteria.
- Policy SC22-RX-008, Quality Assurance in the Pharmacy Department does not include the benchmark for pharmacy IRR testing.
- Policy SC22-RX-015, Pharmacy Transition incorrectly shows WellCare honors prescriptions for new members for 60 days; the *Managed Care Organizations Policy and Procedure Guide, Section 4.2.21.3* requires 90 days.

- The determination and notice in one denial file were out of timeframe by four days due to late routing to BH staff.
- Page two of Policy SC22-HS-AP-002, Member Appeals Policy states an authorized representative is "an individual granted authority to act via SC DHHS form 1282 ME, authorization for release of information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals..." The requirement for the use of the 1283 ME form has been removed from the *SCDHHS Contract*.
- Policy SC22-HS-AP-002, Member Appeals Policy defines the timeframe within which a written appeal request must follow an oral request for a standard appeal. However, this information is not included in Policy SC22-RX-012, Pharmacy Appeals, the Member Handbook, the Provider Manual, and WellCare's website.
- Page 11, item VI (1) of Policy SC22-RX-012, Pharmacy Appeals incorrectly states standard appeal decisions that are adverse to the member, in whole or in part, are provided via written notice to the member no later than 72 hours from the receipt date. The correct timeframe for written notice of a standard appeal resolution is no more than 30 calendar days from the date of receipt of the appeal. Refer to the *SCDHHS Contract, Section 9.1.6.1.2*.
- Policy SC22-RX-012, Pharmacy Appeals does not address the requirement from the *SCDHHS Contract, Section 9.1.6.4.3* that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made.
- The *Expedited Administrative Review Determination Denial Notice* for pharmacy does not include the member's right to file a grievance if they disagree with the denial of the expedited review.
- The *Time Frame Extension Notice* for pharmacy does not include the member's right to file a grievance if they disagree with an extension.
- Policy SC22-RX-012, Pharmacy Appeals does not address the requirement that for upheld and partially upheld resolutions, the MCO must send the notice of appeal resolution to the member via certified mail, return receipt requested.
- Policy SC22-RX-012, Pharmacy Appeals does not include that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending and how to request this or an explanation that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination. Refer to the *SCDHHS Contract, Sections 9.1.6.2.3.2.2* and *9.1.6.2.3.2.3*.
- Page 11, item VI (1) (g) and page 14, item VIII (1) (g) of Policy SC22-RX-012, Pharmacy Appeals, does not include requirements specific to South Carolina. The policy states, "The right to request the next level of review as specified by each State."

- The *SCDHHS Contract, Section 9.1.7.1.2* defines the timeframe for requesting continuation of benefits during the appeal and State Fair Hearing process as, "The intended effective date of the CONTRACTOR's proposed Adverse Benefit Determination." However, the timeframe is incorrectly documented in the Member Handbook and on WellCare's website as follows:
  - Page 70 of the Member Handbook states, "Within 10 calendar days of the intended effective date of the plan's proposed action, whichever is later"
  - The website states, "within 10 calendar days of the intended effective date of the plan's proposed action…"
- The following issues were noted in appeal files reviewed:
  - One expedited appeal was not resolved within the expedited appeal resolution timeframe with no documentation of denial of the expedited appeal request or of an extension of the resolution timeframe.
  - One expedited appeal was downgraded to a standard appeal with no notification the member.
  - One acknowledgement letter was not sent within the timeframe defined in WellCare policy.
  - One resolution for an appeal related to reimbursement for medication was determined to be incorrect based on discussion during the onsite visit. WellCare staff reported this resolution would have been appropriate for a Medicare member but not a Medicaid member.
- Policy SC22-HS-AP-002, Member Appeals Policy and Policy SC22-RX-012, Pharmacy Appeals do not address monitoring or reporting of appeals internally to quality committees for the purposes of identifying opportunities for improvement.

Quality Improvement Plans

- Revise page 56 in the Provider Manual to be consistent with the concurrent review timeframes in Policy SC22-HS-UM-023, Inpatient Concurrent Review and to meet requirements of the *SCDHHS Contract, Sections 8.6.1.3* and *8.6.1.4.*
- Correct the timeframe for written notice of resolution of a standard appeal on page 11, item VI (1) of Policy SC22-RX-012, Pharmacy Appeals.
- Revise Policy SC22-RX-012, Pharmacy Appeals to include that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made.
- Revise the *Expedited Administrative Review Determination Denial Notice* for pharmacy to include the member's right to file a grievance if they disagree with the denial of the expedited review.

- Update the *Time Frame Extension Notice* for pharmacy to include the member's right to file a grievance if they disagree with an extension.
- Revise Policy SC22-RX-012, Pharmacy Appeals to include the requirement that for upheld and partially upheld resolutions, the MCO must send the notice of appeal resolution to the member via certified mail, return receipt requested.
- Include in Policy SC22-RX-012, Pharmacy Appeals that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending, how to request continuation of benefits, and that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination.
- Update page 11, item VI (1) (g) in Policy SC22-RX-012, Pharmacy Appeals and page 14, item VIII (1) (g) in Policy SC22-RX-012, Pharmacy Appeals to include specific South Carolina requirements that the next level of review is a State Fair hearing.
- Correct the timely filing requirement for continuation of benefits on page 70 of the Member Handbook and on the WellCare website.
- Ensure contractual and policy requirements are followed when processing member appeals.
- Ensure appeal resolutions are appropriate for members covered under the Medicaid line of business.

Recommendations

- Edit page 2 in Policy SC22-HS-UM-011, Application of Criteria to reflect both MCG and InterQual Criteria are used for service authorizations.
- Edit Policy SC22-RX-008, Quality Assurance in the Pharmacy Department to include the benchmark for IRR testing of pharmacy staff is 80%.
- Correct the discrepancy in Policy SC22-RX-015, Pharmacy Transition to reflect WellCare honors prescriptions for new members for 90 days, as required in *Managed Care Organizations Policy and Procedure Guide, Section 4.2.21.3* and to be consistent with Policy SC22-RX-011, Medicaid Preferred Drug List Policy.
- Ensure service authorization for denial decisions and notices are rendered to meet timeframe requirements in the *SCDHHS Contract, Section 8.6.1.4.*
- Remove the reference to form 1282 ME, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals from Policy SC22-HS-AP-002.
- Include the timeframe within which a written appeal request must follow an oral request for a standard appeal in Policy SC22-RX-012, the Member Handbook, the Provider Manual, and on the WellCare website.

- Revise Policy SC22-HS-AP-002, Member Appeals Policy and Policy SC22-RX-012, Pharmacy Appeals to include internal reporting of appeals data and activities for quality improvement activities. Specify the committees to which appeals data is reported.

F. Delegation

CCME's external quality review of delegation functions examined the submitted delegate list, delegation monitoring materials, and delegation contracts.

WellCare reported 30 current delegation agreements, as shown in *Table 15: Delegated Entities and Services*.

Table 15: Delegated Entities and Services

Service	Delegated Entities
Utilization Management	Advanced Medical Review; EviCore Healthcare; HealthHelp; Progeny Health; Focus Behavioral Health
Nurse Advice Line	CareNet
Pharmacy	CVS Health
Medication Therapy Management and Outreach	University of Florida College of Pharmacy
Customer Service	Teleperformance; The Results Companies
Crisis Line	Health Integrated
Case Management	Alere
Vision	March Vision
Care Management (Post-acute Care Coordination)	Care Centrix
Credentialing	Advance Health; AU Medical Center; Greenville Hospital System; Integra Partners; Linkia; Medical University Hospital Authority; Minute Clinic; OptumHealth Care Solutions; Palmetto Health University of South Carolina Medical Group; Preferred Care of Aiken; Regional Health Plus LLC; Roper St. Francis Healthcare; St. Francis Physician Services; Take Care Clinics; United Physicians; University Health Link

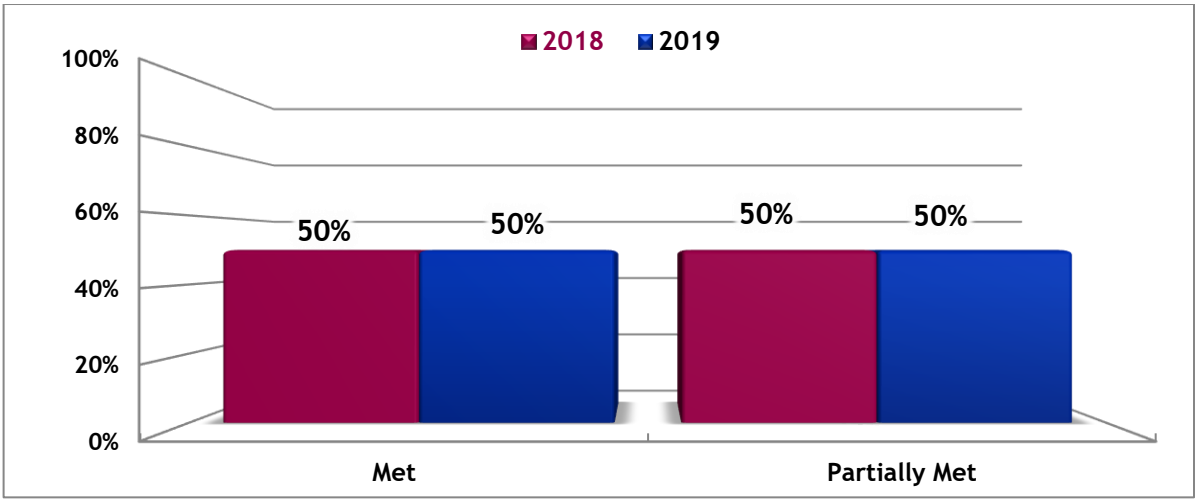
Policy SC22-CP-AO-007, Delegation Oversight and Procedure SC22-CP-AO-007-PR-001, Delegation Oversight Procedure define processes followed for pre-delegation, annual oversight, and ongoing monitoring of delegated functions.

WellCare performed annual delegation monitoring for all entities that handle credentialing and recredentialing. 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 submitted documentation of annual oversight of non-credentialing delegates. The documentation showed WellCare tracks metrics specific to the delegated services. Desk material documentation did not include monthly monitoring of delegates that provide call center functions (Teleperformance, The Results Companies). However, during the onsite visit WellCare staff stated it holds bi-weekly monitoring calls with the call center delegates. WellCare staff also provided the monthly dashboards they use for ongoing monitoring.

As noted in *Figure 8: Delegation Findings,* 50% of the standards in the Delegation section of the review were scored as "Met."

Figure 8: Delegation Findings



Weaknesses

- Annual delegation monitoring was provided for all the entities that perform credentialing and recredentialing. Oversight monitoring audit tools neither address the query of the SCDHHS List of Providers Terminated for Cause nor the Collaborative Agreement/Written Protocol for Nurse Practitioners.

Quality Improvement Plans

- Update the credentialing and recredentialing audit tools to include the query of the SCDHHS List of Providers Terminated for Cause and the Collaborative Agreement/Written Protocol for Nurse Practitioners.

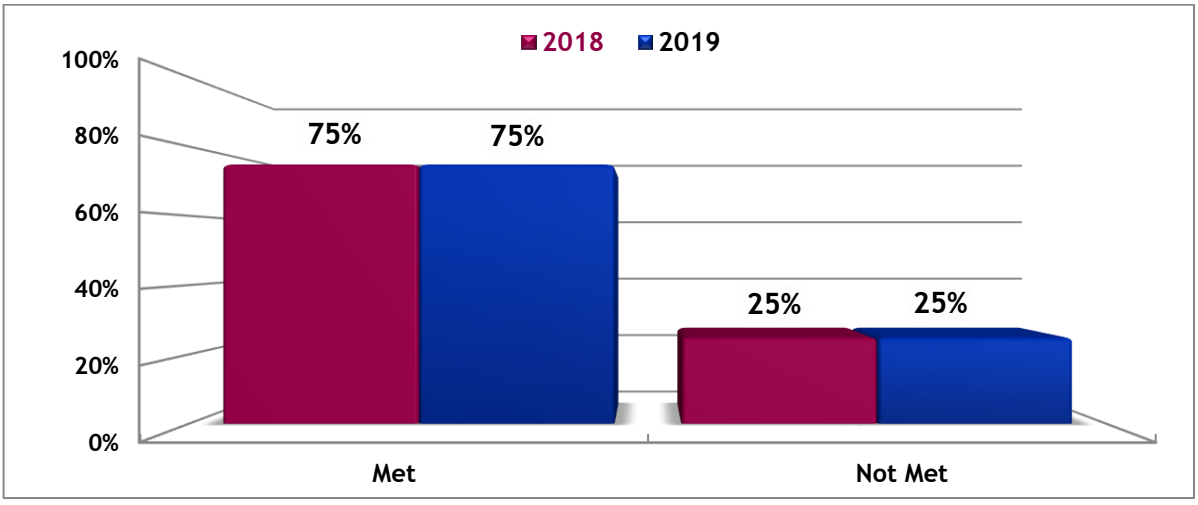
G. State Mandated Services

WellCare's Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program provides a repository to house EPSDT data used for reporting, tracking and trending. The plan monitors compliance with immunization and EPSDT requirements by reviewing primary care physician rates for immunization and well-child visits and through random medical record reviews conducted by nurse reviewers. Distribution of the EPSDT Tool Kit and the 120-day Non-Compliant Report to providers are examples of how WellCare ensures EPSDT services for members through the month of their 21st birthday.

CCME determined during this EQR that an issue identified in the previous EQR has not been corrected. This issue is related to the *SCDHHS Contract* requirement that health plans query the SCDHHS List of Providers Terminated for Cause when credentialing or recredentialing a provider.

As noted in *Figure 9: State Mandated Services*, WellCare achieved a "Met" score for 75% of the State Mandated standards which is unchanged from the 2018 review. The "Not Met" score of 25% is related to unaddressed deficiencies identified in the previous external quality review.

Figure 9: State Mandated Services



Weaknesses

- An issue identified in the previous EQR, related to the contractual requirement to query the SCDHHS List of Providers Terminated for Cause when credentialing or recredentialing a provider, has not been corrected.

Quality Improvement Plans

- Ensure the SCDHHS List of Providers Terminated for Cause is queried for each credentialing and recredentialing file as required by the *SCDHHS Contract, 11.2.10*.

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

October 21, 2019

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 2019 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. The CCME EQR team plans to conduct the onsite visit on **December 17th and 18th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **November 04, 2019.**

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 2019

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 2018 and 2019.

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 2018 through October 2019. 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 2018 through October 2019.

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 (<u>including signed Ownership Disclosure Forms</u>) 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 (<u>including signed Ownership Disclosure Forms</u>) 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 2018 through October 2019. 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 2018 through October 2019, 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://egro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. South Carolina Compliance Plan or South Carolina addendum to the corporate Compliance Plan, if applicable/available.
3. A copy of the letter used to notify members of inclusion in the Pharmacy Lock-in Program.
4. Policy SC22-OP-EN-001, New Member Materials.
5. Provider Appointment Accessibility and After-Hours Coverage Procedure (SC22-OP-NI-002-PR-001).
6. 2018 South Carolina Medicaid-Accessibility of Services Report.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**WELLCARE**
Name of PIP:	**ACCESS TO CARE**
Reporting Year:	**2018**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY 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**	The topic was selected through data collection which is noted on page 2.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The performance improvement project (PIP) addresses enrollee care and service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	The study question is documented on page 4 of the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The measure is defined on page 5.
3.2 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**	The measure is focused on processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Yes. Relevant populations are included.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Yes, The entire population captures all relevant enrollees.
STEP 5: Review Sampling Methods		
5.1 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.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Yes. The data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Yes. Data sources are listed on page 7.
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**	Yes. 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**	Yes. Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Yes. Data analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Yes. Detailed information regarding staff and personnel are provided in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Yes. Interventions are directly related to barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Yes. An analysis was conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Yes. The results are clearly presented.
8.3 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**	Yes. The analysis reports baseline and remeasurement 1.
8.4 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**	Yes. Data analysis is included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The Healthcare Effectiveness Data Set (HEDIS®) methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The AAP rate had a slight increase from 2017 to 2018.
9.3 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**	The improvement appears to be a result of incentive and education.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	The statistical improvement was insignificant, but is calculated and documented.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	The rate has met the target goal yet.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				**Step 6**		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				**Step 7**		
2.1	10	10		7.1	10	10
Step 3				**Step 8**		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		**Step 9**		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	1	1
Step 6				**Step 10**		
6.1	5	5		10.1	NA	NA
6.2	1	1		**Verify**		
6.3	1	1			NA	NA

Project Score	**91**
Project Possible Score	**91**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
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 HEMOGLOBIN A1C TESTING - Clinical
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY 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**	The topic was selected through analysis of data about enrollee care.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Yes. The performance improvement project (PIP) addresses a key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	Yes. All relevant populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Yes. The study question was stated in document.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The measures were clearly defined.
3.2 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**	Yes. The indicator measures changes in health status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Yes. A clear definition of enrollees to whom the study question is relevant is documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Yes. The data collection approach captured all enrollees to whom the study measure applied.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 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.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Yes. The data to be collected was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Yes. The data source was identified.
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**	Yes. The study used a programmed data pull from claims/encounter files of all eligible members.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Yes. There was consistent data collection using program-pulled data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Yes. The data analysis plan was specified as once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Yes. Detailed information about staff and personnel are documented in report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Yes. Several interventions were implemented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Yes, an analysis of findings was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Yes. The results are clearly presented.
8.3 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**	Yes. The analysis reports baseline and remeasurement.
8.4 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**	Yes. The analysis included interpretation of success and continued action plans.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The measurement has a baseline and three remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Yes. The improvement from the previous rate is documented.
9.3 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**	Yes. The improvement has face validity.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance is not required when using the entire population; although it is documented in report.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Yes. The rate has a sustained above-goal rate for the last three remeasurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	1	1
Step 6				Step 10		
6.1	5	5		10.1	5	5
6.2	1	1		Verify	NA	NA
6.3	1	1		TOTAL		

Project Score	96
Project Possible Score	96
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
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:	**2018**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY 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**	Yes. The topic was selected through data collection and noted in the report.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Yes. The performance improvement project (PIP) addresses enrollee care and service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	Yes. All enrolled populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Yes. The study question is documented in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Yes. The measure is defined.
3.2 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**	Yes. The measure is focused on processes of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Yes. The relevant populations are included.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Yes. The entire population captures all relevant enrollees.
STEP 5: Review Sampling Methods		
5.1 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.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Yes. The data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Yes. The data sources are listed in the report.
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**	Yes. The data collection method uses programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Yes. Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Yes. The data analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Yes. Detailed information about staff and personnel are provided in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Yes. The interventions are directly related to identified barriers.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Yes. An analysis was conducted according to data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Yes. The results are clearly presented.
8.3 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**	Yes. The baseline and one remeasurement are presented.
8.4 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**	Yes. Data analysis is included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Yes. The rate was calculated according to Healthcare Effectiveness Data Information Set (HEDIS®) specifications at both measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Yes. Improvement was reported.
9.3 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**	Yes. The improvement appears to be related to interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Yes. Statistical testing is presented.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Only one remeasurement is presented.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**91**
Project Possible Score	**91**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
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 HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS®) MEASURES**
Reporting Year:	**2019**
Review Performed:	**12/2019**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Technical Specifications

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**	The health plan uses National Committee for Quality Assurance (NCQA)-certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

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**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
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**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

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**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	This meets all review requirements.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
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**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	The health plan uses NCQA certified software, Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to HEDIS specifications?	**MET**	Yes. The measures were reported according to HEDIS specifications.

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
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

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	**85**
Measure Weight Score	**85**
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	**CONSUMER ASSESSMENT OF HEALTH PLAN SURVEY (CAHPS) ADULT**
Validation Period	2019
Review Performed	12/2019

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

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**	The statement of purpose is documented. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	The intended audience is identified and documented. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	The survey's reliability is documented. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	The survey's validity and responses are documented. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

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**	Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation*: SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to National Committee for Quality Assurance (NCQA). WellCare's sample size was 3,310. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Correct procedures were used to select the sample. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	The overall response rate was 21.0% which is lower than last year's rate of 22.5%. The target response rate according to NCQA, however, is 40.0%. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation*: SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Yes. The survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
5.3	Were confidentiality procedures followed?	**MET**	Yes. Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Yes. Data were analyzed. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report* *CAHPS Assessment 2019*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Yes. Appropriate statistical tests were used and correctly applied. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Yes. The survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Yes. The overall response rate was 21.0%, which is a decrease from 2017 rate of 22.5%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population as this may not be a representative sample. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
7.4	What conclusions are drawn from the survey data?	The adult survey improved in 9 out of 14 main composite areas and measures including some key areas improving above the 3% market CAHPS improvement goal. The plan improved in all 3 of the smoking cessation areas. Documentation: *CAHPS Assessment 2019*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information year over year was provided and documented. Documentation *SPH Analytics 2019 CAHPS Medicaid Adult Final Report*

CCME EQR Survey Validation Worksheet

Plan Name	**WELLCARE**
Survey Validated	**CONSUMER ASSESSMENT OF HEALTH PLAN SURVEY (CAHPS) CHILD**
Validation Period	2019
Review Performed	12/2019

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

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**	The statement of purpose is documented. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation*2019 SPH Analytics CAHPS Medicaid Child Final Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	The intended audience is identified and documented. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	The survey's reliability is documented. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	The survey's validity and responses are documented. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*

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**	The study population was defined in report. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	The specifications for sampling were documented. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to National Committee for Quality Assurance (NCQA). WellCare's sample size was 3,600. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and correct. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	The overall response rate was 17.0% which is a decrease from last year's response rate of 18.6%. The target response rate according to NCQA is 40.0%. Response rate is assessed in the CAHPS Assessment. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report; CAHPS Assessment 2019*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Yes. A quality assurance plan was in place. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Yes. The survey's implementation followed the planned approach. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
5.3	Were confidentiality procedures followed?	**MET**	Yes. Confidentiality procedures were followed. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Yes. Data were analyzed. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report; 2019 CAHPS Assessment*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Yes. Appropriate statistical tests were used and correctly applied. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Yes. Survey conclusions were supported by findings. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Yes. The overall response rate was 17.0%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population, as those who responded may not be representative of the entire population.
7.4	What conclusions are drawn from the survey data?	The goal was to improve at least 3% for each measure or attribute and an overall improvement in Rating of Health Plan used as part of the business plan improvements. WellCare met the goal in 2 out of 12 areas and achieved a percentage increase overall in 7 out of 12 areas. Achieving statistically relevant improvements in key areas such as Rating of Health Care with a 3.7 % increase and a 4.5% increase in Rating of Health Plan, gives the plan a better chance at a higher rating overall with member satisfaction. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2019 SPH Analytics CAHPS Medicaid Child Final Report*

CCME EQR Survey Validation Worksheet

Plan Name	**WELLCARE**
Survey Validated	**CONSUMER ASSESSMENT OF HEALTH PLAN SURVEY (CAHPS) CHILD CCC**
Validation Period	2019
Review Performed	12/2019

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

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**	The statement of purpose is documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	The intended audience is identified and documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	The survey's reliability is documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	The survey's validity and responses are documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

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**	The study population clearly defined and documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	The specifications for sample frame were documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was correct. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to National Committee for Quality Assurance (NCQA). WellCare's sample size was 1739. Documentation*2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Correct procedures were used to select the sample. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	The specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and correct. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	The overall response rate was 15.9% which is slightly lower than last year's response rate of 16.0% and lower than the average response rate from SPH noted as 17.6%. The target response rate, according to NCQA, is 40.0%. Response rate is assessed in CAHPS Assessment document. Documentation*2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Yes. A quality assurance plan was in place. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Yes. The survey's implementation followed the planned approach. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
5.3	Were confidentiality procedures followed?	**MET**	Yes. Confidentiality procedures were followed. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Yes. Data were analyzed. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report; CAHPS Assessment 2019*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Yes. Correct statistical tests were conducted. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Yes. Survey conclusions were supported by findings. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Yes. The overall response rate was 15.9%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population as the sample may not be representative of the entire population.
7.4	What conclusions are drawn from the survey data?	Getting Needed Care dropped slightly year over year (from 91.3% [2018] to 90.1% [2019]), along with Health Promotion and Education that dropped significantly from 82.0% to 78.1 %, netting a 3.9% drop. The CCC population survey summary rates did not improve by a high enough percentage across all measures to meet the 3% goal. However, the plan did meet the goal in 6 measure areas. The plan should focus efforts on the suggested monitoring areas, along with determining the areas of intersectionality with the other surveys. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report; 2019 CAHPS Assessment*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2019 SPH Analytics Medicaid Child with CCC Measurement Set Final Report*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**WellCare of South Carolina**
Collection Date:	**2019**

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					Policies are organized by department or functional area within the organization. Each policy's business owner is responsible for annual policy review and revision. Regulatory Affairs staff review new policies and policy revisions, and Corporate Compliance staff give final approval. Policies are housed in Compliance 360 and staff may access policies through an intranet site.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Staff are informed of new policies and revisions to policies via a monthly email notification.
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 (CEO, COO, Executive Director);	X					Urcel Fields is President of WellCare since January 2019.
1.2 Chief Financial Officer (CFO);	X					
1.3 * Contract Account Manager;	X					Mark Ruiz is the Contract Account Manager.
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					Brian Pogue is Vice President, Payment Integrity & Claims. He is supported by three Senior Directors, Claims. Jim Westmoreland is Director, Encounters.
1.5 Utilization Management (Coordinator, Manager, Director);	X					Stephanie Williams is Director, Health Services.
1.5.1 Pharmacy Director,	X					Nancy Youssef is Director State Pharmacy. She is licensed as a Pharmacist by the South Carolina Board of Pharmacy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					Mitzi Bagwell is Senior Manager, Field Care Management. Ashley Partridge is Supervisor, Field Care Management. Case Management staff are field-based and regionalized to ensure coverage for members throughout South Carolina.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Mark DaShiell is the Director Quality Improvement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					SaBrina Macon is Senior Manager, Provider Relations.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Kimberly Eloufir is Director, Customer Service. Anton Brown is Member Services Manager.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Robert London is the Chief Medical Officer.
1.10 *Compliance Officer;	X					Don Schmadel is Director Market Compliance and the Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					Matthew Calcutti, Manager of the Special Investigative Unit (SIU), serves as the Program Integrity Coordinator.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Taffney Hooks, Manager Field Regulatory Affairs, serves as the Interagency Liaison.
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					Sultan Simm, MD is the board-certified psychiatrist licensed by the SC Board of Medical Examiners.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					WellCare's internal benchmark for claims processing follows the contractual requirement that 90% of clean claims are processed within 30 days and 99% are processed within 90 days. As of October 2019, WellCare reported an average clean claims processing rate of 99.72% in 30 days and 99.97% in 90 days, surpassing the contractual requirements for clean claims processing.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					WellCare accepts and generates Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic transactions via its partner, RelayHealth. WellCare processes electronic transactions in the standard electronic data interchange format. WellCare

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						converts paper transactions into industry standard electronic claim transactions using optical character recognition.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Enrollment, disenrollment and re-enrollment transactions are received via the 834 eligibility files provided by South Carolina Department of Health and Human Services. Documentation shows WellCare's systems process transactions using a unique subscriber ID assigned during initial enrollment. WellCare noted it can track claim and encounter data across its Medicaid and Medicare systems. WellCare uses a multi-tiered approach that involves software checks and manual reviews to detect potential duplicate records.
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					WellCare's Information Systems Capabilities Assessment (ISCA) documentation shows the health plan's ability to provide required Healthcare Effectiveness Data Information Set (HEDIS®) or HEDIS-like reports and that are reviewed and validated to ensure data is correctly reflected.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ISCA documentation detailed how WellCare maintains claims consistency and integrity. The documentation also described information systems that reside in physically secure facilities and have redundancy measures in place to protect against environmental events. System configurations and installations are required to adhere to WellCare's procedures and to be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						approved by Information Technology management.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					ISCA documentation included information security policies that address HIPAA, protected health information, acceptable system use, and risk management. Access to systems and data requires successful authentication to the Microsoft Active Directory. WellCare also included documentation detailing a recent security assessment that did not find any critical vulnerabilities.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					WellCare submitted its most recent disaster recovery test report which shows WellCare is able to meet recovery point and recovery time objectives. The report also noted that the recovered systems received approval across each of its business units.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The *WellCare Corporate Compliance Program* (Compliance Plan) and *Code of Conduct and Business Ethics* (Code of Conduct), along with policies, procedures, and other documentation, define WellCare's expectations for compliance with laws, regulations, and processes for guarding against fraud, waste, and abuse (FWA), and expectations for employee conduct.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					See standards below for any identified issues.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 Standards of conduct;						WellCare's Code of Conduct applies to all employees and members of corporate and subsidiary Boards of Directors. The Code of Conduct addresses expectations that employees and board members stay committed to standards of ethics, integrity, professionalism, and adhere to all federal health care program requirements. In addition to the Code of Conduct, the WellCare *Associate Handbook* and policies and procedures provide more detail about business ethics and expectations for proper business conduct.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan defines roles of both the corporate Compliance Officer and market Compliance Officers. Policy C13-SIU-FWA-001-SC, Fraud Waste and Abuse Policy describes the role of the Program Integrity Coordinator.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The Compliance Plan includes information about the Corporate Compliance Committee and Market Compliance Oversight Committee. The *Market Compliance Oversight Committee Charter*, a component of the Compliance Plan, defines the committee's purpose, appointment, composition, term, operating principles for meetings, and committee responsibilities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 Compliance training and education;						Compliance training is required at the time of hire and annually for all associates, officers, and directors. WellCare also provides and/or monitors the completion of compliance training to agents, contractors, and first tier, downstream, and related entities involved in its health care operations. The program includes the Code of Conduct, general compliance training, required courses on FWA, and privacy and security. WellCare's *Compliance and Mandatory Training 2019 Plan* includes the monthly training schedule for all associates as well as specialized audiences.
2.6 Lines of communication;						The Code of Conduct advises associates they may ask questions about a suspected violation or report a violation to their Immediate people leader or manager, the Chief Compliance Officer, the General Counsel, a Market Compliance Officer, the Human Resources Department, or the Chief Auditor (if related to financial, accounting or auditing matters). If the associate does not want to speak with the persons listed above nor use the WellCare Hotline, they may report a violation or ask questions about reporting violations by contacting: •The Chair of the Board's Audit, Finance and Regulatory Compliance Committee •The Chair of the Board

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The non-management members of the Board as a group •The full Board •Any other Board member The Compliance Hotline and web portal allow around-the-clock reporting of compliance program violations. Compliance Department staff review calls and web entries and follow through with the assistance of department or area managers (e.g., Legal, Human Resources and Finance). The web portal is hosted by an independent third-party vendor, ensuring complete anonymity.
2.7 Enforcement and accessibility;						The Code of Conduct includes examples of disciplinary actions that can be taken as a result of compliance or conduct violations. These actions can include verbal or written warnings, disqualification for raises and bonuses, suspension, and termination. Senior Management determines corrective action along with the Chief Compliance Officer, the Corporate Compliance Committee, the General Counsel and/or the associate's people leader. Violations of laws, regulations, the Code of Conduct or WellCare policies and procedures could also result in external legal action against the associate, his/her colleagues, and/or WellCare.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Internal monitoring and auditing;						WellCare conducts periodic audits and routine monitoring of business operations to evaluate compliance with internal controls and applicable federal and state laws, regulations, and guidance. Audits may be conducted as part of an investigation or proactively to monitor regulatory compliance in areas of actual or potential risk. This provides an avenue to ensure significant risks are detected and managed. It also ensures compliance with corporate, state, federal, and regulatory requirements. To protect its reputation, WellCare issues formal reports identifying opportunities to improve management controls and compliance. WellCare distributes audit reports to the Audit, Finance, and Regulatory Compliance Committees, department management, and senior leadership, including the Chief Compliance Officer. WellCare's audit report outlines action plans to mitigate risks. Open action plans are followed at least quarterly to ensure timely remediation of issues.
2.9 Response to offenses and corrective action;						WellCare promptly investigates reports of violations of Company policies, federal or state health care program requirements, or applicable laws to determine validity and significance. WellCare may use the Legal Department or outside counsel to conduct these investigations. For reports of misconduct related to payment or delivery of items or services under any contract,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						a delegated member of the Chief Compliance Officer's staff and/or the SIU initiates an inquiry within 14 calendar days from the date of the report.
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						Monthly, WellCare screens current and new employees and contractors against the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities, the General Service Administration's System for Award Management, and the Social Security Administration's Death Master File. Program Integrity databases for SC are also monitored monthly. These include the SC List of Excluded Providers and the SCDHHS List of Providers Terminated for Cause.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					WellCare's Market Compliance Oversight Committee supports and facilitates the identification, evaluation, assessment, oversight, and communication of compliance matters including risks, issues, and mitigation and oversight activities. The committee is chaired by the Market Compliance Officer and meets at least quarterly (and as needed). The *Market Compliance Oversight Committee Charter* states a simple majority of the entire committee constitutes a quorum. CCME's review of committee members revealed there are both

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						voting members and ad hoc members. It is unclear in the charter whether establishment of a quorum is based on both voting members and ad hoc members. Onsite discussion confirmed the established quorum is 50% of the voting members of the committee. CCME's review of committee minutes confirmed quarterly meetings with the presence of a quorum at each. *Recommendation: Clarify the Market Compliance Oversight Committee Charter to show a simple majority of voting members constitutes a quorum.*
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Processes to prevent and detect potential or suspected FWA are documented in the ISCA, the Compliance Plan, and related policies and procedures.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Corporate Compliance Internal Investigation Policy (C13-CP-020) describes processes for investigating reported and detected compliance issues. The South Carolina - Fraud Waste and Abuse Policy (C13-SIU-FWA-001-SC) includes processes for investigating reported and detected FWA activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes for provider payment suspensions and recoupments of overpayments are documented in the ISCA, Policy SC22-RA-008, State-Initiated Prepayment Review Policy, and the *WellCare of South Carolina Member Verification Letters* document.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					The Pharmacy Lock-In Program policy (SC22-RX-005) describes requirements and processes for the contractually-required statewide Pharmacy Lock-In Program. This policy mentions that members can be locked-in to a specific provider but does not explain the process. Onsite discussion revealed this is a new expansion of the Pharmacy Lock-in Program that was implemented in July 2019 allowing for members to be locked-in to a specific PCP to increase care coordination for those members in the Pharmacy Lock-in Program. CCME noted the version of Policy SC22-RX-005 found in the Compliance Plan, Appendix D18 is outdated. It contains track changes and was most recently approved in 2017. *Recommendation: Revise the Pharmacy Lock-In Program policy (SC22-RX-005) to clearly explain processes and requirements for restricting members in the Pharmacy Lock-in Program to a specific provider. Revise the Compliance Plan, Appendix D18 to include the current version of Policy SC22-RX-005.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I E. Confidentiality						
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					The Code of Conduct informs staff that all personal information, including health information of members, must be kept confidential, and that staff must comply with all privacy laws and regulations, including state privacy laws and the rules and regulations of HIPAA. The *Annual General Compliance Training* document includes information that "All associates have an obligation to protect member PHI and preserve the confidentiality of WellCare information regardless of individual role, responsibility or the department in which one works." Policy SC22-OP-CS-002, Medicaid Disclosure and Confidentiality Policy describes requirements and processes to ensure confidentiality of member information. Policy SC22-OP-CR-031, Confidentiality describes requirements and processes to ensure confidentiality of provider information during credentialing and recredentialing processes. Policy C13-CP-006, Corporate Compliance Training Policy states staff must complete designated Compliance training within 30 days of becoming a member of the workforce, unless

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						a different due date is identified. However, onsite discussion confirmed new employees receive training about confidentiality and HIPAA on the first day of employment. *Recommendation: Revise Policy C13-CP-006, Corporate Compliance Training Policy to include a statement that new staff receive training on confidentiality on the first day of employment.*

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
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				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* discusses the process WellCare uses for credentialing and re-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						credentialing practitioners and organizational providers. Policy SC22 OP-CR-001, Credentialing and Re-credentialing provided with the desk materials did not address whether WellCare is performing federal and state database checks for persons identified on Ownership Disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2*. CCME identified this issue during the 2018 EQR. When discussed during the onsite, CCME learned that the wrong policy was uploaded. WellCare provided the corrected policy. Also, Policy SC22-OP-CR-024, Medicaid Eligibility Federal and State Sanctions and Opt Out details various queries required at credentialing and recredentialing but omits the querying of the Social Security Death Master File as required by the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2*. During the onsite WellCare discovered CCME was given the wrong policy. WellCare gave CCME a red-lined version that included the query of the Social Security Death Master File.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC22-OP-CR-009, Assessment of Organizational Providers, includes obtaining the ownership disclosure information. However, this policy omits performing federal and state database checks for persons identified on Ownership Disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2.* *Quality Improvement Plan: Update Policy SC22-OP-CR-009, Assessment of Organizational Providers to explain how WellCare performs federal and state database checks for persons identified on the Ownership Disclosure forms with an ownership or controlling interest as required in the SCDHHS Contract, Section 11.2.10 and the Managed Care Organizations Policy and Procedure Guide, Section 11.2.*
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					WellCare's Credentialing Committee is the clinical peer review committee that oversees credentialing and recredentialing. This committee has final authority to approve or disapprove provider applications. The committee has delegated the authority to approve clean files to the Medical Director. In addition to its credentialing functions, the Credentialing Committee is the peer review committee for potential quality of care issues.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Senior Medical Director chairs the Credentialing Committee. Other voting members include four network providers whose specialties include cardiology, hematology/oncology, family medicine, pediatrics, and a licensed clinical social worker. The committee meets monthly, or not less than nine times per year. Minutes are recorded for each meeting. A review of a sample of meeting minutes showed the committee met monthly and a quorum of voting members was present for each meeting.
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:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;			X			None of the credentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried, as required by the *SCDHHS Contract, 11.2.10*. CCME identified this issue during the 2018 EQR. *Quality Improvement Plan: Implement a plan to ensure the SCDHHS List of Providers Terminated for Cause is queried for each credentialing file and proof of the query is documented in the file.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;		X				Three files did not address the Clinical Laboratory Improvement Amendment (CLIA). The applications used for credentialing did not address whether laboratory services would be provided at the practice location nor if the provider was queried about laboratory services. *Quality Improvement Plan: Ensure that a copy of the CLIA Certificate is obtained during the credentialing process. If laboratory services are not addressed in the credentialing application, query the provider to determine if a CLIA is needed.*
3.1.16 Ownership Disclosure form.	X					Two files contained old or outdated Ownership Disclosure forms. *Recommendation: Ownership Disclosure forms must be current.*
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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. One nurse practitioner recredentialing file contained an outdated collaborative agreement. The agreement was dated 2/9/16 and the recredentialing file was approved on 4/10/19. Also, the supervising physicians that signed the agreement in 2016 were not this practitioner's current supervising physicians. *Recommendation: Obtain an updated collaborative agreement for nurse practitioners during the recredentialing process.*
4.1 Recredentialing conducted at least every 36 months;	X					The recredentialing files contained most requirements. There were a few missing or deficient items noted in the standards that follow.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
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			None of the recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried as required by the *SCDHHS Contract, 11.2.10*. CCME identified this uncorrected issue during the 2018 EQR. *Quality Improvement Plan: Implement a plan to ensure the SCDHHS List of Providers Terminated for Cause is queried for each recredentialing file.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					
4.2.15 Ownership Disclosure form.	X					One file contained an outdated Ownership Disclosure form. *Recommendation: Ownership Disclosure forms must be current.*
4.3 Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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. The following are issues identified in the credentialing and recredentialing file review for organizational providers: •One recredentialing file did not contain a copy of the facility's Department of Health and Environmental Control License. •One credentialing file and two recredentialing files contained an outdated Ownership Disclosure form. *Recommendation: Ensure a copy of the Department of Health and Environmental Control License is obtained for all applicable organizational providers and the Ownership Disclosure forms are current.* •Six recredentialing files contained the WellCare Ownership Disclosure form instead of the required SCDHHS 1514 form.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•None of the organizational credentialing and recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause List was queried. CCME identified this uncorrected issue during the 2018 EQR. *Quality Improvement Plan: Ensure the SCDHHS 1514 Ownership Disclosure form is obtained. Document proof of the query of the SCDHHS List of Providers Terminated for Cause in the organizational provider credentialing and recredentialing files.*
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 defines the process of ongoing monitoring for participating providers. The policy states that in addition to providers being checked during initial and recredentialing, all current participating providers are monitored monthly.
II B. Adequacy of the Provider Network						
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 standards for primary care provider access as 90% of the Managed Care eligible population in the county with access to at least

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						one PCP within 30 miles and within 45 minutes or less driving time. Page three of Policy SC22 OP-NI-001 states, "The geocoded solution includes only required Providers (i.e. those with a status of 1 in the Table below). All PCP's are to be reported in a single combined report and all specialists are to be included in separate reports for each specialty." However, there is no table included in the policy. The *2018 Medicaid Quality Improvement Program Evaluation* showed 100% of PCPs met the 90% goal of members having access within 30 miles. *Recommendation: Include the table of Status 1 Providers in Policy SC22 OP-NI-001 or remove the reference to the table on page three.*
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 following access standards: •Required specialists: 90% of the Managed Care eligible population in the county must have access to the required specialist within 50 miles and within 75 minutes or less driving time. •Hospitals: 90% of the Managed Care eligible population in the county must have access to a hospital within 50 miles and within seventy (75) minutes or less driving time.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion confirmed the reference to "seventy (75) minutes" is a typographical error and the correct standard is 75 minutes. *Recommendation: Correct the typographical error in the hospital access standard in Policy SC22 OP-NI-001, GeoAccess Reporting.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					WellCare runs GeoAccess Reports twice yearly and evaluates provider access by county.
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 provides an overview of WellCare's activities to ensure services and materials are provided in a culturally competent manner to members, including those with limited English proficiency. The policy indicates WellCare maintains a copy of the *Cultural Competency Program and Plan 2019-2020* (Cultural Competency Plan) on its website and informs providers of this. CCME confirmed WellCare's Cultural Competency Plan is available on the website. The Provider Manual includes a detailed description of the Cultural Competency Program, including information about oral and written translation services and technology. The manual instructs providers to coordinate needed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						translation services through the Member Services Department. Staff are educated on cultural competency and sensitivity through the Compliance Training Program at the time of hire and annually.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The *2018 Medicaid Quality Improvement Program Evaluation* showed access requirements were not met for Pulmonary Medicine (rural) (Q4 86%). The EQRO SMD 10_14_19 document uploaded to the Provider Network folder in the desk materials (#4) indicates the following Status 1 specialists are not meeting geographic access requirements: •Neurology (nine counties) •Pulmonary Medicine (three counties) •Urology (two counties) WellCare staff reported that efforts continue to recruit providers in the categories that do not meet access requirements and that relationships have been established with out-of-network providers to provide services to WellCare members as needed. WellCare reported that a barrier to recruiting those non-participating providers into WellCare's network is that the providers are at maximum capacity for their member panels.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						When reviewing the 2019 SC Medicaid Q2 Work Plan Network Adequacy, CCME noted the work plan does not include all Status 1 Providers for monitoring. (Example: Neurology and Urology) *Recommendation: Include all Status 1 Providers on the Quality Improvement Work Plan to ensure bi-annual monitoring of network adequacy.*
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					WellCare's *Provider Directory* meets all contractual requirements. The printed *Provider Directory* includes indices for providers who speak alternate languages and providers who have extended hours. The directory includes icons to indicate providers who are board certified, who have wheelchair access, and who are not accepting new patients. There is one icon (car) with no explanation in the key. Onsite discussion revealed this icon indicates the provider is on a public transportation route. *Recommendation: Ensure all icons used in the Provider Directory are explained in the directory key.*
3.Practitioner Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 states timeliness of access to care for network providers is monitored through Appointment Accessibility and After-Hours telephone surveys. Results are reported to the Medical Advisory Committee and/or the Quality Improvement Committee. The policy describes actions taken when providers don't meet the compliance threshold of ≥90%. The Medical Director will contact providers who remain non-compliant, and continued non-compliance may result in panel closure and/or termination. Policy SC22-OP-NI-002 defines the appointment/access standards to which providers are expected to comply. These standards meet or exceed *SCDHHS Contract, Section 6.2.2.3* requirements. CCME noted the policy defines the appointment timeframe for routine PCP visits as 4 weeks, but the results documented in the *2018 Medicaid Quality Improvement Program Evaluation* indicate the survey measures compliance to a timeframe of 4-6 weeks. Onsite discussion confirmed the 4-6 week timeframe is correct. The *2018 Medicaid Quality Improvement Program Evaluation* states a contracted vendor conducts the Appointment Accessibility and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						After-Hours telephone surveys and WellCare reviews and validates the results received from the vendor. The 2018 survey results documented in the program evaluation revealed appointment access standards were not met for several categories. Actions taken by WellCare to address the areas of non-compliance were documented. *Recommendation: Revise Policy SC22-OP-NI-002 to reflect the correct timeframe WellCare uses to measure provider compliance for routine PCP appointments.*
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, CCME conducted a Telephonic Provider Access Study that focused on primary care providers. WellCare gave CCME a list of current providers. From this list, CCME identified a population of 2,312 unique PCPs. CCME randomly selected a sample of 240 providers from this population and attempted to contact these providers to ask a series of questions about access members have with them. Calls were successfully answered 80% of the time (158 out of 197) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 68%, this year's study had a statistically significant increase in successful calls (p=<.001).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						For those calls not answered (n=39), 18 (46%) were unsuccessful because the call was never answered. 78 providers responded to the question about accepting WellCare—of the 78, 69 (88%) indicated they accept WellCare. 67 providers responded to the question about accepting new patients. Of the 67, 22 (33%) would accept new patients and 45 (67%) would not accept new patients. Only 22 providers responded to the question about a screening process for new patients. Of the 22, 17 (77%) indicated an application or prescreen was necessary. The breakdown of responses is as follows: •Eight (47%) required ID and insurance card •Four (23%) required medical record review •One (6%) required both application and medical record review •Three (18%) required application only one (6%) required a referral
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					The Provider Relations staff conducts orientation and training for new providers within 30 calendar days of active status as noted in Policy SC22-HS-PR-001, Provider Training and Education. A Provider In-Service Checklist is used during orientation for providers and office staff which covers topics such as managed care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						program and services, WellCare's policies and procedures, and review of the Provider Manual. Also, the provider orientation presentation is located on the provider section of the website. During the onsite WellCare explained that providers are responsible for training their office staff on WellCare's Compliance Plan, found in Section 8 of the Provider Manual, which is confirmed by a signed attestation. Policy NM 159.109, Department Staff Training explains that all Provider Network Management employees complete an orientation-training program to meet their specific job function. The policy also shows that ongoing employee training occurs quarterly during staff meetings.
2. Initial provider education includes:						The *Provider Training Presentation* and *Provider In-Service Checklist* covers required topics. Providers are referred to the Provider Manual and other resources for topics not covered in the presentation, such as criteria for utilization management decisions and member benefits and services. Specific comments are made in sections 2.1-2.11 that follow.
2.1 MCO structure and health care programs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					Instructions for billing guidelines and processes are noted throughout the Provider Manual and on the website.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					The Provider Manual informs providers of appointment availability standards and the requirement to provide or arrange for 24-hour coverage.
2.6 Recommended standards of care;	X					Information on clinical practice guidelines and standards of care are available on the website and throughout the Provider Manual.
2.7 Medical record handling, availability, retention and confidentiality;	X					Requirements for medical record review, documentation, and retention standards are outlined in the Provider Manual.
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Reassignment of a member to another PCP;	X					Page 28 of the Provider Manual explains that providers complete a PCP Request For Transfer of Member Form and fax it to Provider Services with supporting documentation. As an alternative, providers can assist the member in completing a Change Request Form. Both forms can be accessed from embedded links in the Provider Manual and are available on the website.
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					Policy SC22-HS-PR-001, Provider Training and Education Policy describes the training process for providers. WellCare implements various methods for ongoing trainings, such as updates in the Provider Manual, site visits from Provider Representatives, letters/faxes to providers, and inclusions in the Provider Newsletter. The training section, on the secured provider portal, lists available required and non-required continuing education topics for providers and their staff. Additionally, WellCare conducted provider summit meetings in four regions of South Carolina in 2018.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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, SC - Provider Clinical Practice Guidelines and Preventive Health Guidelines states that WellCare will adopt preventive health guidelines that are designed to detect and improve the health status of WellCare members by providing preventive care to screen for a host of acute and potentially chronic illnesses. The guidelines are reviewed at least once a year and revised as necessary.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Practice guidelines are distributed to physicians via the website, and upon request.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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						
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					WellCare adopts validated, evidence-based clinical practice guidelines and uses the guidelines as clinical decision support tools. Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines and Preventive Health Guidelines defines the process of evaluation and adoption of practice guidelines.
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					
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Procedure SC22-HS-UM-019-PR-001, Care Coordination Continuity and Transition of Care describes how WellCare monitors continuity and coordination of care for all members between PCPs, specialists, medical and behavioral health facilities, ancillary providers, and pharmacy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers. Examples of WellCare encouraging continuity and coordination of care are noted throughout the Provider Manual. In addition, the following standards in the annual medical record review assess for continuity and coordination of care: referrals and results of specialist referrals, documentation of emergency and/or after-hours encounters and follow-up, and signed and dated consent forms.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					WellCare's processes for conducting annual practitioner medical record reviews is described in Policy SC22-HS-QI-005, Medical Record Review. These reviews do the following: •Focus on primary care and OB/GYN providers but may include additional specialties •Identify opportunities for improvement in medical record documentation •Identify areas that require practitioner peer review The policy describes the established scoring benchmark (80%) and actions taken when the benchmark is not met, including review of additional records, implementation of a corrective action plan, and re-auditing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Feedback is given to the provider throughout the review process.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Standards for acceptable documentation in member medical records are consistent with contract requirements. The standards are documented in Policy SC22-HS-QI-005, Medical Record Review and the Provider Manual. The Medical Record Review Tool includes all required elements.
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					For the 2019 Annual Medical Record Review Audit: •100% of 97 providers passed the Adult Medical Record Review Audit with an average final score of 97.9%. This represents an increase of 0.9% over the 2018 average final score. The lowest overall scoring elements were due to lack of documentation regarding employment, responsible party, and health education provided. •100% of 88 providers passed the Child Medical Record Review Audit with an average final score of 92.8%. This represents a decrease of 3.2% from the 2018 average final score. The lowest scoring element was due to lack of documentation regarding employment and responsible party.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Plans to address the lower scoring elements include market Quality Practice Advisors and Provider Relations Representatives continuing to educate and outreach to providers regarding required components of medical record documentation with a focus on deficit areas such as employment, responsible party, and health education provided.
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					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
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					WellCare guarantees member rights and responsibilities as outlined in Policy SC22-OP-CS-023, Medicaid Customer Service Disclosure of Rights and Responsibilities. Members are informed of their rights in newsletters, on the website, and in the Member Handbook. Additionally, providers are notified of member rights and responsibilities in the Provider Manual and members can obtain information from Member Service Representatives.
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately listed in the Member Handbook, Provider Manual, and on the website. See specific comments in Sections 2.1-2.6 that follow.
2.1 To be treated with respect and with due consideration for dignity and privacy;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
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						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of		X				Policy SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy states "members receive a *Quick Start Guide* within 5 days and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
enrollment data of all benefits and MCO information including:						will be issued an ID card within 15 days of receiving enrollment data from SCDHHS and after enrollment." The *Quick Start Guide* includes instructions to access or request a Member Handbook and the Provider Directory, and to contact Member Services. Procedure SC22-OP-CS-009-PR-001, Medicaid New Enrollee Welcome Calls Procedure describes new members receive orientation calls within five days from Eliza, an outside vendor, to conduct a scripted orientation of the plan. At the onsite WellCare explained that during 2019, orientation calls changed from automated and are now made by live staff. Additionally, page 42 of the Member Handbook reminds pregnant women that their baby will be covered by WellCare from the date of birth. See specific comments for the "Partially Met" score in Standard 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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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. Copayments do not apply to children younger than 19 years old, pregnant women, institutionalized individuals, or federally recognized Native Americans. In addition, the *WellCare Member Minibook* and the *Co-Pay Chart* list copayment fees that members must pay.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The process and requirements for prior approval of medical, behavioral health, and pharmaceutical services is described on the website and in the Member Handbook. In addition, services that require prior authorization are clearly listed throughout the Provider Manual. Prior approval is not required for family planning services and emergency visits.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The Member Handbook describes emergency care, post-stabilization care, and urgent care for physical, behavioral health, or dental issues. Members are informed that in addition to their primary care provider, the Nurse Advice Line is available 24 hours a day, seven days a week.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						The Member Handbook informs members WellCare will send written notice at least 15 days from becoming aware of the PCP's termination from the network and at least 30 days preceding the intended effective date to changes in their benefits. Policy SC22-HS-UM-017, Continued Care with Terminated Provider and Notification to Member of Specialist Termination shows a new PCP will be selected based on the members ZIP Code or the member can contact Customer Service for assistance in selecting an alternate PCP. Changes to the Preferred Drug List are available on the website under "Pharmacy Services."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Page 18 of the Member Handbook instructs members how to change their PCP. In addition, members can manage PCP selections by registering for a secure online account or by calling Customer Services for assistance.
1.11 Procedures for disenrolling from the MCO;						Disenrollment information and instructions provided in the Member Handbook meet *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;						The Member Handbook informs members to contact Member Services or use the *Provider Directory* to select a PCP and obtain information on, but not limited to, the PCP's age, gender, hospital affiliation, language spoken and address. A searchable *Provider Directory* is available on the website or members can request a paper copy.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
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;						The Member Handbook contains information for the three different types of Advance Directives: living wills, healthcare surrogates, and anatomical donations. Members are instructed to contact their PCP or an attorney to get an Advanced Directive. The Provider Manual explains that each member over 18 years of age should receive information on living wills and Advance Directives.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.21 Information on how to report suspected fraud or abuse;						Fraud and abuse are defined in the Member Handbook and on the website. Instructions are provided for members to anonymously report Fraud and Abuse to WellCare and SCDHHS via telephone or online.
1.22 Additional information as required by the contract and/or federal regulation;						The Member Handbook *Change Control Log* posted on the website does not have the date it was last revised as required by the *SCDHHS Contract, Section 3.13.2.16.* *Quality Improvement Plan: Include revision dates on the Member Handbook Change Control Log as required by SCDHHS Contract Section 3.13.2.16.*
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Instructions for members to request copies of member materials, including the Member Handbook and Provider Directory, were noted in the review of sampled BeWell Newsletters. CCME could not identify how members are notified of their right to request a copy of the *Provider Directory*. During onsite discussions, WellCare staff explained instructions requesting a *Provider Directory* are communicated in the Q2 2019 member newsletter. Issues identified in the following BeWell Newsletters: •Volume 3-2018, page nine, states, “Call to request a handbook or other member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						materials", but it does not specify Member Handbook or Provider Directory. •Q2 2019, page four, addresses requests for new member materials only. •Fall 2019, page nine, addresses requirements to request a Member Handbook but not the *Provider Directory*. *Recommendation: Ensure members are clearly informed of their right to request a copy of the Member Handbook and Provider Directory, at least once each calendar year, as required in SCDHHS Contract, Section 3.13.2.18.*
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					WellCare notifies members in writing of changes in benefits at least 30 days before the effective date of a change and within 15 days after a provider's termination from the network.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.		X				Policy SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy and Policy SC22-SM-004, Medicaid Written Marketing Review and Approval Process define requirements for member program materials. WellCare ensures member materials are written no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. CCME could not identify the font size used for regular and large print materials as required in the *SCDHHS Contract, Sections*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						3.15.1.3 and *3.15.2.8.* Onsite discussions revealed WellCare uses 12-point font size for regular print and 18-point font size for large print member materials. *Quality Improvement Plan: Edit policies SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy and SC22-SM-004, Medicaid Written Marketing Review and Approval Process to include the requirement to use 12-point font size for regular print and 18-point font size for large printed member materials as per the SCDHHS Contract, Sections 3.15.1.3* and *3.15.2.8.*
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					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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						leave a message to which a response is provided within one 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						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Policy SC22-OP-CS-006, Change of Primary Care Physician and page 18 of the Member Handbook describe the process for members to choose a PCP. Members can select one PCP for all members of the family or choose different PCPs according to their needs. 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 disenrollment initiated by WellCare, SCDHHS, or the member. WellCare must request member disenrollment in writing to SCDHHS.
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 are informed of scheduled preventive health services and available care management programs on the website, Member Handbook, and via member newsletters. Members are also informed how to obtain educational support for medical, behavioral health, and pharmaceutical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						services on the website, Member Handbook, and via member newsletters. Incentives are offered for members to participate in the recommended services through the Healthy Rewards Program.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					WellCare identifies EPSDT-eligible members who are missing or due for services and sends periodicity letters to encourage them to obtain a health assessment and preventive care. The letters remind members about immunizations and screenings that are due and offers assistance in scheduling appointments and transportation for these services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					The BeWell Member Newsletter provides a variety of wellness and prevention information on cancer screening and prevention, allergies and asthma, and flu shot myths. This information is also available on the website. The *2018 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 describes how the corporate office identifies pregnant members to provide educational materials about their pregnancy, postpartum care, and newborn care. The policy also explains WellCare's incentive to complete a required number of prenatal and postnatal visits.
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 contracts with SPH Analytics, a certified CAHPS Survey vendor, to conduct the Child and Adult Surveys. Response rates for all three surveys decreased in comparison to last year's response rates. The Child CAHPS Survey response rate was 17%; the Adult CAHPS Survey response rate was 21%; and the Children with Chronic Conditions (CCC) CAHPS Survey response rate was 15.9%. All response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%. *Recommendation: Continue to implement and develop methods to increase awareness and importance of the survey to members such as website reminders, posters in clinics and care settings, and Call Center scripts.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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 2019 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 2019 CAHPS Survey results were reported to providers via the 2019 Q3 Provider Newsletter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 2019 results for Child, Adult, and the CCC surveys as noted in minutes from 9/25/19. Analysis of data is provided in CAHPS Assessment 2019.
III F. Grievances						
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 describe processes for receiving, reviewing, and resolving grievances.
1.1 The definition of a grievance and who may file a grievance;	X					Page one of Policy SC22-OP-CS-021, Medicaid Customer Service Intake of Member Grievances contains and outdated definition of the term "grievance." It states a grievance is "an expression of dissatisfaction about any matter other than an action." The correct terminology is "adverse benefit determination." Refer to *42 CFR §438.400 (b)* and the *SCDHHS Contract, Section 9.1 (a)*. *Recommendation: Update the definition of a grievance in Policy SC22-OP-CS-021, Medicaid Customer Service Intake of Member Grievances.*
1.2 Procedures for filing and handling a grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;		X				Policy SC22-OP-GR-001, Medicaid Grievance Policy, the Member Handbook, the Provider Manual, and the *Grievance Notice of Extension* letter template do not address the member right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe. Refer to the *SCDHHS Contract, Section 9.1.6.1.5* through *9.1.6.1.5.2* and *42 CFR § 438.408 (c) (2) (ii)*. *Quality Improvement Plan: Revise the documents listed above to address the requirement that the member must be notified of their right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe.*
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					
2. The MCO applies grievance policies and procedures as formulated.		X				CCME's review of 20 grievance files found that the grievance resolutions were timely, and the grievances were properly referred for review as potential quality of care issues.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Two of the 20 files were noted with untimely acknowledgement letters. One file contained documentation that "Grievance was resolved within Acknowledgement Letter timeframe. Therefore, one letter sent to member." However, the resolution letter was sent 10 business days after receipt of the grievance. This is outside of the five business-day window to send the acknowledgement letter. One file had an inappropriate resolution to a grievance about the member being billed for physician fees for an emergency room visit. The resolution letter to the member indicated that because this facility is not in the WellCare network, WellCare is limited in its ability to get the facility to stop billing the member. WellCare took no further action to prevent the member from being billed for the emergency services. The *SCDHHS Contract, Sections 4.2.11.1.1, 4.2.11.1.2, and 4.2.11.1.4* states the MCO shall: •cover and pay for emergency services •provide emergency services without prior authorization •promptly pay for emergency services regardless of whether the provider has a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						contract with the MCO consistent with *42 CFR § 438.114(c)(1)(i)*. *Quality Improvement Plan: Ensure grievance acknowledgement letters are sent within five business-days of receipt of the grievance, as stated in Policy SC22-OP-GR-001. Ensure appropriate actions are taken to address incorrect member billing for emergency services by non-participating providers.*
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 states grievance data is analyzed to identify outstanding issues and adverse trends. WellCare tracks, trends, and reports grievance data routinely (monthly, quarterly, and annually) to health plan management and to the following committees: •Customer Service Quality Improvement Workgroup •Utilization Medical Advisory Committee (UMAC) •Quality Improvement Committee (QIC) CCME's review of UMAC minutes confirmed presentation and discussion of grievance data during meetings held on 2/11/19, 5/13/19, and 8/19/19. QIC minutes for December 2018, March 2019, June 2019, and September 2019 did not include

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						clear documentation that grievance data is reported to the QIC, as noted in Policy SC22-OP-GR-001. Onsite discussion confirmed the data is documented in the UMAC minutes that are reviewed during QIC meetings.
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						
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					WellCare's Quality Improvement (QI) Program operates under a plan of continuous improvement. The *2019 Medicaid Quality Improvement Program Description* (QI Program Description) describes the program's structure, accountabilities, scope, goals and available

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resources. The 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					
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					Annually, WellCare develops a *QI Work Plan* to guide and monitor activities for the year. The health plan provided the *2018* and *2019 QI Work Plans*. Both work plans were complete and addressed the requirements. Both work plans were labeled as 2017; however, the dates associated with each QI activity reflected the correct date. Also, the cover page labeled as "Work Plan Evaluation Statement" incorrectly states "WellCare quality improvement activities and performance measures will be reviewed, evaluated, and revised annually as outlined in the 2016 Quality Improvement Program Description." *Recommendation: Update the 2019 QI Work Plan and correct the errors identified.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The primary committee responsible for QI activities is the Quality Improvement Committee (QIC). The QI Program Description includes the primary responsibilities of the QIC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Utilization Management Advisory Committee (UMAC) 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. Practicing network physicians specializing in oncology, cardiology, family medicine, behavioral medicine, and pediatrics are included on the UMAC. The attendance for some of the network providers on the UMAC was poor. Four of the nine providers did not attend any meetings or only attended one meeting. *Recommendation: Recruit additional network providers to serve on the UMAC.*
3. The QI Committee meets at regular quarterly intervals.	X					The QIC meets monthly and the UMAC meets 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					Minutes are recorded for each meeting and document committee discussion points and decisions.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					WellCare uses Inovalon, a certified software organization, for calculation of Healthcare Effectiveness Data Information Set (HEDIS®) rates. CCME found the measures met all requirements. The comparison from the previous to the current year revealed a strong

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						increase (>10%) in a few rates, including Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy - 21-75 years (Male), Comprehensive Diabetes Care, specifically the Eye Exam (Retinal), and Metabolic Monitoring for Children ages 6 to 11 years old. A performance improvement project (PIP) was initiated previously to address improving retinal eye exams which likely impacted the rate. The measure that decreased substantially (>10%) was Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase. The rate decreased just over 13%. WellCare provided a three-year trend of HEDIS rates in the *2018 Medicaid Quality Improvement Program Evaluation*. Many of the rates had met or exceeded the 25th percentile goal over the three-year trend. *Recommendation: Move the goal rate to 50th percentile for those HEDIS measures that have met the 25th percentile for several years.* Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					WellCare submitted three projects. They included Improving Dilated Retinal Exam Screening, Access to Care, and Improving Hemoglobin A1C Testing.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The Dilated Retinal Exam Screening PIP had a rate improvement from the baseline over 10% and the Improving Hemoglobin A1C has sustained a rate above the goal rate. The Access to Care PIP improved only slightly. The incentives and education appear to be having a small impact. All PIPs scored in the "High Confidence" range and had improvement in rates. Details of the validation of the PIPs 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					Network providers are invited to participate on various committees. These providers play an active role in the ongoing QI 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						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					WellCare evaluated the QI Program and summarized the results of this evaluation in the *2018 Medicaid Quality Improvement Program Evaluation*. Most of the program's objectives were met. WellCare analyzed areas not meeting the goals and identified needed interventions to improve performance.
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 *2018 Utilization Management (UM) Program Description* outlines the goals, scope, staff roles for physical health, behavioral health, and pharmaceutical services for members in South Carolina. Several policies, such as SC22 HS-UM-011, Application of Criteria, provide guidance on UM processes and requirements. The *UM Program Description* explains how the UM Program is integrated with the Quality Improvement Program to support quality of care and continuous quality improvement and how it interfaces with the Care Management and the Disease Management Programs to support care coordination.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Requirements for service authorization time frames are described in Procedure SC22-HS-UM-025-PR-001, Service Authorization Decisions Procedure, Policy SC22-HS-UM-023, Inpatient Concurrent Review, the Member Handbook, and Provider Manual. However, the table on page 56 in the Provider Manual incorrectly lists the determination timeframe for concurrent reviews as 24 hours and extensions up to 72 hours. *Quality Improvement Plan: Revise page 56 in the Provider Manual to be consistent with the concurrent review timeframes in Policy SC22-HS-UM-023, Inpatient Concurrent Review and to meet requirements in the SCDHHS Contract, Sections 8.6.1.3* and *8.6.1.4.*
1.5 consideration of new technology;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Medical Director roles for physical and behavioral health are described in the *UM Program Description*. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting UM reviews, and participation on plan committees. Dr. Robert London is the Medical Director and Dr. Sultan Simms is the Behavioral Health Medical Director.
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					WellCare annually evaluates the UM Program to assess its strengths and effectiveness, and to develop recommendations to address areas of concern. The evaluation and recommendations are submitted to UMAC and QIC for review and approval annually. The UMAC consists of representatives of the provider network who participate and provide input on the UM Program. The *2018 UM Program Evaluation* includes an analysis of UM resources, metrics, and key performance indicators. The *2018 UM Program Evaluation* was presented and approved by the UMAC on May 13, 2019.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					The *UM Program Description* and Policy SC22-HS-UM-011, Application of Criteria lists UM standards and evidenced-based criteria used for determining medical necessity. WellCare's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						criteria includes but is not limited to Milliman Care Guidelines (MCG), South Carolina Medicaid Provider Handbooks, and SC statutes, laws, and regulations. At the onsite, WellCare staff explained that MCG was added in 2019 and that InterQual Criteria is still used for service authorizations. However, Policy SC22-HS-UM-011, Application of Criteria does not reflect that InterQual is used. *Recommendation: Edit Policy SC22-HS-UM-011, Application of Criteria (page two) to reflect both MCG and InterQual Criteria are used for service authorizations and to be consistent with the UM Program Description.*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM approval files reflect consistent decision-making using approved criteria and relevant medical information as described in the *UM Program Description* and Policy SC22-HS-UM-011, Application of Criteria.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Processes and requirements for coverage of hysterectomy, sterilization, and abortion procedures are specified in SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions. Therapeutic abortions must be documented with a completed Abortion Statement Form which is located in the Provider Manual and on the provider section of the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					WellCare allows for unique patient decisions in UM determinations, as noted in SC22-HS-UM-01, Application of Criteria. The policy describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. Additionally, page 102 of the *2019 QI Program Description* states, "Each medical decision must be case specific regardless of available practice guidelines." Files reflect consideration of individual member's needs and requests to obtain additional information when applicable.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					The *2019 QI Program Description* states, "inter-rater reliability (IRR) testing is conducted at least annually for Medical Directors and all clinical review staff involved in utilization decisions using a commercially available IRR program product from McKesson and/or Milliman Care Guidelines (MCG)." The Health Services Training Department conducts the annual IRR exam for licensed reviewers, who must achieve a passing score of 85%. Results are reported to UMAC and the QIC as noted in Policy SC22-HS-UM-007, Interrater Reliability. Additionally, Policy SC22-RX-008, Quality Assurance in the Pharmacy Department describes that WellCare's Pharmacy Quality Assurance (QA) Team performs monthly QA Reviews for pharmacy coverage determinations

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						using case reviews and IRR testing. CCME could not determine the benchmark for pharmacy IRR testing. At the onsite, WellCare staff confirmed the benchmark is 80%. *Recommendation: Edit Policy SC22-RX-008, Quality Assurance in the Pharmacy Department to include the benchmark for IRR testing of pharmacy staff is 80%.*
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 enrolled members. Pharmacy benefit information is available in Policy C22-RX-011, Medicaid Preferred Drug List, the Member Handbook, the website, and the Provider Manual. The Preferred Drug List (PDL) provides formulary restrictions indicating medications that require prior authorization, limitations, or step therapy. The Member Handbook describes the process for members to obtain over-the-counter medications that are covered with and without a prescription. Additionally, the *2019 Over-The-Counter (OTC) Benefit* booklet explains that members can call Member Service or log into the member portal to choose $10 worth of health and wellness items every month, which

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						includes medications such as pain relievers, vitamins and antacids. The *QI Program Description* indicates the Pharmacy and Therapeutics Committee (P&TC) consists of independent clinical pharmacists and physicians who make decisions regarding preferred drug list management activities. Policy SC22-RX-011, Medicaid Preferred Drug List Policy explains WellCare will honor existing prescriptions needing a prior authorization under WellCare's formulary for a period up to 90 days. However, page two of Policy SC22-RX-015, Pharmacy Transition indicates 60 days. Onsite discussions confirmed WellCare honors prescriptions for new members for 90 days. *Recommendation: Correct Policy SC22-RX-015, Pharmacy Transition to reflect WellCare honors prescriptions for new members for 90 days, as required in Managed Care Organizations Policy and Procedure Guide, Section 4.2.21.3 and to be consistent with Policy SC22-RX-011, Medicaid Preferred Drug List Policy.*
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Policy SC22-RX-003, South Carolina - Emergency Medication Overrides Policy and Policy SC22-PD-002, Covered Service Policy describe pharmacy requirements and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process for making exceptions to the closed formulary based on medical necessity. WellCare will authorize up to a 3-day emergency supply of medication 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					Policy SC22-PD-002, Covered Service, Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services, the Provider Manual, and the Member Handbook correctly describe emergency medical services and post-stabilization services and requirements.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and policies such as SC22-HS-UM-025, Service Authorization Decisions and UM.008S, Clinical Criteria describe staff who are licensed and trained to perform physical and behavioral health clinical reviews. A qualified Medical Director will render denials and review cases that the UM staff cannot approve. In addition, the Drug Evaluation Review Process policy explains that a Pharmacist or Medical Director conducts pharmacy clinical reviews.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for UM approval files are consistent with Policy SC22-HS-UM-025, Service Authorization Decisions Policy and *SCDHHS Contract* requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. Denials						
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					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
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					Denial files reveal denial decisions are made according to the processes described in Policy SC22-HS-UM-025, Service Authorization Decisions Policy and the accompanied procedure document. Denial decisions are communicated via phone or fax and followed by a written letter. The determination and notice in one denial file were out of timeframe compliance by four days due to late routing to behavioral health staff and this was acknowledged in UM notes. Adverse benefit determination letters to the provider and member indicate the criteria used for decision-making, give explanations that are easily understood, and include clear instructions for the appeal process. *Recommendation: Ensure service authorization for denial notices are rendered*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to meet timeframe requirements in SCDHHS Contract, Section 8.6.1.4.
V C. Appeals						
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					Processes and requirements for receiving, reviewing, and resolving member appeals are documented in Policy SC22-HS-AP-002, Member Appeals Policy and Policy SC22-RX-012, Pharmacy Appeals.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Policy SC22-HS-AP-002, Member Appeals Policy, page two, states an authorized representative is "an individual granted authority to act via SC DHHS form 1282 ME, authorization for release of information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals..." The requirement for the use of the 1283 ME form was removed from the SCDHHS Contract several years ago. *Recommendation: Remove the reference to form 1282 ME, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals from Policy SC22-HS-AP-002.*
1.2 The procedure for filing an appeal;	X					Policy SC22-HS-AP-002, Member Appeals Policy defines the timeframe within which a written

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appeal request must follow an oral request for a standard appeal. However, this information is not included in the following: •Policy SC22-RX-012, Pharmacy Appeals •Member Handbook •Provider Manual •WellCare's website *Recommendation: Include the timeframe within which a written appeal request must follow an oral request for a standard appeal in Policy SC22-RX-012, the Member Handbook, the Provider Manual, and on the WellCare website.*
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 not previously reviewed the case;	X					
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				Page 11, item VI (1) of Policy SC22-RX-012, Pharmacy Appeals incorrectly states standard appeal decisions that are adverse to the member, in whole or in part, are provided via written notice to the member no later than 72

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						hours from the receipt date. The correct timeframe for written notice of a standard appeal resolution is no more than 30 calendar days from the date of receipt of the appeal. Refer to the *SCDHHS Contract, Section 9.1.6.1.2.* Policy SC22-RX-012, Pharmacy Appeals does not address the requirement from the *SCDHHS Contract, Section 9.1.6.4.3* that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made. The *Expedited Administrative Review Determination Denial Notice* for pharmacy does not include the member's right to file a grievance if they disagree with the denial of the expedited review. The *Time Frame Extension Notice* for pharmacy does not include the member's right to file a grievance if they disagree with an extension. *Quality Improvement Plan: Correct the timeframe for written notice of resolution of a standard appeal on page 11 in item VI (1) of Policy SC22-RX-012, Pharmacy Appeals. Revise*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC22-RX-012, Pharmacy Appeals to include that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made. Revise the Expedited Administrative Review Determination Denial Notice for pharmacy to include the member's right to file a grievance if they disagree with the denial of the expedited review. Update the Time Frame Extension Notice for pharmacy to include the member's right to file a grievance if they disagree with an extension.
1.6 Written notice of the appeal resolution as required by the contract;		X				Issues noted in Policy SC22-RX-012, Pharmacy Appeals include: •The policy does not address the requirement that for upheld and partially upheld resolutions, the MCO must send the notice of appeal resolution to the member via certified mail, return receipt requested. •The policy does not include that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending, and how to request this or an explanation that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination. Refer to the *SCDHHS Contract, Sections 9.1.6.2.3.2.2 and 9.1.6.2.3.2.3.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Page 11, item VI (1) (g) and page 14, item VIII (1) (g) do not include requirements specific to South Carolina. The Policy states, "The right to request the next level of review as specified by each State." *Quality Improvement Plan: Revise Policy SC22-RX-012, Pharmacy Appeals to include the requirement that for upheld and partially upheld resolutions, the MCO must send the notice of appeal resolution to the member via certified mail, return receipt requested. Also include that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending, how to request continuation of benefits, and that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination. Update page 11, item VI (1) (g) and page 14, item VIII (1) (g) to include specific South Carolina requirements that the next level of review is a State Fair hearing.*
1.7 Other requirements as specified in the contract.		X				The timeframe for requesting continuation of benefits during the appeal or State Fair Hearing process is incorrectly documented on page 70 of the Member Handbook and on the WellCare website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The Member Handbook states, "Within 10 calendar days of the intended effective date of the plan's proposed action, whichever is later" •The website states, "within 10 calendar days of the intended effective date of the plan's proposed action whichever is later" The *SCDHHS Contract, Section 9.1.7.1.2* defines this requirement as, "The intended effective date of the CONTRACTOR's proposed Adverse Benefit Determination." *Quality Improvement Plan: Correct the timely filing requirement for continuation of benefits on page 70 of the Member Handbook and on the WellCare website.*
2. The MCO applies the appeal policies and procedures as formulated.		X				The following issues were noted in appeal files reviewed: •One expedited appeal with not resolved within the expedited appeal resolution timeframe with no documentation of denial of the expedited appeal request or of an extension of the resolution timeframe. •One expedited appeal was downgraded to a standard appeal with no notification the member. •One acknowledgement letter was not sent within the timeframe defined in WellCare policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•One resolution for an appeal related to reimbursement for medication was determined to be incorrect based on discussion during the onsite visit. WellCare staff reported this resolution would have been appropriate for a Medicare member but not a Medicaid member. *Quality Improvement Plan: Ensure contractual and policy requirements are followed when processing member appeals. Ensure appeal resolutions are appropriate for members covered under the Medicaid line of business.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Documentation in the *2018 Medicaid Quality Improvement Program Evaluation* indicates appeals are monitored on an ongoing basis to identify opportunities for improvement and are reported to the Customer Service Quality Improvement Work Group (CSQIW), UMAC, and the QIC. Policy SC22-HS-AP-002, Member Appeals Policy and Policy SC22-RX-012, Pharmacy Appeals do not address monitoring or reporting of appeals internally to quality committees for the purposes of identifying opportunities for improvement. *Recommendation: Revise the two appeals policies to include internal reporting of appeals data and activities for quality*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						improvement activities. Specify the committees to which appeals data is reported.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The *2018 Care Management Program Description* and Policy SC22-HS-CM-001, Care Management Program Description Process describes the Care Management (CM) Program and indicates the Disease Management (DM) Program is incorporated within it. Field and telephonic techniques are used for Physical and Behavioral Health CM and DM services.
2. The MCO has processes to identify members who may benefit from case management.	X					The CM Program Description describe methods which eligible members are identified and referred into CM, such as medical, BH, and pharmacy claims, laboratory and health risk assessment results, medical records, and UM data. WellCare uses a proprietary ID Strat model to identify and stratify members for CM. Identified members are assigned low-risk, moderate-risk, and high-risk scores based on cost, utilization, and severity. Identified members will receive an additional flag if they have a chronic illness such as asthma.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					WellCare's approach to member engagement is outlined in Policy SC22-HS-DM-012, Disease Management - Program Operation Document. It describes in detail the CM services provided to members in each stratification level; low risk, moderate risk, and high risk.
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.						
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 onsite WellCare confirmed Senior Manager Mitzy Bagwell serves as the Transition Coordinator.
6. The MCO measures case management performance and member satisfaction, and has	X					The *2018 QI Program Evaluation* and the *CM Program Description* describe how WellCare measures performance of the CM Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
processes to improve performance when necessary.						WellCare annually evaluates the quality and effectiveness of the program and the information obtained is used to assess strengths, weaknesses, and to develop recommendations for improvement of the CM and DM Programs. Member satisfaction is tracked and monitored by surveys and by investigating complaints.
7. Care management and coordination activities are conducted as required.	X					CM files show activities are conducted as required and Care Managers follow policies to conduct the correct level of case management. Files reflect clearly written case notes, evidence of hospital follow up, identifying care-gaps, and assessment of community resources. Unable to contact letters and education materials are correctly used. CM staff demonstrate consistent continuity of care by faxing updated care plans to the PCP or specialist.
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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						on findings for several services about utilization.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
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					
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 documentation of annual oversight of non-credentialing delegates. The documentation showed WellCare tracks metrics

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specific to the delegated services. Desk material documentation did not include monthly monitoring of delegates that provide call center functions (Teleperformance, The Results Companies). However, during the onsite visit WellCare staff stated it holds bi-weekly monitoring calls with the call center delegates. WellCare staff also provided the monthly dashboards they use for ongoing monitoring. WellCare performed annual delegation monitoring for all entities that handle credentialing and recredentialing. 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. *Quality Improvement Plan: Update the credentialing and recredentialing audit tools to include the query of the SCDHHS List of Providers Terminated for Cause and the Collaborative Agreement/Written Protocol for Nurse Practitioners.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					WellCare ensures pediatric immunization requirements are monitored by instructing providers to bill appropriate vaccine codes, as described on page six of the *EPSDT Toolkit*. The Provider Manual informs providers that WellCare monitors compliance with immunization requirements by reviewing PCP immunization rates and through random medical record reviews conducted by nurse reviewers.
1.2 performing EPSDTs/Well Care.	X					WellCare follows the EPSDT periodicity schedule according to the American Academy of Pediatrics and uses several methods to ensure EPSDT requirements are tracked. Methods include listing billing requirements for EPSDT services in the Provider Manual and conducting annual medical record reviews. The *EPSDT Toolkit* states that the EPSDT Program provides a "repository to house EPSDT data for reporting, tracking and trending." Providers receive a 120-day Non-Compliant Report informing them of impending or missed EPSDT services.
2. Core benefits provided by the MCO include all those specified by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Issues identified in the previous EQR that have not been corrected include: •The SCDHHS Contract requires health plans to query the SCDHHS List of Providers Terminated for Cause when credentialing or recredentialing a provider. CCME identified this issue during the 2018 EQR. The credentialing and recredentialing files reviewed during this EQR did not contain proof that the SCDHHS List of Providers Terminated for Cause was queried as required by the *SCDHHS Contract, 11.2.10.* *Quality Improvement Plan: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.*