IPRO
Improving Healthcare for the Common Good

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2018
Period of Review: September 1, 2017 – March 31, 2018
MCO: WellCare of Nebraska

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Care Management **General Requirements** The MCO must develop a care management program that focuses on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in C7CM MD-1.2-PR-005, Case Management Program Description Process (Case Management Nursing Care Plans) and the 2018 Care Management Program Description.	
The MCO must work with its providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem. Principles that guide this care integration include: 1. The system of care must be accessible and comprehensive, and fully integrate an array of prevention and treatment services for all age groups. It must be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement. 2. Mental illness and substance use disorder are health care issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings. 3. Many people suffer from both mental illness and substance use disorder. As care is provided, both illnesses must be understood, identified, and treated as primary conditions. 4. Relevant clinical information must be accessible to both the primary care and behavioral health providers consistent with Federal and State laws and other	**Documents** Policy/procedure Program description Onsite discussion of how the MCO works with providers to ensure medical/behavioral health care integration and presentation of examples	Full	These requirements are addressed in the Care Management Program Description and policy C7-CM-MD-1.2, Case Management Program Description. The care manager coordinates the interdisciplinary team to provide communication and collaboration.	

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applicable standards of medical record confidentiality and the protection of patient privacy.				
The MCO must assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2.	
The MCO must incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. CM must engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Substantial	This requirement is addressed in the Care Management Program Description. File Review Results Sixteen (16) of 20 files reviewed included self-management strategies. One file did not meet the requirement and one file was not applicable. **Recommendation** Members should be engaged in self-management strategies for identified diseases/conditions and these strategies should be documented in the case file. It is suggested that WellCare evaluate populations, and then within those populations identify the individual member's needs. WellCare can develop a framework based on a disease/condition that outlines self-management strategies for that condition. For example, "HTN" as a population/condition; what are the self-management strategies you suggest members consider for their optimum health? Those can be communicated to the client which then meets this contract requirement.	

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			MCO Response Exploring self-management strategies is an expectation through the care planning process based on the member's interest and willingness to engage. WellCare will evaluate the internal audit process of Care Managers to ensure opportunities to pursue disease state interventions and self-management are documented. **IPRO Final Findings** No change in review determination.	
The MCO must identify members who require medium/intensive CM based on their chronic conditions. The MCO must identify and track members whose clinical conditions or social circumstances place them at a higher risk of eventually needing intensive CM services. The proactive engagement of and early intervention with at-risk members may prevent or minimize their eventual need for more intensive CM services.	**Documents** Policy/procedure Program description Evidence of identification of members requiring medium/intensive CM based on their chronic conditions	Full	This requirement is addressed in C7CM 1.2-PR-016, Case Management Member Identification and Selection – Behavioral Health and C7CM MD-1.2-PR-009, Case Management Member Identification and Selection – Medical. WellCare uses a predictive algorithm to identify risk in the MCO's member population.	
The MCO's CM program must address the social determinants of health and how they may affect members' health and wellness. This requirement includes: 1. Ensuring that all covered services, including mental health or substance use disorder treatment services, appropriate to a member's level of need, are available when and where the member needs them. 2. Ensuring that all care management staff are familiar with available community resources and will refer	**Documents** Policy/procedure Program description Evidence of educating CM staff about available community resources View community resource tool/directory onsite	Full	1. This requirement is addressed in C7-CM-MD-1.2. 2. This requirement is addressed in C7-CM-MD-1.2. WellCare also provided a PowerPoint presentation for Referral Tracker 2.0 that describes the MCO's social service resource database. 3. This requirement is addressed in C7-CM-MD-1.2. WellCare also provided a PowerPoint presentation for Referral Tracker 2.0 that	

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members to these resources, such as, but not limited to, housing assistance programs and shelters, food banks/pantries, educational opportunities, and organizations which can assist with and address physical and/or sexual abuse. 3. Developing, subscribing to, or acquiring a tool accessible to its care management staff that maintains updated information regarding these resources in Nebraska communities within 90 calendar days of the contract start date. The MCO shall make access to this information available to MLTC staff on request.			describes the MCO's social service resource database. WellCare provided evidence of staff training.	
A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained about how social determinates affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, and violence. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.	**Documents** Evidence of MCO staff training including agendas, meeting materials and attendance records	Full	WellCare provided a PowerPoint presentation for Referral Tracker 2.0 and slides for cultural competency training. WellCare provided evidence of CM/DM integration training.	
The MCO is required to provide CM separate from, but integrated with, utilization management (UM) and quality improvement (QI) activities. The major components of CM include advocacy, communication, problem-solving, collaboration, and empowerment.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2.	
As part of the CM system, the MCO must employ care coordinators and care managers to arrange, assure delivery of, monitor, and evaluate basic and	**Documents** Position descriptions for care coordinator and care manager Organizational chart for CM department	Full	This requirement is addressed in the Organization Structure for Field Health Services and the position descriptions for behavioral	

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comprehensive care, treatment, and services to a member.			health care manager (senior), behavioral health care manager and field care manager.	
The MCOs must submit policies and procedures specific to care management for individuals who are dually eligible, have adult-onset disabilities, developmental disabilities and/or otherwise receive institutional or community-based long-term supports and services that address the unique needs of these populations.	**Documents** Policies/procedures	Full	This requirement is addressed in Policy C7CM MD-4.8, Individuals with Special Health Care Needs; Procedure C7 CM MD-4.8-PR-001, Individuals with Special Health Care Needs; Policy C7-CM-MD-4.7, Developmental Disabilities; and Procedure C7-CM-MD-4.7-PR-001, Developmental Disabilities.	
In addition, the MCO must annually review, and update as necessary, with the input, review, and approval of the Clinical Advisory Committee (CAC), the CM policies and procedures. All appropriate staff must be trained about the CM policies and procedures; they must also be shared with providers to promote consistency of care.	**Documents** Evidence of CAC approval of CM policies and procedures Evidence of MCO staff training including agendas, meeting materials and attendance records Evidence of sharing policies/procedures with providers	Full	The charter for the Clinical Advisory Committee (CAC) addresses review of policies and procedures for care management. The CAC minutes provided demonstrate review/approval of clinical practice guidelines which, per the MCO, include care management policies/procedures. WellCare provided the CM/DM Integration training deck as evidence of staff training in CM policies and procedures. The Provider Manual includes a description of the care management program.	
Health-Risk Screening/Assessment The MCO must provide a health-risk screening to all members on enrollment to identify members in need of CM services.	**Documents** Policy/procedure Template screening instrument **Reports** Examples of CM reports showing completion rates by new enrollees	Full	This requirement is addressed in the Care Management Program Description. WellCare also provided the 2-page WellCare Nebraska Health Survey, the comprehensive health assessment tool and the Medicaid NE Welcome and HRA report.	
As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management Program Description. Referrals	

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potentially in need of CM services, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, evaluation of claims data, member self-referral, and physician referral	Member Handbook Provider Manual		by members and physicians are addressed in the Member Handbook and Provider Manual, respectively.	
Health-risk assessments must be developed to collect information such as, but not limited to: 1. Severity of the member's conditions/disease state. 2. Co-morbidities, or multiple complex health care conditions. 3. Recent treatment history and current medications. 4. Long-term services and supports the member currently receives. 5. Demographic and social information (including ethnicity, education, living situation/housing, legal status, employment status, food security). 6. Activities of daily living (including bathing, dressing, toileting, mobility, and eating). 7. Instrumental activities of daily living (including medication management, money management, meal preparation, shopping, telephone use, and transportation). 8. Communication and cognition. 9. Indirect supports.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description and the comprehensive HRA assessment tool. File Review Results Twenty (20) of 20 files reviewed included a health risk assessment.	

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10. General health and life goals. 11. Safety (need for welfare/protection to eliminate harm to self or others). 12. The member's current treatment providers and care plan, if applicable. 13. Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma. 14. Substance use, including alcohol. 15. Interest in receiving CM services.				
The MCO must assign members to risk stratification levels (low, medium, high), which determines the intensity of intervention levels and follow-up care required for each member.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Substantial	Prior Results (2017) Substantial-8 of 20 files included a risk stratification level. For the eight files, the risk stratification level was not documented in most of the files presented. The MCO produced a separate listing of this information. Twelve files were not applicable. MCO Response Each Care Manager will have 3 cases audited a month to include risk stratification. Any noted errors will be considered coaching opportunities and will be reviewed with care management leadership during monthly 1:1 sessions. This requirement is addressed in the Care Management Program Description. WellCare uses a proprietary ID Strat model to identify and stratify members for care management.	

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			Members are assigned a score of high, moderate or low. File Review Results Twelve (12) of 20 files reviewed included a risk stratification level. For the remaining 8 files, WellCare produced a separate listing of this information. **Recommendation** The assigned risk stratification level should be documented in each care management file. It is important to stratify clients into high, medium and low risk. Sometimes a client can have multiple conditions but maintain a very satisfactory level of health. WellCare should describe how its risk stratification model accounts for this. **MCO Response** WellCare agrees that risk stratification is an important component of the CM process. WellCare will evaluate our internal documentation process to ensure that stratification levels are included in files. **IPRO Final Findings** No change in review determination.	
The MCO must ensure that members who have high costs or potentially high costs, or otherwise qualify, be assigned to the medium or high risk level and receive more intensive CM services.	**Documents** Policy/procedure Onsite presentation of case assigned to medium or high risk level based upon high costs or potentially high costs	Full	This requirement is addressed in the Care Management Program Description. Slides provided of standard ID Strat Predictive Risk Model show cost as a factor in determining risk level. WellCare provided a report of High Cost	

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			Members including PM/PM cost, member utilization history and diagnosis.	
The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management Program Description and ID Strat Predictive Risk Model.	
The MCO must conduct ongoing predictive modeling to identify members who may need CM evaluation.	**Documents** Policy/procedure **Reports** Examples of predictive modeling reports	Full	This requirement is addressed in the Care Management Program Description and ID Strat Predictive Risk Model. WellCare provided a report of High Cost Members including PM/PM cost, member utilization history and diagnosis and a report of Pharmacy High Dollar Claims.	
Behavioral Health Principles of Care The MCO must ensure that "active treatment" is being provided to each member. Active treatment includes implementation of a professionally-developed and supervised individual plan of care, in which the member participates and shows progress.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Substantial	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. File Review Results Nineteen (19) of 20 files reviewed met this requirement. The plan of care in one file was not implemented until 2 months after the health risk assessment was completed. **Recommendation** A plan of care should be implemented timely upon member enrollment in care management and completion of the health risk assessment. **MCO Response** The CM typically has 30 days from the date of referral to complete an assessment and document a care plan. WellCare will evaluate the internal audit process of Care Managers to ensure the timely development and	

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			implementation of care plans is appropriately documented. **IPRO Final Findings** No change in review determination.	
Basic CM Services The MCO must develop and adopt a CM program consistent with existing State policies and procedures to ensure all members who are eligible for CM have access to basic CM services.				
The MCO's basic CM program must promote empowerment of the person and shared decision making. Examples of basic level CM services the MCO may provide include: 1. Assistance with appointment scheduling and identifying participating providers, when necessary.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Substantial	This requirement is addressed in the Care Management Program Description and the care coordinator training for Outreach. File Review Results Twelve (12) of 20 files reviewed met this requirement. Seven (7) files were not applicable and one file lacked evidence of assistance. **Recommendation** As needed, care management files should reflect assistance with appointment scheduling and identification of participating providers. **MCO Response** WellCare will evaluate the internal audit process of Care Managers to ensure efforts to assist with appointment scheduling and identifying participating providers are appropriately documented. **IPRO Final Findings**	

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			No change in review determination.	
2. Assistance with CM and accessing primary care, behavioral health, preventive and specialty care, as needed.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Substantial	This requirement is addressed in the Care Management Program Description and the care coordinator training for Outreach. File Review Results Twelve (12) of 20 files reviewed met this requirement. Seven (7) files were not applicable and one file lacked evidence of assistance. **Recommendation** As needed, care management files should reflect assistance with accessing primary care, behavioral health, preventive and specialty care. **MCO Response** WellCare will evaluate the internal audit process of Care Managers to ensure efforts to assist with accessing primary care, behavioral health, preventative and specialty care are appropriately documented. **IPRO Final Findings** No change in review determination.	
3. Coordination of discharge planning with a focus on the seriously mentally ill population.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description, C7-CM-MD-1.2 and the care coordinator training for Outreach. File Review Results	

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			One (1) of 20 files reviewed met this requirement and 19 files were not applicable.	
4. Coordination that links a member to providers, medical services, or residential, social, community, and other support services, when needed.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the Care Management Program Description, C7-CM-MD-1.2 and the care coordinator training for Outreach.	
5. Continuity of care that includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. Continuity of care activities must ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress, or problems. Continuity of care activities must provide processes by which MCO members and network/non-network provider interactions are effective and must identify and address those that are not.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Substantial	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. File Review Results Eleven (11) of 20 files reviewed met this requirement. Seven (7) files were not applicable and two files lacked evidence of continuity of care. **Recommendation** As needed, care management files should reflect continuity of care including collaboration and communication with other providers involved in a member's transition to another level of care. Appropriate personnel including the PCP should be kept informed of the member's treatment needs, changes, progress, or problems. **MCO Response** WellCare submitted CM files to cover the audit look-back period rather than full files and this may have limited the opportunity to assess continuity of care. WellCare plans to evaluate the materials sent to PCPs when cases are closed to ensure continuity of care.	

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			IPRO Final Findings No change in review determination.	
6. Assistance with identifying and referral to the social supports and community resources that may improve the health and living circumstances of a member, including but not limited to, nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description, C7-CM-MD-1.2, the care coordinator training for Outreach and the Navigator resource list. File Review Results Eleven (11) of 20 files reviewed met this requirement and 9 files were not applicable.	
7. Following up with members and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.	**Documents** Policy/procedure Program description Examples of follow-up with members and providers	Full	This requirement is addressed in the Care Management Program Description. WellCare provided the Care Management Dashboard screenshot: Case Management Monthly Throughput-Clinical that shows face-to-face contacts. A sample member newsletter, Member Focus, was provided. WellCare provided provider newsletters and bulletins. Meeting agendas for in-person provider meetings were provided. On a case-by-case basis, care plans are provided to primary care providers for their respective members.	
The MCO must develop and adopt policies and procedures annually to address the following: 1. A strategy to ensure that all members and/or authorized family members or guardians are involved in care planning, as appropriate.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. File Review Results Twenty (20) of 20 files reviewed met this requirement.	

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2. A method to actively engage members in need of CM who are unresponsive to contact attempts or disengaged from CM.	**Documents** Policy/procedure Onsite discussion of methods used	Full	This requirement is addressed in the Care Management Program Description, C7-CM-MD-1.2 and the care coordinator training for Outreach. WellCare also provided an Unable to Contact letter example.	
3. An approach that uses pharmacy utilization data to tailor CM services.	**Documents** Policy/procedure Evidence of using pharmacy utilization data to tailor CM services	Full	This requirement is addressed in C7-CM-MD-1.2 and the Pharmacy High Dollar Claims report. WellCare also uses pharmacy utilization data to identify members potentially needing to be placed in restricted services.	
4. An approach to encourage participation in CM activities by, and collaboration among, the following providers: a. PCPs and behavioral health providers. This includes policies that ensure that PCPs refer members to behavioral health specialists when SMI is present or the member identifies as having a SMI. b. HCBS service coordinators. c. Community support providers.	**Documents** Policy/procedure Description of approach for encouraging participation in CM activities and collaboration among providers	Full	This requirement is addressed in C7-CM-MD-1.2.	
5. Procedures and criteria for making referrals to specialists and sub-specialists to ensure that services can be furnished to members promptly and without compromising care. The MCO must (a) provide the coordination necessary for referral of MCO members to specialty providers to determine the need for services outside the MCO network and (b) refer a member to the appropriate service providers.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management Program Description and C7 UM-63, Referrals to Non-Contracted Providers.	

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6. Results of the identification and assessment of any member with SHCNs to ensure that services and activities are not duplicated and to identify any ongoing special conditions that require a course of treatment or regular care monitoring.	**Documents** Policy/procedure	Full	During the onsite review, WellCare explained that the MCO uses algorithms to identify and refer members with SHCNs to care management. Foster care members have a dedicated care manager and any foster child with needs remains in active care management or is monitored on an ongoing basis. The MCO meets twice a month with the Division of Children and Family Services to coordinate care.	
7. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.	**Documents** Policy/procedure	Non-Compliance	WellCare provided C7 UM-4.5, Care Coordination, Continuity of Care and Transition of Care. This procedure addresses transition to another MCO but does not address transition to another PCP. **Recommendation** WellCare should establish a policy/procedure that addresses maintenance of care plans and referral services when a member changes PCPs. **MCO Response** WellCare will review and update the identified policy to ensure the appropriate requirements are included. **IPRO Final Findings** No change in review determination.	
8. Documentation of referral services and medically indicated follow-up care in each member's medical record.	**Documents** Policy/procedure Provider communication regarding medical record documentation	Full	This requirement is addressed in the Provider Manual.	

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9. Documentation in the member's medical record of all urgent care, emergency encounters, and any medically indicated follow-up care.	**Documents** Policy/procedure Provider communication regarding medical record documentation	Full	This requirement is addressed in the Provider Manual.	
10. A process that ensures that when a provider is no longer available through the MCO, the MCO allows members, who are undergoing an active course of treatment, to access services from non-contracted providers for an additional 90 calendar days to ensure continuity of care.	**Documents** Policy/procedure	Full	This requirement is addressed in C7 UM 4.5, Care Coordination, Continuity of Care and Transition of Care.	
11. A process that ensures continuity of care for members with SHCNs who are in CM.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management Program Description.	
For members assigned to medium risk care management, the MCO must meet basic care management requirement and: 1. Facilitate relapse prevention plans for members with depression and other high-risk behavioral health conditions and their PCPs (e.g., patient education, extra clinic visits, or follow-up telephone calls).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Substantial	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. File Review Results Two (2) of 20 files reviewed met this requirement and 16 files were not applicable. Two (2) files did not demonstrate facilitation of relapse prevention. **Recommendation** Care management files should include relapse prevention plans for members with depression and other high-risk behavioral health conditions. WellCare should partner with behavioral health providers to develop a universal relapse condition plan for higher volume patient needs, such as depression. **MCO Response**	

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			WellCare will review recovery and resiliency plans which address relapse prevention and implement the use of a plan to meet the individual health care of needs of our members. **IPRO Final Findings** No change in review determination.	
2. Partner with provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.	**Documents** Policy/procedure Onsite discussion	Full	Prior Results (2017) Substantial- WellCare has access to the EQuIPP dashboard that provides performance tracking on pharmacy measures. The MCO has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence. Per the MCO, once best practices are identified, one method for sharing these practices will be through outreach by the quality practice advisors. MCO Response Through process of clinical leadership data review, in alignment with the current work being done by the Drug Utilization Review (DUR) process, focused drug classifications will be identified. Data from Providers and Practices whose adherence rates are meeting HEDIS or other recognized standards will be used to create education and reporting to share with Providers and Practices not meeting standards. This information will be shared with the Providers and Practices during the encounters made with the identified practice by our Quality Practice Advisors.	

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			WellCare provided information on the PIP related to Tdap administration during pregnancy. This PIP includes identification of best practices and sharing of practices with lower performing providers.	
3. Educate provider office staff about symptoms of exacerbation(s) and how to communicate with patients.	**Documents** Policy/procedure Examples of education provided to office staff	Full	This requirement is addressed in the Care Management Program Description and clinical practice guidelines, e.g., Management of Asthma in Children and Adults, and COPD. Clinical practice guidelines are available on the MCO website.	
4. Develop speaking points and triggers for making emergency appointments.	**Documents** Policy/procedure Onsite discussion	Full	WellCare provided an asthma action plan template. Clinical practice guidelines address this requirement. Disease management materials assist members in identifying triggers for emergency situations.	
5. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors, or unmet needs.	**Documents** Policy/procedure Examples of forms and monitoring tools	Full	WellCare uses several forms and monitoring tools, such as the HRA, PHQ-9, SF-12, SF-10, action plans, and disease-specific screening tools.	
For members assigned to high risk care management, the MCO must meet requirements for members assigned to low and medium risk care management and the MCO must develop and adopt policies and procedures for the following: 1. As appropriate, organize the care using a person-centered, inter-disciplinary primary care and specialty treatment team to assist with development and implementation of individual medical care plans, that are in accordance with State QI and UM standards.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. File Review Results Two (2) of 20 files reviewed met this requirement and 18 files were not applicable.	

Care Management				
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2. Provide list of community resources (for referral).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. Referral Tracker 2.0 also addresses this requirement. Referral Tracker 2.0 includes the Community Activity Tracker and Local Activity Tracker (activity or event-focused resources, limited duration programs or services) and Navigator (organization-focused, multiple, ongoing services). The Navigator listing includes local and national resources. File Review Results Seven (7) of 20 files reviewed met this requirement and 13 files were not applicable.	
3. Plan for coordination and communication with State staff who are responsible for management of HCBS waivers.	**Documents** Policy/procedure	Full	This requirement is addressed in C7-CM-MD-1.2.	
4. Develop a process to engage non-compliant members.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in C7-CM-MD-1.2 and care coordinator training for Outreach. File Review Results Thirteen (13) of 20 files reviewed met this requirement and 7 files were not applicable.	
5. Develop a strategy for communication with members and their families, as well as key service and support providers and local social and community service agencies.	**Documents** Communication strategy	Full	This requirement is addressed in C7-CM-MD-1.2.	
6. Identify providers with special accommodations (e.g., sedation dentistry).	**Documents** Policy/procedure Provider directory	Full	This requirement is addressed in the WellCare Provider Directory on the MCO website.	

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7. Educate staff about barriers members may experience in making and keeping appointments.	**Documents** Evidence of staff education	Full	Prior Results (2017) Substantial- WellCare provided the following staff training documents: Integrated Model of Care: Case Managing Member Guidelines; CM Audit Tool Review (& More): Nebraska Training, 9/8/17; and WellCare of Nebraska Care Management Overview. A WellCare University Transcript (training record) was also provided. Barriers to accessing treatment such as transportation are addressed. C7-CM-MD-1.2 Case Management Program Description includes case manager assistance with scheduling appointments but does not address barriers. MCO Response Training will be developed and deployed to the team to address barriers members may experience in making and keeping appointments to include: Transportation Language Health literacy Personal healthcare beliefs Finding provider. WellCare provided slides showing a training regarding member barriers, titled Barriers Preventing Members from Making and Keeping Appointments. Evidence of training by care management staff was provided. The MCO also expanded its transportation benefit in January 2018 to provide transportation to WIC appointments, breastfeeding classes and childbirth classes.	

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8. Facilitate group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes, or tobacco use.	**Documents** Policy/procedure Onsite discussion	Full	Individual members are discussed at interdisciplinary team meetings. Examples of group events provided include: Fall Festival flier, Popsicles for a Poke, Purple Cry flier, World Breastfeeding Week flier with information on a health fair and a lunch n learn for providers. WellCare maintains clinical practice guidelines for perinatal care, diabetes and tobacco cessation.	
9. Communicate on a member-by-member basis on gaps/needs to ensure that a member obtains baseline and periodic medical evaluations from his/her PCP.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management Program Description and C7-CM-MD-1.2. File Review Results Ten (10) of 20 files reviewed met the requirement and 10 files were not applicable.	
The MCO must develop, implement, and evaluate written policies and procedures consistent with existing State policies and procedures, regarding continuity of care. In particular, the policies and procedures must address the following situations: 1. Members whose treating providers become unable to continue service delivery for any reason. 2. Member transitions from the children's system to the adult system. 3. Member transitions to/from IHS or other tribal agencies.	**Documents** Policies/procedures	Full	This requirement is addressed in the Care Management Program Description, C7-CM-MD-1.2 and C7 UM-4.5.	

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4. Member discharges from inpatient and residential treatment levels of care, including State psychiatric hospitals.				
Coordination with Providers and Other CM Programs Members who are aged, blind, or disabled; dual eligible; or who are enrolled in HCBS waiver programs or other State programs are likely to have one or more case or care managers. The MCO must demonstrate an understanding of health care and social service programs and initiatives offered by MLTC and other State agencies, and leverage those programs when appropriate for members receiving medium and intensive CM. Leveraging of existing programs may take the form of subcontracting or highly collaborative partnering, for example, and is intended to take advantage of existing resources and infrastructures to reduce or eliminate duplication of effort. Highly collaborative partnering must include, but is not limited to, crisis response services in coordination with behavioral health system entities.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in C7-CM-MD-1.2. Programs and services offered by MLTC and other agencies are included in the Navigator listing of resources.	
The MCO must attempt to ascertain whether a member has any other case or care managers, and, if so, to engage with them. The MCO must also attempt to ascertain whether a member has any other identified caregivers in the member's care planning and CM, and, if so, to engage with them.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in C7-CM-MD-1.2. File Review Results Two (2) files met this requirement and 18 files were not applicable.	
The MCO is responsible for ensuring coordination between its providers and the WIC program.	**Documents** Policy/procedure	Full	This requirement is addressed in C7-CM-MD-1.2. A WIC pamphlet was also provided. The	

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.			MCO's quality practice advisors provide these pamphlets to provider offices during site visits.	
The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in C7 UM-4.5.	
Coordination with HCBS Service Coordinators The MCO must collaborate and coordinate with HCBS case managers in a manner that complements, but does not duplicate, the member's plan of services and supports. The MCO must develop a policy and procedures for coordination with HCBS case managers. This policy and these procedures must address methods the MCO will use to ensure that coordination services are not duplicated.	**Documents** Policy/procedure	Full	This requirement is addressed in C7-CM-MD-1.2.	

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State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination with Tribal Organizations The MCO must develop policies for care coordination/collaboration for members who are Tribal members or are eligible for care through IHS or other Tribally-funded health and human services program, including: 1. Identification and appointment of a Tribal Liaison, to work with IHS and the Tribes. 2. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the MCO's network. 3. Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally-operated facility/ program, and urban Indian clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638. 4. Development of methods for regular planning to coordinate on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate health service delivery.	**Documents** Policy/procedure	Full	WellCare provided C7 CM-040, Care Coordination for IHS or tribal members and C7 CM-040-PR-001, Care Coordination for IHS or tribal members. 1. This requirement is addressed in the above policy/procedure. WellCare has a dedicated tribal liaison. 2. This requirement is addressed in the above policy/procedure. WellCare also provided a report showing attribution of IHS members to tribal—operated providers and reports showing pharmacy claims by facility/provider. 3. The MCO meets regularly with tribal providers. On a case-by-case basis coordination occurs through customer service interactions including face-to-face interactions at the MCO welcome rooms. 4. WellCare provided evidence of attendance at Tribal Health Advisory Committee meetings.	

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Coordination with the Division of Children and Family Services The MCO must develop processes and procedures for collaboration with the Division of Children and Family Services for children who are in foster care placement. CM must include collaborating with the child's Children and Family Services Specialist and identifying and responding to a child's health care needs including behavioral health. Policies and procedures must include: a. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice. b. How health needs identified through screenings will be monitored and treated. c. How medical information will be updated and appropriately shared, which may include the development and implementation of an electronic health record. d. Steps to ensure continuity of health care services. e. The oversight of prescription medications.	**Documents** Policy/procedure	Substantial	WellCare provided C7-BH-006, Nebraska – Behavioral Health Collaboration with Division of Children and Family Services and C7-BH-006-PR-001, Nebraska – Behavioral Health Collaboration with Division of Children and Family Services. A similar policy for non-behavioral health collaboration was not provided. **Recommendation** WellCare should establish a policy for non-behavioral health care coordination with the Division of Children and Family Services. **MCO Response** WellCare will review and update the identified policy to ensure the appropriate requirements are included. **IPRO Final Findings** No change in review determination.	

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Provider Network Requirements **General Provider Network Requirements** The network must be supported by written contracts between the MCO and its providers.	**Documents** Template provider contract – one per provider type	Full	This requirement is addressed by the following provider contract templates that were provided: WHP-PR1-PROVIDER CONTRACT TEMPLATE_ANC_MED FAC WHP-PR1-PROVIDER CONTRACT TEMPLATE_PRAC	
The MCO must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in Policy WHP-PR2-C6NI-002, which states that "All network providers, both first-tier and downstream providers, offer hours of operation that are no less than the hours of operation offered to Commercial and Fee-for-Service patients."	
There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.	**Documents** Policy/procedure	Full	This requirement is addressed in the Provider Manual, which states that "Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week."	
The MCO must have available non-emergent after-hours physician or primary care services within its network.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in Policy WHP-PR2-C6NI-002, which states that the MCO requires its primary care providers to arrange for coverage of services after-hours.	
Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in Attachment 39 – Revised Access Standards. The MCO must ensure that providers are available within these requirements. **Attachment 39:**	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in Policy WHP-PR5-C6NI-001-PR-001_GeoAccess Reporting Procedure, which contains an addendum specifically for Nebraska that references Attachment 39 and sets forth the MCO's Access standards.	

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Appointment Availability Access Standards 1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas. 2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO. 3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation. 4. Family planning services must be available within seven calendar days. 5. Non-urgent, preventive care must be available within 4 weeks. 6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week. 7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.				

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8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care. 9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists. <u>Geographic Access Standards</u> 1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties. 2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics. 3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.				

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a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences. b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences. c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences. 4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC. 5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in				

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those counties, the MCO must utilize telehealth options. 6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census. 7. The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.				
The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements.	**Documents** Policy/procedure	Full	This requirement is addressed in Policy C6NI-002, which states that in the event standards are not met, the MCO will take corrective action, as appropriate. This is also stated in Policy WHP-PR6-C6ND MD-001 Network Development.	
The MCO must make a good faith effort to contract with urgent care centers in the State to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in Policy C6CL MD-005Emergency Room and Urgent Care Services, wich includes an addendum specifically referring to emergency services for members in Nebraska. This requirement is also addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development).	

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In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not advertise or otherwise hold itself out as having an exclusive relationship with any provider.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development).	
The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters.	**Documents** Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development). WellCare's Provider Manual (page 33) also contains a section on the importance of cultural competency.	
The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development). The Provider Manual states that providers are inventoried for their language abilities. This information is available in the Provider Directory so members can choose a provider who speaks their primary language. Members are also offered interpreter services.	
The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development).	

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			The Provider Manual states that the MCO will conduct inspection to ensure accessibility (page 17).	
Provider Discrimination Prohibition A MCO may not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider who/that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification.	**Documents** Policy/procedure Provider manual	Full	Prohibiting discrimination is contained in both the Provider Manual (page 23) and in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development).	
MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**Documents** Policy/procedure Provider manual	Full	Prohibiting provider selection discrimination is stated in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development).	
If a MCO declines to include individual or group providers in its network, it must give the affected providers written notice of the reason for its decision. Federal requirements at 42 CFR 438.12(b) shall not be construed to: 1. Require the MCO to contract with providers beyond the number necessary to meet the needs of its members. 2. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. 3. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to its members.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development). The MCO also has two written policies on provider termination: WHP-PR15-C6ND-015 Termination of Existing Providers Without Cause and WHP-PR15-C6ND-015-PR-001 Termination of Existing Providers Without Cause.	

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Mainstreaming of Members To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f): 1. Denying or not providing a member any covered service or access to an available facility. 2. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary. 3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	Each component of this requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development). Further, the Provider Manual also contains a section on mainstreaming of members.	

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4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.				
If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development), which acknowledges the impact of contracting with a provider with the intent of implementing barriers to care.	
If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures shall subject the MCO to intermediate sanction or contract termination.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development).	
Establishing the Network The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members. The MCO must submit documentation to MLTC, in a format approved by MLTC, to demonstrate it meets this requirement at contract start date and any time there is a significant change (as defined by the State) in the MCO's operations that impacts services.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development), which contains language about its network containing an appropriate range of services. This requirement is also addressed in the MCO's GeoAccess policy and reports.	

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The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, and pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.	**Documents** Policy/procedure Onsite discussion	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no no provider service gaps were identified. It should be noted that access to hospitals in the Frontier region fell below 85%. As such, the MCO should continue to develop the hospital network in the Frontier region.	
The MCO must provide an adequate network of (PCPs) to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to	**Documents** Policy/procedure	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018.	

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State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
select or change their PCP. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.			After review of the 1st quarter 2018 report, no no provider service gaps were identified.	
The MCO's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members. In addition, the MCO must make a good faith effort to include providers currently contracted with behavioral health regions in Nebraska.	Onsite discussion	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no no provider service gaps were identified.	
The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.	**Documents** Policy/procedure Member Handbook	Full	Policy WHP-PR23-C7UM-4.16-PR-001 states no referrals to a women's health specialist are needed.	
For members who meet SHCN criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.	**Documents** Policy/procedure Member Handbook	Full	The MCO's Network Development policy includes language regarding allowing members with SHCN direct access to care.	
The MCO must ensure that its provider network includes sufficient numbers of network providers	**Documents** Policy/procedure	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network	

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with experience and expertise regarding the following behavioral health conditions: 1. Co-occurring mental health and substance use disorders. 2. Co-occurring mental health and substance use disorders and developmental disabilities. 3. Serious and persistent mental illness. 4. Severe emotional disturbance among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., Child Welfare, Probation, Developmental Disabilities, etc.). 5. Sex-offending behaviors. 6. Eating disorders. 7. Co-occurring serious mental illness (SMI) and common chronic physical illnesses.	Onsite discussion		template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no no provider service gaps were identified. During the onsite review, the MCO noted no single case agreements were required for Behavioral Health providers during the review period.	
If any service or provider type is not available to a member within the mileage radius specified in Attachment 39 – Revised Access Standards, the MCO must submit to MLTC, for approval a minimum of 45 calendar days prior to implementation, verification that the covered services are not available within the required distance.	**Documents** Policy/procedure Examples of notification to MLTC	Full	The MCO stated that it has provided the Network Adequacy and Cultural Competency Reports for Q2 which address this requirement. During the onsite review, the MCO advised that notification of non-covered services to MLTC was not required during the review period.	

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The MCO is not precluded from making arrangements with a provider outside the State for members to receive a higher level of skill or specialty than the level that is available within the State.	**Documents** Policy/procedure	Full	The standard is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development)	
Contracting with FQHCs and RHCs A MCO must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the MCO and a FQHC or RHC, the MCO must notify MLTC.	**Reports** Geo access reports Onsite discussion	Full	According to the MCO's 12/2017 GeoAccess report, RHCs and FQHCs are represented in both urban and rural areas. The MCO advised contracts are in place for all FQHCs and RHCs.	
Adequate Capacity When establishing and maintaining the network, the MCO must consider: Its anticipated Medicaid enrollment. The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCO. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. The numbers of network providers who/that are not accepting new Medicaid patients. The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	**Documents** Policy/procedure Network development plan Onsite discussion	Full	The standard is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development). The MCO stated that it will consider all of the elements in the regulation in establishing and maintaining its provider network.	

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Members with special health care needs, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.				
Appointment Availability and Referral Access Standards Nebraska's appointment availability standards are included in Attachment 39 – Revised Access Standards. MLTC will monitor each MCO's compliance with these standards through regular reporting per Attachment 38 – Revised Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.				
Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Substantial	The 45 minute wait time standard is stated in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development. However, the language in the Provider Manual in Access Standards and the Member Handbook Grievances section do not specifically indicate that wait times for scheduled appointments should not routinely exceed 45 minutes. **Recommendation** The MCO should update the Member Handbook and the Provider Manual with the language indicated in state contract	

Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			requirements related to the 45 minute wait time. **MCO Response** WellCare will update our Member and Provider Handbooks so that the appropriate requirement is included. **IPRO Final Findings** No change in review determination.	
Follow-up to emergency room visits must be available in accordance with the attending provider's discharge instructions.	**Documents** Policy/procedure Template provider contract – one per provider type Provider Manual	Full	The standard is addressed in the MCO's Network Development policy (WHP-PR6-C6ND MD-001 Network Development. Ideally, the language should be made available to providers in the Provider Manual as well.	
Direct contact with a qualified MCO clinical staff person must be available to members through a toll-free telephone number at any time. The MCO may not require a PCP referral for appointments with behavioral health providers when the behavioral health providers are in the MCO's network.	**Documents** Policy/procedure Template provider contract – one per provider type Provider Manual Member Handbook	Full	This requirement is addressed in the Member Handbook.	
The MCO is responsible for monitoring and assuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment availability including results and f/u actions	Full	The MCO's Quarterly Appointment Availability and Accessibility Timely Access Report includes the monitoring of appointment availability standards and results.	
The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are	**Documents** Policy/procedure **Reports**	Full	The MCO's Provider-Requested No-Show Outreach Workflow (WHP-PR35-301) describes the process used to monitor and reduce the appointment no-show rate.	

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identified, MLTC may require that they be implemented by the MCOs.	Evidence of monitoring of appointment "no-show" rate including results and f/u actions			
The MCO must monitor the practice of placing members who seek any covered services on waiting lists. If the MCO determines that a network provider has established a waiting list and the service is available through another network provider, the MCO must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider. In circumstances in which the member requires residential behavioral health services and is placed on a waiting list, the MCO must require its providers to offer interim services until residential services are available.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual **Reports** Evidence of monitoring of waiting lists including results and f/u actions	Full	This requirement is addressed on page 42 of the Network Development Policy (WHP-PR6-C6ND MD-001 Network Development).	
Geographic Access Standards The MCO must comply with maximum travel times and/or distance requirements per Attachment 39 – Revised Access Standards. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.	**Documents** Policy/procedure Requests for exception submitted to MLTC **Reports** Evidence of Geo access monitoring including results and f/u actions	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no no provider service gaps were identified.	
If there are gaps in the MCO's provider network, the MCO must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the MCO must document its efforts to engage any available providers (three good-faith	**Documents** Policy/procedure Provider network availability plan	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no no provider service gaps were identified.	

Provider Network Requirements				
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attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.				
The MCO must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The MCO must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.	**Documents** Policy/procedure Provider network availability plan **Reports** Evidence of monitoring utilization including results and f/u actions	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no no provider service gaps were identified.	
Provider Credentialing and Re-Credentialing The MCO is required to establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.	**Documents** Policy/procedure	Full	The MCO's Provider Credentialing Report (WHP PR41) to address this requirement and the MCO's Credentialing Recredentialing Procedure describes the process.	
The MCO must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCO must: 1. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or 2. Deny the application and ensure that the provider is not used by the MCO. A provider whose application is denied must receive written notification of the	**Documents** Policy/procedure Template denial letter	Full	This requirement is addressed in the MCO's Credentialing Recredentialing Procedure	

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decision, with a description of his/her/its appeal rights. A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.				
The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCO must also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's Credentialing/Recredentialing procedure.	
The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.	**Documents** Policy/procedure **Onsite file review** Credentialing file review results	Full	This requirement is addressed in the MCO's Credentialing Program Description (pg. 14). File Review Results Ten (10) of 10 files met this requirement.	
The MCO must re-credential each provider a minimum of every three (3) years, at a minimum, taking into consideration various forms of data, including but not limited to grievances, results of quality reviews, results of member satisfaction surveys, and utilization management information.	**Documents** Policy/procedure **Onsite file review** Re-credentialing file review results	Full	This requirement is addressed in the MCO's Credentialing Program Description (pg. 14). File Review Results Eight (8) re-credentialing files were available for review during the measurement period. All 8 files met this requirement.	

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The MCO must communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.	**Documents** Policy/procedure	Full	During the onsite review, the MCO provided a Provisional Licensure Report for the review period.	
Network Administration The MCO must maintain and continually update its network provider database that contains, at a minimum, the following information for each network provider: 1. Network provider name 2. Contracted services 3. Site address(as) (street address, city, zip code, region of the State) 4. Site telephone numbers 5. Site hours of operation 6. Emergency/after-hours provisions 7. Professional qualifications and licensing; 8. Areas of specialty, including specialties related to behavioral health conditions 9. Cultural and linguistic capabilities 10. Malpractice insurance coverage and malpractice history	**Documents** Policy/procedure View network provider database onsite	Full	The MCO's Provider Directory policy (C6NI-004) includes the elements in the standard. During the onsite review, the current Provider Directory on the MCO's website was review and evaluated to address this requirement.	

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11. Credentialing status				
The MCO must have the capability to produce a list of network providers, sorted by type of service and by providers' capability to communicate with members in their primary languages. This list must be available to the MCO's clinical staff at all times, and available to network providers and other interested parties upon their request and at no charge. As described in the Member Services section of this RFP, this list must be available on the MCO's website and updated in real time.	**Documents** Policy/procedure View website onsite	Full	The MCO has a Provider Network policy that addresses the standard. During the onsite review, the current Provider Directory on the MCO's website was review and evaluated to address this requirement.	
Network Development Plan Future network development plans must be submitted by November 1st of each contract year. This document is an assurance of the adequacy and sufficiency of the MCO's provider network. The MCO must also submit, as needed, an updated plan when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, payments, or eligibility of a new population.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the MCO's Network Development Plan (WHP-PR6-C6ND MD-001 Network Development). The MCO provided evidence of timely submission to MLTC.	
The MCO must include in its stated future plans a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis must be derived from: Quantitative data, including performance of appointment standards/appointment availability, eligibility/enrollment data, utilization data, network inventory, demographic	**Documents** Policy/procedure Network development plan	Full	The MCO has several policies that address this standard: WHP-PR6-C6ND MD-001 Network Development WHP-PR29-2018 Network Development Plan.FINAL.v4 WHP-PR6_GeoAccess_WHP_2017_Q4 WHP-PR5-C6NI-001 GeoAccess Reporting_Procedure	

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(age/gender/race/ethnicity) data, and the number of single case contracts by service type.			During the onsite review, the MCO advised no single-case contracts were initiated during the review period.	
Qualitative data (including outcomes data), when available, including grievance information; concerns reported by eligible or enrolled members; grievances, appeals, and requests for hearings data; member satisfaction survey results; and, prevalent diagnoses.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the WHP-PR29-2018 Network Development Plan.FINAL.v4.	
Status of provider network issues within the prior year that were significant or required corrective action by the MCO, including findings from the MCO's annual operational review.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the WHP-PR29-2018 Network Development Plan.FINAL.v4.	
A summary of network development efforts conducted during the prior year.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the WHP-PR29-2018 Network Development Plan.FINAL.v4.	
Plans to correct any current material network gaps and barriers to network development.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the WHP-PR29-2018 Network Development Plan.FINAL.v4.	
Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing priorities.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the WHP-PR29-2018 Network Development Plan.FINAL.v4.	
The participation of members, family members/caretakers, providers, including State-operated providers, and other community	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in WellCare's Network Development Policy (C6ND MD-00, Nebraska Addendum).	

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stakeholders in the annual network planning process.				
Provider Network Policies and Procedures The MCO must have policies about how it will: Communicate with the network regarding contractual and/or program changes and requirements.	**Documents** Policy/procedure	Full	The MCO's Network Development Policy (C6ND MD-001, Nebraska addendum) states that the MCO's Provider Relations Dept. is responsible for communicating policy updates to the provider network.	
Monitor network compliance with State rules, MLTC policies, and MCO policies, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring a member's care is not compromised during the grievance/appeal processes.	**Documents** Policy/procedure	Full	The MCO's Network Development policy (C6ND MD-001) addresses this standard	
Evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full	The MCO's Network Development policy (C6ND MD-001) addresses this standard	
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.	**Documents** Policy/procedure	Full	The MCO's Network Development policy (C6ND MD-001), addresses this standard	
Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.	**Documents** Policy/procedure	Full	The MCO's Network Development policy (C6ND MD-001), addresses this standard. The MCO also provided reports that it uses to monitor access (WHP PR30 and 39).	
Process provisional credentials for behavioral health service providers.	**Documents** Policy/procedure	Full	The MCO in its Network Development Policy addresses the need for outreach to behavioral health providers.	

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			During the onsite review, the MCO provided Policy C6-CR-019-PR-001 Credentialing Committee - Peer Review Procedure to address the requirement for provisional credentialing of providers.	
Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling.	**Documents** Policy/procedure	Full	This requirement is addressed in the Credentialing Program Description. Further, the MCO's Provider Handbook (page 41) outlines its QI oversight activities.	
Provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full	During the onsite review, the MCO provided evidence of quarterly training with the sign-in sheets from the Town Hall RSVP list.	
Educate its provider network regarding appointment time requirements.	**Documents** Policy/procedure	Full	This requirement is addressed in the Provider Handbook.	
Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.	**Documents** Policy/procedure **Reports** Evidence of tracking/trending of provider inquiries/complaints/requests for information including results and f/u actions	Full	The MCO's Known Issues Log, which shows how the MCO tracks issues and how these issues are handled and resolved addresses this requirement.	
Provider-Patient Communication/Anti-Gag Clause Subject to the limitations described in 42 CFR 438.102(a)(2), the MCO must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Handbook (page 24).	

Provider Network Requirements				
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benefits for such care or treatment are provided under the contract, for the following: a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the member needs in order to decide among relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a) (1) will be subject to intermediate sanctions. The MCO must comply with the provisions of 42 CFR 438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members and information disclosure requirements related to physician incentive plans.				
Confidentiality The MCO must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Handbook (page 24).	

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identifies a particular member, as well as any and all other applicable provisions of privacy law.				

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Provider Complaint System A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by the MCO. The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.	**Documents** Policy/procedure	Substantial	Addressed in WHP-C6 GR-NE-30, Nebraska Provider Complaint System Policy and C6-CS-059, Medicaid Provider Complaint Process. The provider complaint process was discussed onsite. Written complaints are considered formal complaints and are routed to the Grievance department. Complaints received by phone and not resolved are routed through the provider escalation team to the Grievance department. WellCare is in the process of amending its policies to address informal disputes; complaints received and resolved by phone. Informal disputes are maintained in the MCO's customer service database. **Recommendation** WellCare's policies/procedures should clearly define informal complaints (disputes) and formal provider complaints and include a description of how each is tracked and reported. **MCO Response** WellCare is currently revising the identified policy to clarify the difference between provider complaints and informal verbal inquiries/disputes. The updated policy will describe the different processes for each type of provider concern. **IPRO Final Findings** No change in review determination.	
This system must be capable of identifying and tracking complaints received by telephone, in writing,	**Documents** Policy/procedure	Substantial	Addressed in WHP-C6 GR-NE-30. The Grievance System Log provided includes, for example,	

Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.	**Reports** Provider complaint system reports produced during the review period		type of issue (complaint, appeal), complaint type, date received, resolution date, outcome, provider demographics. The MLTC-approved log does not collect method of request, e.g., verbal, however this information is noted in the individual case files. The log provided only includes complaints filed by a provider on a member's behalf and appeals. Provider complaints were not included. WellCare explained that provider complaints are captured in their grievance system and a report is in development that will address provider complaints. **Recommendation** WellCare should document and implement a process for reporting provider complaints. Evidence of reporting should be provided during the next compliance review. **MCO Response** WellCare will implement a process for reporting provider complaints and provide evidence of this reporting for the next audit period. **IPRO Final Findings** No change in review determination.	
The MCO must prepare and implement written policies and procedures that describe its provider complaint system.	**Documents** Policy/procedure Provider manual Template complaint resolution notice	Substantial	WHP-C6 GR-NE-30 provided. 1. The above policy inconsistently states the timeframe for providers to file a complaint. In one section the policy states that providers	

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Provider Services				
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The policies and procedures must include, at a minimum: 1. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the resolution timeframes. 2. A description of how providers may file a complaint with the MCO for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function. 3. A description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf. 4. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues. 5. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation. 6. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary. 7. A process for giving providers (or their representatives) the opportunity to present their cases in person.	**Onsite File Review** Provider complaint file review results		may file a complaint at any time and in another section, the policy states 30 days. An updated policy is awaiting MLTC approval. 2. The existing policy does not address complaints that may be filed directly to MLTC. An updated policy is awaiting MLTC approval. 3. Customer service representatives use a self-guided call path to distinguish between provider complaints and grievances and appeals filed by providers acting on a member's behalf. A training presentation for handling Medicaid grievances was also provided. 4. WellCare provided a procedure for handling multiple claims errors due to the same or similar issue. The Provider Handbook does not address a process by which providers are allowed to consolidate complaints. 5. Addressed in WHP-C6 GR-NE-30. 6. Addressed in WHP-C6 GR-NE-30. The Grievance department produces reports for provider relations and credentialing staff regarding provider complaints including volume and type of issue. 7. The provider's opportunity to present in person was not found in policy, the Provider Handbook or on the MCO website. 8. Addressed in WHP-C6 GR-NE-30.	

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8. Identification of specific individuals who have authority to administer the provider complaint process. 9. A description of the system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.			9. Addressed in WHP-C6 GR-NE-30. Complaints are captured in the MCO's grievance database. Associated documentation is maintained in the case file. File Review Results A total of 10 files were reviewed. All files included documentation of investigation of the substance of the complaint. Six (6) of 10 files were completed timely. Nine (9) of 10 files included a resolution notice. **Recommendation** An updated policy addressing all requirements should be implemented upon MLTC approval. The Provider Handbook should include instructions for providers for consolidating complaints regarding multiple claims that involve the same or similar payment or coverage issues. The provider's opportunity to present in person should be documented in MCO policy and in the Provider Handbook. Provider complaints should be resolved within the MCO-defined timeframe. All files should include a copy of the resolution notice sent to the provider. **MCO Response** WellCare's updated Provider Compliant System Policy was approved by MLTC 8/10/18. WellCare will review to ensure all elements are	

Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			addressed and implemented. Updates to the Provider Handbook regarding consolidating complaints and the opportunity to present complaints in person are currently in progress. **IPRO Final Findings** No change in review determination.	
The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It must include specific instructions regarding how to contact the MCO's provider services staff and contact information for the MCO staff person who receives and processes provider complaints.	**Documents** Policy/procedure Provider manual View website onsite	Substantial	WellCare provided a website screenshot that shows: p. 1 provider complaint request form p. 2 right to file a formal written complaint for non-claims issues. The timeframes for filing a request and for resolution of the complaint are not consistent with the timeframes stated in the MCO's policy. The MCO explained that an updated policy is awaiting MLTC approval. The 2018 Medicaid Provider Handbook was also provided. Similarly, the resolution timeframe stated is not consistent with the MCO policy. The Handbook references the provider complaint form provided on the website. The Handbook also refers to the Quick Reference Guide and provides a link for more information on how to contact the grievance department. **Recommendation** An updated policy addressing all requirements should be implemented upon MLTC approval. WellCare should ensure that the MCO website and Provider Handbook are consistent with the updated policy.	

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Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			MCO Response WellCare's updated Provider Compliant System Policy was approved by MLTC 8/10/18. WellCare will review to ensure all elements are addressed and implemented. Updates to the Provider Handbook to ensure consistency are in progress. **IPRO Final Findings** No change in review determination.	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Subcontracting Requirements As required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3), the MCO is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to: The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	**Documents** Policy/procedure List of subcontractors including scope of services provided and date of initial delegation **Reports** Pre-delegation evaluation report for each subcontractor contracted with during the review period Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Minimal- WellCare presented a list of 43 subcontractors. During onsite discussion, it was determined that two of the subcontractors had withdrawn, two had merged and one was not in effect until after the review period. This left a universe of 39 contracts to review. Four (4) of the 39 contracts under review for the period had initial effective dates of 1/1/17 or later and therefore evidence of a pre-delegation evaluation was expected. One of the four is actually the MCO's own Third Party Administrator, Comprehensive Health Management and there would not be a pre-delegation review because of the affiliated nature of the two entities and because many of the sub-contractor agreements are actually in the name of Comprehensive health. Of the three remaining subcontractors, one had evidence of a pre-delegation audit by the MCO, and two (Amenity Consulting and Gold Group Enterprise) did not. MCO Response WellCare will review Nebraska contractual requirements and internal policies related to when a pre-delegation review is required. When required, appropriate documentation of pre-delegation review will be submitted for future review periods. In addition, WellCare indicated that Amenity is not a delegate, and unclear if Gold Group is delegated. WellCare presented a list of 27 subcontractors. It was determined that two (2), Alere and	

Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Optum, were the same entity and thus were combined for the purpose of review. An additional thirteen (13) were determined to be providers to whom only credentialing of their own medical staff was delegated and therefore not in scope. Finally, one subcontractor listed (Progeny) does not yet have a contract in place, and thus was removed. This left a universe of twelve (12) subcontracts to review. Of the twelve (12) subcontractors, ten (10) were reviewed during the last EQR review in September 2017. Therefore, we would not expect to see pre-delegation authorization for existing subcontractors. Of the remaining two (2), both had evidence of pre-delegation evaluation.	
The MCO must have a written contract between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	**Documents** Contract with each subcontractor Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Substantial- Of the 39 subcontractors reviewed, all 39 had written contracts that were provided for review by the MCO. Thirty eight (38) contained appropriate scopes of work. Thirty eight (38) of the 39 contained the appropriate provisions for revocation or termination due to performance. One subcontractor, Advanced Medical Review (AMR), did not appear to have a contract that contained a clear scope of work and clear reporting requirements and frequency. MCO Response WellCare will issue an addendum to the AMR contract that clearly delineates the specific activities delegated to the subcontractor, as well as all required reporting and schedule of	

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			report deliverables expected from the subcontractor. Going forward, the MCO will provide a clear narrative to guide the EQRO in the case of name changes for any of the sub-contractors. Of the twelve (12) subcontractors, ten (10) were reviewed during the last EQR review in September 2017. Therefore, we would not expect to see new contracts to review. For the two (2) new subcontractors, the MCO provided agreements that met all of the requirements related to effective dates, scope, specific activities, reporting and termination. In addition, WellCare provided the agreement for AMR to satisfy the recommendation from the 2017 compliance review.	
The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Minimal- Of the 39 subcontractors, four would not be expected to have evaluations either because they are contracts entered into less than one year earlier. Evidence of formal evaluation of the subcontractor's performance and/or ongoing monitoring and analysis of the subcontractor was only present for 10 of the remaining 35 cases reviewed. The 25 subcontractor missing evidence of ongoing monitoring and formal annual review are: Administep.com LLC Amenity Consulting Centauri Operating Company-	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			CDR Associates, LLC Cotiviti/Connoly Concentrix CSI Southeast, Inc., d/b/a Interpretek CyraCom International, d/b/a Voiance Language Services Eliza Corporation Equian, LLC Financial Recovery Group First Recovery Group, LLC HumanArc Krames Staywell McKesson Health Solutions MTM Multilingual Group, Inc. NewGen ONEIL Digital Solution, LLC Results Technologies RR Donnelley & Sons Company Syrtis Solutions, LTD Translation Station TransUnion Healthcare, Inc. (formerly Med Data) VRI, Valued Relationships, Inc. MCO Response WellCare will review Nebraska contractual requirements and internal policies related to required oversight and monitoring of subcontractors. While WellCare has specific centralized policies and procedures for the monitoring and reviews of subcontractors who are designated as delegated entities, a different process may need to be developed for other types of subcontractors. Appropriate	

Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			documentation of monitoring and reviews of subcontractors will be submitted for future review periods. Of the twelve (12) subcontractors reviewed, one (1), HealthHelp, has an effective date less than one year prior to the time of the compliance review. This entity has not had annual monitoring as of yet, however being that it has not reached its one year anniversary, that is deemed acceptable. Of the remaining eleven (11) subcontractors, all had evidence of ongoing and annual monitoring. All of the 'credentialing only' subcontractors had evidence of monitoring as well.	
If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Minimal- Five (5) of the 10 subcontractors that had evidence of formal review by the MCO contained deficiencies that required remediation. All had communication from the MCO in regards to areas of improvement or corrective action plans. Since only 10 subcontractors received proper monitoring, it is difficult to fully assess compliance with this specific element. MCO Response WellCare will review Nebraska contractual requirements and internal policies related to corrective action of subcontractors. While WellCare has specific centralized policies and procedures for monitoring and corrective	

Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			action of subcontractors who are designated as delegated entities, a different process may need to be developed for other types of subcontractors. Appropriate documentation of monitoring and reviews of subcontractors will be submitted for future review periods. Of the eleven (11) subcontractors subject to annual monitoring during the review period, only three (3) had identified deficiencies during ongoing monitoring. All three (3) had evidence that the MCO engaged in corrective action plans and followed up on those plans.	

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Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Member Rights and Protections **Member Rights** The MCO must have written policies regarding members' rights that are specified in this section and in compliance with 482 NAC 7-001. At a minimum, each MCO member is guaranteed the right to: a. Be treated with respect and consideration of his/her dignity and privacy. b. Receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information. c. Participate in decisions regarding his/her health care, including the right to refuse treatment. Refusal of treatment is not a reason for which the MCO can request disenrollment of the member from the MCO. d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. e. Request and receive a copy of his/her medical records, and request that they be amended or corrected as specified in 42 CFR 438.100. f. Obtain available and accessible health care services covered under the contract. g. Request disenrollment per 42 CFR 438.56.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the Member Handbook, pages 110-112.	
Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook, pages 110-112.	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
rights will not adversely affect the member's treatment by the MCO, its providers, or MLTC.	Member Handbook			
Indian Health Protections Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, the MCO must: Permit any American Indian who is enrolled in a MCO and eligible to receive services from a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a PCP, to choose that I/T/U as his/her PCP, as long as that provider has the capacity to provide the service. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian members who are eligible to receive services from such providers.	**Documents** Policy/procedure **Reports** Provider adequacy report for I/T/U providers	Full	Prior Results (2017) Substantial- The MCO provided two reports, WHP-MSE-03-NetworkAdequacyandCulturalCompetencyReport_WHP_2017_Q1 and WHP-MSE-03-NetworkAdequacyandCulturalCompetencyReport_WHP_2017_Q2, for the onsite visit. These reports provide data for utilization of phone line and in-person translation for different languages, including Native American languages, under the "Cultural" tab. However, the number of members with Native American languages as their primary language or the number of providers with these languages are not listed in these files (Spanish, Arabic, Vietnamese, Russian, and French break-downs are provided); therefore, network adequacy is difficult to determine from these reports. Onsite, the MCO explained that they rely on monthly claims and pharmacy claims to assess utilization of I/T/Us in their network; since I/T/Us do not have to be contracted to service members, there are no contract documents. The MCO provided two reports during the onsite visit pertaining to claims tracking: WHP-MSE-03-IHSPharmacyReport_WHP_2017_Q2 and WHP-MSE-03-MonthlyclaimsReport_WHP_2017_07. The former report details pharmacy claims for I/T/Us, while the latter report breaks out monthly claims by provider type, including for Indian health hospital clinics (line 54) and	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Tribal 638 clinics (line 55) under the "Provider Type" tab. MCO Response WellCare continues to track and measure utilization of I/T/U services as well as claims payment activity to ensure provider adequacy and timely access for eligible members. This requirement is addressed in WellCare's Indian Health Protection Policy on page 2. The MCO provided pharmacy claims reports titled "Tribal Pharmacy Claims 2017 Q4" and "Tribal_Q4_2018_Claims", as well as a report of the number of members attributed to four Indian Health providers. It is difficult to ascertain if there are a sufficient number of I/T/U providers in WellCare's network to ensure timely access to services from the documents provided. Onsite, the MCO stated that there are 10 counties where members reside that need these services, and that there are no access to care issues. Additionally, the MCO provided a map of coverage in tribal areas: high volume specialties, PCP, and hospitals. It is difficult to ascertain the difference between the "All providers" symbol and "With access" symbol on the map. As there was no explanation of the map provided, it is difficult to determine network adequacy. Recommendation While onsite, the MCO stated that there are 10 counties where members reside that need I/T/U provider services, and that there are no access to care issues. This should be codified	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			within a document/report, to provide evidence of appropriate access for those members identified as eligible to receive services from such providers. Further, IPRO recommends the MCO provide detail of the elements on the coverage map for ease of interpretation in the next compliance review.	
Notice to Members of Provider Termination The MCO must make a good faith effort to provide affected members with written notice of a provider's termination from the MCO's network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.	**Documents** Policy/procedure Template notice of provider termination	Full	This requirement is addressed in WellCare's corporate policy, "Mass Transfers-All Lines of Business", page 3, under "Medicaid NE"; pages 10-11; and the template for the provider termination letter to members.	
The MCO must provide notice to a member who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice must be provided within ten (10) calendar days from the date the MCO becomes aware of the change, if the notice is provided in advance.	**Documents** Policy/procedure Template notice of provider termination	Full	This requirement is addressed in WellCare's corporate procedure "Continued Care with Terminated Provider and Notification to Members of Specialist Termination", page 9, bullet 2.	
Failure to provide notice prior to the termination date is allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when the provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under any of these circumstances, notice must be issued immediately upon the MCO becoming aware of the circumstances.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy, "Mass Transfers-All Lines of Business", page 11.	

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Oral Interpretation and Written Translation Services In accordance with 42 CFR 438.10(b)(1), MLTC will provide to the MCOs, and on its website, the prevalent non-English languages spoken by members in the State. The MCO must make real-time and culturally and linguistically appropriate oral interpretation services available free of charge to each Medicaid enrollee and member. This applies to all non- English languages, not just those that Nebraska specifically requires. The member must not be charged for interpretation services. The MCO must notify its members that oral interpretation is available for any language, written information is available in Spanish, and how they can access these services. Materials that provide this information must be written in English and Spanish. The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately.	**Documents** Policy/procedure	Substantial	This requirement is partially addressed in WellCare's corporate policy "Medicaid Post Enrollment Member Materials Policy", pages 1-2, policy statement, page 22, Addendum B; and WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37. There is no language which states the following: "The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately." During the onsite interview, the MCO stated they provide translation services for all written marketing materials in any language that is spoken by 5% or more members. **Recommendation** IPRO recommends the MCO add the missing contract requirement to the policy, and follow the written standard of providing translation services for all written marketing member materials in any language spoken by 4% or more members. **MCO Response**	

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			WellCare will revise the relevant policy so that it clearly states the contract requirement and will adhere to this requirement. **IPRO Final Findings** No change in review determination.	
Requirements for Member Materials The MCO must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet a.	
The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullets b and c.	
The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can find on the website and how to obtain written materials if the member does not have access to the website.	**Documents** Policy/procedure Member materials for new members	Substantial	This requirement is partially addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet d. There is a discrepancy for the number of days the MCO must distribute member materials: the policy says within 30 days, and the state contract says within 10 days. Onsite, IPRO brought this to the MCO's attention. The MCO responded by stating that they are using the 10 calendar day standard written in the contract and that the policy would be updated to reflect the 10 calendar day standard. **Recommendation**	

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			IPRO recommends the MCO update the policy to reflect the 10 calendar day standard. **MCO Response** This standard was changed from the original RFP standard of 30 days to 10 days in Addendum 6. While WellCare follows the 10-day standard, the policy was not updated. The identified policy will be revised to reflect the contract standard of 10 days to distribute member welcome packets. **IPRO Final Findings** No change in review determination.	
Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet e.	
All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet f.	
The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. The MCO must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.	**Documents** Policy/procedure Examples of member materials in English and Spanish, such as newsletters and other informational materials	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet g.	

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Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans, if applicable.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullets h and I.	
The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials.	**Documents** Policy/procedure Sample marketing materials	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet j.	
All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.	**Documents** Policy/procedure Examples of member materials	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet k.	
All written materials related to MCO enrollment and PCP selection must advise members to verify with their usual providers that they are participating providers in the selected MCO and are available to see the member.	**Documents** Policy/procedure Member materials for new members	Full	This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 37, bullet L.	
Member Handbook The MCO must develop, maintain, and post to the member portal of its website a Member Handbook in both English and Spanish. The MCO must publish the Member Handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy Member Handbook if they want it.	**Documents** Policy/procedure Member Handbook View website onsite Onsite discussion	Full	Prior Results (2017) Substantial- This requirement is addressed in the Updates to WellCare Websites (WHP-MSE-57-C6MMO-019 Updates to the WellCare Websites_CHR_05272016) policy on pages 20 and 25. Although this policy details policy for another state, the MCO indicated that it is a corporate policy that applies to Nebraska, as well .Onsite, the MCO demonstrated that the Member Handbook is accessible on their	

Member Services and Education				
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At a minimum, the MCO must review and update the Member Handbook annually The MCO's updated Member Handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the MCO must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.			website in English. The MCO indicated that the Handbook in Spanish is currently being developed and should be online soon. MCO Response WellCare agrees the Spanish Language Handbook should be made available online to members. The Spanish version of the WellCare of Nebraska Member Handbook was posted on 4/12/17, and then an updated version was posted on 10/16/17. This requirement is addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy", page 38, bullets a-d; the onsite demonstration of a member signing into the member portal and accessing educational materials and ordering the Member Handbook. The updated English and Spanish versions of the Member Handbook are posted to the public-facing website.	
At a minimum, the Member Handbook must include: 1. A table of contents.	**Documents** Member Handbook should address all sub-elements	Full	This requirement is addressed in the Member Handbook, pages iii-vi.	
2. A general description of basic features of how MCOs operate and information about the MCO in particular.		Full	This requirement is addressed in the Member Handbook, pages i-ii.	
3. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The Member Handbook shall provide the toll-free telephone number, fax number, email address, and mailing		Full	This requirement is addressed throughout various sections of the Member Handbook.	

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address of the Member Services department as well as its hours of operation.				
4. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.		Full	This requirement is addressed in the Member Handbook, page 17.	
5. Member rights/protections and responsibilities.		Full	This requirement is addressed in the Member Handbook, pages 110-114.	
6. Appropriate and inappropriate behavior when seeing a MCO provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action.		Full	This requirement is addressed in the Member Handbook, pages 10-11.	
7. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the Member Handbook.		Full	This requirement is addressed in the Member Handbook, page 15.	
8. A description of the PCP selection process and the PCP's role as coordinator of services.		Full	This requirement is addressed in the Member Handbook, pages 11-12.	
9. The member's right to select a different MCO or change providers within the MCO.		Full	This requirement is addressed in the Member Handbook, pages 12-13, page 104.	
10. Any restrictions on the member's freedom of choice of MCO providers.		Full	This requirement is addressed in the Member Handbook, page 37.	
11. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them.		Full	This requirement is addressed in the Member Handbook, pages 10-11.	

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12. The amount, duration and scope of benefits available to the member under the contract between the MCO and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.		Full	This requirement is addressed in the Member Handbook, pages 23-34	
13. Procedures for obtaining benefits, including authorization requirements.		Full	This requirement is addressed in the Member Handbook, page 23, and pages 45-47.	
14. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.		Full	This requirement is addressed in the Member Handbook, page 23.	
15. Information about health education and promotion programs, including chronic care management.		Full	This requirement is addressed in the Member Handbook, pages 38-43.	
16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full	This requirement is addressed in the Member Handbook, pages 48-49.	
17. How to make, change, and cancel medical appointments and the importance of cancelling or rescheduling an appointment, rather than being a “no show”.		Full	This requirement is addressed in the Member Handbook, page 11.	
18. Information about a member’s right to a free second opinion and how to obtain it.		Full	This requirement is addressed in the Member Handbook, page 48.	
19. The extent to which, and how, after-hours and emergency coverage are provided, including: a. What constitutes an emergency medical condition, emergency services, and post-stabilization services. b. That prior authorization is not required for emergency services.		Full	This requirement is addressed in the Member Handbook, pages 48-50.	

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c. The process and procedures for obtaining emergency services, including use of the 911-telephone system. d. That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.				
20. The policy about referrals for specialty care and for other benefits not furnished by the member's PCP.		Full	This requirement is addressed in the Member Handbook, page 45.	
21. How to obtain emergency and non-emergency medical transportation.		Full	This requirement is addressed in the Member Handbook, pages 63-64.	
22. Information about the EPSDT program and the importance of children obtaining these services.		Full	This requirement is addressed in the Member Handbook, pages 65-66.	
23. Information about notifying the MCO if a female member becomes pregnant or gives birth, the importance of early and regular prenatal care, and obtaining prenatal and post-partum care.		Full	This requirement is addressed in the Member Handbook, pages 51-56.	
24. Information about member copayments.		Full	This requirement is addressed in the Member Handbook, page 21.	
25. The importance of notifying the MCO immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.		Full	This requirement is addressed in the Member Handbook, page 114.	
26. How and where to access any benefits that are available under the Medicaid State Plan that		Full	This requirement is addressed in the Member Handbook, pages 35-36.	

Member Services and Education				
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are not covered under the MCO's contract with MLTC, either because the service is carved out or the MCO will not provide the service because of a moral or religious objection.				
27. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds.		Full	This requirement is addressed in the Member Handbook, pages 27 and 110.	
28. Member grievance, appeal, and state fair hearing procedures and timeframes, as follows: a. For grievances and appeals: i. Definitions of a grievance and an appeal. ii. The right to file a grievance or appeal. iii. The requirements and timeframes for filing a grievance or appeal. iv.. The availability of assistance in the filing process. v. The toll-free number(s) the member can use to file a grievance or an appeal by telephone. vi. The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.		Full	This requirement is addressed in the Member Handbook, pages 94-97.	

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b. For state fair hearing: 1. Definition of a state fair hearing. 2. The right to request a hearing. 3. The requirements and timeframes for requesting a hearing. 4. The availability of assistance to request a fair hearing. 5. The rules on representation at a hearing. 6. The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.		Full	This requirement is addressed in the Member Handbook, pages 98-99.	
29. A description of advance directives that includes: a. The State's and MCO's policies about advance directives. b. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.		Full	This requirement is addressed in the Member Handbook, pages 92-93.	
30. Information about how members can file a complaint with MLTC or the Division of Public		Full	This requirement is addressed in the Member Handbook, page 93.	

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Health about a provider's failure to comply with advance directive requirements.				
31. How a member may report suspected provider fraud and abuse, including but not limited to, the MCO's and MLTC's toll-free telephone number and website links created for this purpose.		Full	This requirement is addressed in the Member Handbook, page 108.	
32. Any additional information that is available upon request, including but not limited to: a. The structure and operation of the MCO. b. The MCO's physician incentive plan (42 CFR 438.6(h)). c. The MCO's service utilization policies. d. How to report alleged marketing violations to MLTC. e. Reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.		Full	This requirement is addressed in the Member Handbook, page 112.	
33. A minimum of once a year, the MCO must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.		Full	This requirement is addressed in the "Member Focus" newsletter, issue 3, 2017; and the "Medicaid Post Enrollment Member Materials" policy, pages 24 and 28.	
Other Member Notifications The MCO must also provide the following information to each member:	**Documents** Policy/procedure Evidence of member notification	Full	This requirement is addressed in WellCare's "Disenrollment Policy" on page 44 of Addendum L; and in the "Other Member Notification" letter template, page 1.	

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A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.				
A minimum of annually, the MCO will inform all members of their right to request the following information. 1. An updated Member Handbook, at no cost to the member. 2. An updated provider directory, at no cost to the member.	**Documents** Policy/procedure Evidence of member notification	Full	This requirement is addressed in the "Other Member Notification" letter template, page 2.	
Member Newsletter The MCO must develop and distribute, a minimum of twice a year, a member newsletter. This publication must be available on the member portal and mailed to members on request. Topics covered in the newsletter must be timely and relevant to the member population. Suggested topics to discuss include but are not limited to: 1. Educational information on chronic illnesses and ways to self-manage care. 2. Behavioral health information. 3. Reminders of flu shots and other prevention measures at appropriate times. 4. Medicare Part D issues. 5. Cultural competency issues. 6. Tobacco cessation information and programs. 7. HIV/AIDS testing for pregnant women. 8. Other topics as requested by MLTC.	**Documents** Policy/procedure copies of member newsletters issued during the review period	Full	This requirement is addressed in the "Member Focus" newsletter provided by the MCO. The MCO provided issues 3 and 4 from 2017, and issue 1 from 2018. This indicates that the newsletter is quarterly.	

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Provider Directory for Members The MCO must develop and maintain a provider directory for its members in three (3) formats: 1. A hard copy directory, when requested, for members, potential members, and the enrollment broker. 2. A web-based, searchable, online directory for members, potential members, and the general public. 3. An electronic file of the directory to be submitted and updated weekly to MLTC or its designee, and the enrollment broker.	**Documents** Policy/procedure Provider directory View website onsite	Full	This requirement is addressed in WellCare's corporate "Web-based Provider Directory" Policy, on page 11, bullet a i-iii.	
The hard copy directory for members must be updated a minimum of monthly. The web-based version must be updated in real time, and no less often than three (3) business days after notification of any change. Daily updates are preferred, if possible.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate "Web-based Provider Directory" Policy, page 11, bullet c.	
In accordance with 42 CFR 438.10(f)(6), the provider directory must include, but not be limited to: 1. Names, locations, telephone numbers, specialties, and non-English languages spoken of all current contracted providers (including urgent care clinics, FQHCs, RHCs, labs, radiology providers, behavioral health providers, hospitals, and pharmacies) in the MCO's network. Those PCPs, specialists, and other providers who/that	**Documents** Policy/procedure Provider directory View website onsite	Full	This requirement is addressed in WellCare's corporate "Web-based Provider Directory" Policy, page 11, bullet d; screenshots of the provider directory on WellCare's website; and the onsite demonstration of locating a behavioral health provider via the web-based provider directory, which contains the language, business hours, address, phone number, and other pertinent information about the provider.	

Member Services and Education				
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are not accepting new patients must be identified. 2. Hours of operation, including identification of providers with non-traditional hours (before 8 am, after 5 pm, or any weekend hours).				
Member Website The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the MCO and receive responses). The MCO website must include general and up-to-date information about the Nebraska Medicaid program and the MCO. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. Use of proprietary items that would require use of a specific browser or other interface is not allowed.	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed in WellCare's corporate policy titled "Updates to the WellCare Websites", pages 38-39, bullets a-f; and WellCare's member website screenshots; and the onsite demonstration of a member signing into the member portal and accessing educational materials and ordering the Member Handbook.	

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The MCO must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members: 1. The most recent version of the Member Handbook. 2. Telephone contact information for the MCO, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number. 3. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the MCO network. 4. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment. 5. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility. 6. Information about how to file grievances and appeals.	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed in WellCare's corporate policy titled "Updates to the WellCare Websites", page 39, bullet g i-vi; and WellCare's member website screenshots.	
Advance Directives The MCO must maintain written policies and procedures for advance directives. The MCO must provide written information to all adult members with respect to:	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's corporate policy titled "Advance Directives", page 7, Addendum C (Nebraska) bullets a-e.	

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1. Their rights under applicable law. 2. The MCO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. The MCO is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. The MCO must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with MLTC or the DHHS Division of Public Health. Any written information on advance directives must reflect changes in State law as soon as possible, but no later than 90 calendar days after the effective date of a change.				

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Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Quality Management The MCO must include QM processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members. The MCO's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract. The MCO must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system as a result of this RFP. The MCO will be provided with the final Quality Strategy when it is approved by CMS. The MCO must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities.				
The MCO's QM program must include: 1. A quality assurance and performance improvement (QAPI) program. 2. Performance improvement projects (PIPs). 3. Quality performance measurement and evaluation. 4. Member and provider surveys.	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	

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Quality Management				
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5. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program.				
The MCO must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as UM and CM. The MCO is expected to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.	**Documents** QM Program Description Corporate organizational chart QM department organizational chart	Full	This requirement is addressed in the 2017 QI Annual Program Description as well as the QM Department Organizational Chart and Corporate Organizational Chart.	
Quality Management Deliverables The MCO must submit the following QM deliverables to MLTC: Description and composition of the QAPI Committee (QAPIC).	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	
A written description of the MCO's QM program, including detailed QM goals and objectives, a definition of the scope of the program, accountabilities, and timeframes. QM Program Description due date: 30 calendar days following 12th month of contract year	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description. The Program Description was submitted timely to MLTC on 2/16/18.	
A QM work plan and timeline for the coming year that clearly identifies target dates for implementation and completion of all phases of the MCO's QM activities, consistent with the clinical quality performance measures and targets set by MLTC, including, but not limited to: 1. Data collection and analysis. 2. Evaluation and reporting of findings.	**Documents** QM work plan	Full	This requirement is addressed in the 2018 Nebraska Medicaid Work Plan. The QM Workplan was submitted timely to MLTC on 2/16/18.	

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Quality Management				
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3. Implementation of improvement actions, where applicable. 4. Individual accountability for each activity. QM work plan due date: 30 calendar days following 12th month of contract year				
Procedures for remedial action for deficiencies that are identified.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in policy C7QI-033 –PR-001 – Quality Improvement Program and Provider Involvement and the Program Description.	
Specific types of problems requiring corrective action.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in policy C7QI-033 –PR-001 – Quality Improvement Program and Provider Involvement and the Program Description.	
Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in policy C7QI-033 –PR-001 – Quality Improvement Program and Provider Involvement and the Program Description.	
Procedures for provider review and feedback about results.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in policy C7QI-033 –PR-001 – Quality Improvement Program and Provider Involvement and the Program Description.	
Annual QM evaluation that includes: 1. Description of completed and ongoing QM activities.	**Documents** QM Evaluation Onsite discussion	Full	This requirement is addressed in 2017 Medicaid Quality Assessment and Performance Improvement Program Evaluation – January 1, 2017 – December 31, 2017.	

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Quality Management				
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2. Identified issues, including tracking of issues over time. 3. Analysis of and tracking progress about implementation of QM goals and the principles of care, as appropriate. Measurement of and compliance with these principles must be promoted and enforced through the following strategies, at a minimum: a. Use of QM findings to improve practices at the MCO and subcontractor levels. b. Timely reporting of findings and improvement actions taken and their relative effectiveness. c. Dissemination of findings and improvement actions taken and their relative effectiveness to key stakeholders, committees, members, families/caregivers (as appropriate), and posting on the MCO's website. d. Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. The MCO must use an industry-recognized methodology, such as SIX SIGMA or other appropriate method(s), for analyzing data. The MCO must demonstrate inter-rater reliability testing of evaluation, assessment, and UM decisions. e. An analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of			Evidence of timely submission to MLTC was provided onsite.	

Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
service to members, and overall effectiveness of the QM program. QM Evaluation due date: 30 calendar days following 12th month of contract year				
Procedures assessing the quality and appropriateness of care furnished to members with SHCNs. The assessment mechanism must use appropriate health care professionals to determine the quality and appropriateness of care.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the 2017 QI Annual Program Description.	
QAPI Program The MCO's QAPI program, at a minimum, must comply with State and Federal requirements (including 42CRF 438.204) and UM program requirements described in 42 CFR 456. The QAPI program must: Ensure continuous evaluation of the MCO's operations. The MCO must be able to incorporate relevant variables as defined by MLTC.	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	
At a minimum, assess the quality and appropriateness of care furnished to members.	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	
Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician.	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	
Maintain a health information system that can support the QAPI program. The MCO's information system must support the QAPI process by collecting, analyzing, integrating, and reporting data required by	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	

Quality Management				
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the State's Quality Strategy. All collected data must be available to the MCO and MLTC.				
Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually.	**Documents** Evidence of providing information about the QAPI program to members and providers	Full	Prior Results (2017) Substantial- Providers are informed about the QAPI program in the Provider Handbook. Both members and providers that are enlisted to join the QAPIC are better informed about the role of the committee and the program in general; there is an opportunity to present this information to the broader WellCare membership by incorporating it into the Member Handbook or on the MCO website. The MCO's progress in meetings its goals are assessed annually per the QAPI Program Description. MCO Response Language to describe as well as invite members to join our QAPIC and MAC committees will be found in the Quality section of the 2018 Member Handbook. This requirement is addressed in the 2018 Member Handbook, per the following statement: As a member, it is free for you to join, you can join us and share your thoughts on how we are doing. You can join two different committees. The Member Advisory Committee brings people together to talk about the services we offer. You can tell us how we are doing and any needs of your community. The Quality Assessment and Performance Improvement Committee is in charge of all	

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			Quality Programs. Members hear about all of the work that is being done to improve your health and wellness. This committee listens to Member ideas and concerns from other committees. Both committees meet up to four times per year and can be joined in person, by video or by phone. If you would like to become involved, please call Member Services at 1-855-599-3811.	
Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance. The MCO must further develop, operationalize, and implement the outcome and quality performance measures with the QAPIC, with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders.	**Documents** Description of methods used to solicit feedback and recommendations Onsite discussion	Full	During the onsite review, the MCO noted feedback is solicited via their website and during QAPIC and Member Advisory Committee meetings.	
Require that the MCO make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-site operational review of the MCO and any additional QM reviews. This may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description.	
QAPIC The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the	**Documents** QM Program Description Description of QAPIC	Full	This requirement is addressed in the 2017 QI Annual Program Description and the QM Evaluation (page 18).	

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monitoring of service quality and determining strategies to improve outcomes. The MCO must form a QAPIC no later than one month following the contract's start date. The MCO's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC.				
The MCO must include, at a minimum, the following as members of the committee: 1. The MCO's QM Coordinator. 2. The MCO's Performance and Quality Improvement Coordinator. 3. The MCO's Medical Management Coordinator. 4. The MCO's Member Services Manager. 5. The MCO's Provider Services Manager. 6. Family members/guardians of children or youth who are Medicaid members. 7. Adult Medicaid members. 8. Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.	**Documents** QAPIC membership	Substantial	This requirement is addressed in the 2017 QI Annual Program Description. QAPIC meeting minutes and agendas were also provided as evidence detailing attendees. The MCO advised that three WellCare members joined the QAPIC and CAC as of April 2018. **Recommendation** The MCO should have representation from providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. **MCO Response** WellCare will solicit member recommendations from providers currently serving on committees as well as the general provider network in order to ensure representation from providers knowledgeable about disability, mental health, and substance use disorder. **IPRO Final Findings** No change in review determination.	
The MCO's QAPIC must:	**Documents**	Full	This requirement is addressed in the 2017	

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1. Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC. 2. Review the Cultural Competency Plan. 3. Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify. 4. Establish annual performance targets. 5. Review and approve all member and provider surveys prior to their submission to MLTC. 6. Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries. 7. Provide training; participation stipends; and reimbursement for travel, child care, or other reasonable participation costs for members or their family members. Participation stipends should only be provided if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization. 8. Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.	QM Program Description Agendas and meeting minutes for all committee meetings held during review period		QI Annual Program Description. QAPIC meeting minutes and agendas were also provided.	

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Additional required committees must include: 1. Clinical Advisory Committee. 2. Corporate Compliance Committee. 3. Provider Advisory Committee. 4. Utilization Management Committee. 5. The additional required committees must report, on a minimum of a quarterly basis, to the QAPIC. The QAPIC must monitor performance as part of its annual QAPI Work Plan and Program Evaluation.	**Documents** Committee descriptions List of membership for each committee QM work plan QM Evaluation	Full	This requirement is addressed in the Quality Assurance and Performance Improvement Committee (QAPIC) Charter Description and composition of the QAPIC. As well as the QI Evaluation 2017 (pgs. 6-10). Evidence of Monitoring addressed in the NE MDCD Workplan Final 2017.	
Data Collection The MCO must collect performance data and conduct data analysis with the goal of improving members' quality of care. The MCO must document and report to the State its results on performance measures chosen by MLTC to improve quality of care and members' health outcomes.	**Reports** Reports of state-required performance measures	Full	This requirement is addressed in Contract Amendment 3 – executed 11/6/17.	
Data analysis must consider the MCO's previous year's performance, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. Data must be collected from administrative systems, medical records, and member and provider surveys. The MCO must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCO's encounter data system. The MCO	**Documents** Process for verifying the accuracy and completeness of provider and vendor reported data Process for screening data for completeness, logic and consistency Evidence of collecting service utilization data using MLTC-developed templates **Reports**	Full	This requirement is addressed in Contract Amendment 3 – executed 11/6/17. The MCO also provided the QAPIC Q3-2017 Report as evidence of quarterly data analysis for this requirement.	

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must ensure that data received from providers is accurate and complete by: 1. Verifying the accuracy and timeliness of reported data. 2. Screening the data for completeness, logicalness, and consistency. 3. Collecting service information using MLTC-developed templates. A quarterly report from the Quality Oversight Committee containing an activity summary as is due to MLTC 45 calendar days following the most recent quarter	Sample data analysis produced by MCO providing information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals			
The MCO is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for performance measures and PIPs must be returned by the MCO in a format specified by MLTC, and by the due date specified. Any extension to collect and report data must be made in writing in advance of the initial due date and is subject to approval by MLTC. Failure to follow the data collection and reporting instructions that accompany the data request may result in a penalty being imposed on the MCO.	**Documents** Evidence of timely and accurate reporting of encounter data to MLTC **Reports** Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up	Full	This requirement is addressed in Contract Amendment 3 – executed 11/6/17. The MCO is following the reporting schedule in Attachment 38 of the Heritage Health Contract. WellCare provided evidence that the PIP Report was submitted timely on 2/16/18.	
Quality Performance Measurement and Evaluation The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period.	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final audit report and IDSS rates CAHPS report	Full	This requirement is addressed in Contract Amendment 3 – executed 11/6/17. During the onsite review, the MCO noted that HEDIS is ongoing and they will submit all necessary performance measures, per	

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Performance measures include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required by CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC. HEDIS results due date: June 30 CHIPRA quality measures and Adult core measures due date: 45 calendar days following 12th month of contract year **Attachment 7:** <u>Adult Core Measures</u> 1. Cervical Cancer Screening (CCS) 2. Chlamydia Screening in Women (CHL) 3. Flu Vaccinations for Adults Age 18 and Older (FVA) 4. Screening for Clinical Depression and Follow-Up Plan (CDF) 5. Breast Cancer Screening (BCS) 6. Adult Body Mass Index Assessment (ABA) 7. PC-01: Elective Delivery (PC01) 8. PC-03: Antenatal Steroids (PC03) 9. Prenatal & Postpartum Care: Postpartum Care Rate (PPC) 10. Initiation and Engagement of Alcohol and Other 11. Drug Dependence Treatment (IET) 12. Medical Assistance with Smoking and Tobacco Use Cessation (MSC) 13. Antidepressant Medication Management (AMM) Follow-Up After Hospitalization for Mental Illness (FUH)	Onsite discussion		Attachment 7, by the appropriate due dates, according to Attachment 38. Attachment 7 is found in NE_QM_5_C7QI-055_Healthcare Effectiveness Data and Information Set (HEDIS).	

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14. Adherence to Antipsychotics for Individuals with Schizophrenia (SAA) 15. Controlling High Blood Pressure (CBP) 16. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C) 17. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)* 18. PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01) 19. PQI 08: Heart Failure Admission Rate (PQI08) 20. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05) 21. PQI 15: Asthma in Younger Adults Admission Rate (PQI15) 22. Plan All-Cause Readmissions (PCR) 23. HIV Viral Load Suppression (HVL) 24. Annual Monitoring for Patients on Persistent Medications (MPM) 25. Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR) 26. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA) <u>Child Core Measures</u> 1. Child and Adolescents' Access to Primary Care Practitioners (CAP) 2. Chlamydia Screening in Women (CHL) 3. Childhood Immunization Status (CIS) 4. Well-Child Visits in the First 15 Months of Life (W15) 5. Immunizations for Adolescents (IMA)				

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6. Developmental Screening in the First Three Years of Life (DEV) 7. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) 8. Human Papillomavirus Vaccine for Female Adolescents (HPV) 9. Adolescent Well-Care Visit (AWC) 10. Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI) 11. PC-02: Cesarean Section (PC02) 12. Live Births Weighing Less Than 2,500 Grams (LBW) 13. Frequency of Ongoing Prenatal Care (FPC) 14. Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC) 15. Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) 16. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD) 17. Follow-Up After Hospitalization for Mental Illness (FUH) 18. Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)* 19. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC) 20. Medication Management for People with Asthma (MMA) 21. Ambulatory Care – Emergency Department (ED) Visits (AMB) 22. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including				

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Medicaid and Children with Chronic Conditions Supplemental Items) (CPC) HEDIS Measures 1. Comprehensive Diabetes Care 2. Medication Management for People with Asthma (Adults) 3. Lead Screening in Children 4. Appropriate Testing for Children with Pharyngitis 5. Race/Ethnicity Diversity of Membership 6. Appropriate Treatment for Children with Upper Respiratory Infection (URI) 7. Use of Spirometry Testing in the Assessment and Diagnosis of COPD 8. Pharmacotherapy Management of COPD Exacerbation 9. Use of Appropriate Medications for People with Asthma 10. Annual Monitoring for Patients with Persistent Medications 11. Adults' Access to Preventative/Ambulatory Health Services 12. Antibiotic Utilization 13. Frequency of Ongoing Prenatal Care 14. Timeliness of Prenatal Care				
MLTC may utilize a hybrid or other methodology for collecting and reporting performance measure rates, as allowed by NCQA for HEDIS measures or as allowed by other entities for nationally recognized measures. The MCO must collect data from medical records, electronic records, or through approved processes, such as those utilizing a health information exchange. The number of records that the MCO collects will be based on HEDIS, external quality review (EQR), or	**Reports** HEDIS final audit report and IDSS rates	Full	This requirement is addressed in the HEDIS final audit report and IDSS rates, as well as in Contract Amendment 3 – executed 11/6/17. During the onsite review, the MCO noted that HEDIS is ongoing and they will submit all necessary performance measures, per Attachment 7, by the appropriate due dates, according to Attachment 38.	

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other sampling guidelines. It may also be affected by the MCO's previous performance rate for the measure being collected. The MCO must provide MLTC on request with its methodology for calculating performance measures.			Attachment 7 is found in NE_QM_5_C7QI-055_Healthcare Effectiveness Data and Information Set (HEDIS).	
The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that does not show statistically significant improvement in a measure rate. MLTC may require the MCO to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.	**Reports** HEDIS final audit report and IDSS rates Trended performance measure results	Full	This requirement is addressed in the HEDIS final audit report and IDSS rates, as well as in Contract Amendment 3 – executed 11/6/17. During the onsite review, the MCO noted that HEDIS is ongoing and they will submit all necessary performance measures, per Attachment 7, by the appropriate due dates, according to Attachment 38. Attachment 7 is found in NE_QM_5_C7QI-055_Healthcare Effectiveness Data and Information Set (HEDIS).	
The MCO must report results of measuring or assessing outcomes and quality, and must incorporate these performance indicators into its PIPs. To the extent possible, results should be posted publicly on the MCO's website immediately after being accepted by the QAPI Committee and approved by MLTC.	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final IDSS rates	Full	This requirement is addressed in the BH PIP Proposal submitted for Follow-up after Emergency Room Visit with a Diagnosis of Mental Health Illness or Substance Use Disorder (submission date 12/1/17). The MCO also provided as evidence the 17p and Tdap PIP Annual Reports. The MCO provided a screenshot of their website. The Find-a-Provider tool has the capability to display Quality Measures for individual providers as a breakdown of their HEDIS scores.	

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Any outcomes and performance measure results that are based on a sample of member, family, or provider populations must demonstrate that the samples are representative and statistically valid. Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks.	**Reports** HEDIS final audit report and IDSS rates Methodology for non-HEDIS performance measure reporting Trended performance measure results and comparison to national benchmarks including f/u actions taken	Full	This requirement is addressed in the Contract Amendment 3 – executed 11/6/17. The MCO provided as evidence the PIP for Reducing Preterm Births, and the 17p and Tdap Annual Reports to demonstrate non-HEDIS performance measure reporting.	
Performance Improvement Projects The MCO must conduct a minimum of two clinical and one non-clinical PIPs. A minimum of one (1) clinical issue must address an issue of concern to the MCO's population, which is expected to have a favorable effect on health outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.	**Reports** PIP proposals and status reports	Full	This requirement is addressed in the BH PIP Proposal submitted for Follow-up after Emergency Room Visit with a Diagnosis of Mental Health Illness or Substance Use Disorder (submission date 12/1/17). The MCO also provided as evidence the 17P PIP 2017 Annual Report and the Tdap PIP 2017 Annual Report.	
The MCO must participate in a minimum of one (1) joint PIP with the other MCOs; the topic will be identified by MLTC.	**Reports** PIP proposals and status reports	Full	This requirement is addressed in the BH PIP Proposal submitted for Follow-up after Emergency Room Visit with a Diagnosis of Mental Health Illness or Substance Use Disorder (submission date 12/1/17). The MCO also provided as evidence the 17P PIP 2017 Annual Report and the Tdap PIP 2017 Annual Report.	
PIPs must be addressed in the MCO's annual QM Program Description, Work Plan, and Program	**Documents** QM Program Description	Full	This requirement is addressed in the 2017 QI Annual Program Description pages 4-5	

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Evaluation. PIPs must comply with CMS requirements, including: 1. A clear study topic and question as determined or approved by MLTC. 2. Clear, defined, and measurable goals and objectives that the MCO can achieve in each year of the project. 3. A study population. 4. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The MCO must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate. 5. The methodology for evaluation of findings from data collection. 6. Implementation of system interventions to achieve quality improvement. 7. A methodology for the evaluation of the effectiveness of the chosen interventions. 8. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable.	QM work plan QM Evaluation		NE MDCD Workplan 2017 – PIPs tab details quarterly PIP activity. Evidence was also provided in the PIP Objectives in the QI Evaluation 2017 (pages 70-73).	

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9. Planning and initiation of activities for increasing and sustaining improvement.				
The MCO must submit to MLTC the status or results of its PIPs in its annual QM Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.	**Documents** QM Program Description QM work plan QM Evaluation	Full	This requirement is addressed in the QI Program Evaluation, in the 2017 QI Annual Program Description, and in the NE MDCD Workplan 2017.	
Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCO's quality assessment and performance improvement program.	**Reports** PIP proposals and status reports	Full	This requirement is addressed in the PIP proposal reports that were submitted 12/1/2017 for each of the three topic areas, and in the monthly QuIC meetings that are held between MLTC and the MCOs.	
CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.	Onsite discussion	Not Applicable	During the onsite review, the MCO advised that no additional performance measures or PIPs were requested by CMS or other stakeholders.	
Member Satisfaction Surveys The MCO must contract with a vendor that is certified by NCQA to perform CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions (CCC) supplemental items.	**Documents** Identity of CAHPS vendor **Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the WellCare of NE 2017 CAHPS Simulation MCS Report, 2017 CAHPS Simulation MAS Report, and 2017 MCSCCC CAHPS Simulation Report. This requirement is also addressed in the following policies: C7-QI-003-PR-001 Customer Satisfaction Survey Procedure and C7-QI-003 Customer Satisfaction Survey Policy. During the onsite review, the MCO advised that the 2018 CAHPS will be full surveys for the	

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			Adult and Child populations. The MCO anticipates better performance rates in 2018.	
The MCO must use the most current version of CAHPS for Medicaid enrollees. For the CAHPS Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and separate data and results when submitting reports to MLTC to fulfill the CHIPRA requirement.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the WellCare of NE 2017 CAHPS Simulation MCS Report, 2017 CAHPS Simulation MAS Report, and the 2017 MCSCCC CAHPS Simulation Report submitted to MLTC. Evidence was also provided in policies: C7-QI-003-PR-001 Customer Satisfaction Survey Procedure and C7-QI-003 Customer Satisfaction Survey Policy.	
Samples of members 18 years of age and older and caregivers/family members of children and youth should be included in all member surveys. Samples should be representative of members and caregivers/family members based on the type of question asked.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the WellCare of NE 2017 CAHPS Simulation MCS Report, 2017 CAHPS Simulation MAS Report, 2017 MCSCCC CAHPS Simulation Report submitted to MLTC. Evidence was also provided in policies: C7-QI-003-PR-001 Customer Satisfaction Survey Procedure and C7-QI-003 Customer Satisfaction Survey Policy.	
Each survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and State benchmark standards. Survey results and action plans derived from these results are due 45 calendar days after the end of each contract year. MLTC reserves the right to make CAHPS member survey results public.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the WellCare of NE 2017 CAHPS Simulation MCS Report, 2017 CAHPS Simulation MAS Report, and the 2017 MCSCCC CAHPS Simulation Report submitted to MLTC. Evidence was also provided in policies: C7-QI-003-PR-001 Customer Satisfaction Survey Procedure and C7-QI-003 Customer Satisfaction Survey Policy.	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Survey results and descriptions of the survey process must be reported to MLTC separately for each required CAHPS survey. Upon administration of the CAHPS Child surveys, results for Medicaid children and CHIP children must be reported separately. CAHPS reports due date: 30 calendar days following 12th month of contract year	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the WellCare of NE 2017 CAHPS Simulation MCS Report, 2017 CAHPS Simulation MAS Report, and the 2017 MCSCCC CAHPS Simulation Report submitted to MLTC. Evidence was also provided in policies: C7-QI-003-PR-001 Customer Satisfaction Survey Procedure and C7-QI-003 Customer Satisfaction Survey Policy.	
Provider Satisfaction Surveys The MCO must conduct an annual provider survey to assess providers' satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes, including medical reviews and support for PCMH implementation.	**Documents** Provider satisfaction survey tool Onsite discussion	Full	This requirement is addressed in the WellCare of Nebraska Provider Satisfaction Survey Summary and Action Plan 2017 submitted to MLTC. WellCare of Nebraska's Provider Satisfaction Survey was administered via phone from October 25, 2017 to December 15, 2017. The survey collected responses from 150 providers of the total sample size of 1,163 providers yielding a response rate of 13.9%. Of the providers that responded, 74% were identified as PCPs and Specialists, while the remaining 26% were identified as Behavioral Health providers. 48.9% of the respondents stated that WellCare of Nebraska represented 10% or less of their total business. Per the MCO, it should be noted that due to a low response rate (n= 1), Avesis Provider Survey data was not included in the analysis. There is lack of statistical power to extrapolate results across WHP's OPT/OPTH network. For 2018, Avesis will implement strategies to increase response rates, including additional	

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			provider education via face-to-face outreach, newsletters, and web portal.	
The provider satisfaction survey tool and methodology must be submitted to MLTC for approval a minimum of 90 calendar days prior to its intended administration. The methodology used by the MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.	**Documents** Provider satisfaction survey tool and methodology Onsite discussion	Full	During the onsite review, WellCare advised that the tool submitted and approved by MLTC on 12/23/2016 was used for the October Provider Satisfaction Survey.	
The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results. Provider satisfaction survey report due date: 30 calendar days following 12th month of contract year	**Reports** Provider satisfaction survey results including f/u actions taken	Full	This requirement is addressed in the WellCare of Nebraska's Provider Satisfaction Survey Summary and Action Plan 2017 submitted to MLTC. As per Action Plan for 2018: WellCare of Nebraska understands the importance of a high quality, fiscally responsible provider network. Through various integrated actions with other monitoring and educational activities, an action plan to improve upon the scores of the 2017 Provider Satisfaction Survey has been developed. This action plan has focus on four key areas: 1.Claims processing and operational efficiency 2.Provider call center satisfaction 3.Collaboration with care management 4. Relationship development	

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Member Advisory Committee To promote a collaborative effort to enhance the MCO's patient-centered service delivery system, the MCO must establish a Member Advisory Committee that is accountable to the MCO's governing body. Its purpose is to provide input and advice regarding the MCO's program and policies.	**Documents** Member Advisory Committee description	Full	This requirement was addressed in the Member Advisory Committee Report dated 12/21/17. The purpose and responsibilities of the MAC are also detailed in the QI Program Description 2018.	
The MCO's Member Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO's membership.	**Documents** Member Advisory Committee description Member Advisory Committee membership	Full	This requirement is addressed in the QI Program Description 2017 (page 23).	
At a minimum, the MCO's Member Advisory Committee must provide input into the MCO's planning and delivery of services; QM/quality improvement activities; program monitoring and evaluation; and, member, family, and provider education.	**Documents** Member Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in three MAC minutes held during the review period: 9/28/17, 12/21/17 and 3/21/18. Agenda/topics are included in the minutes. WellCare's Member Newsletter and Member Handbook shares information related to the MCO's quality improvement activities. The newly opened Concierge Rooms across the state are also featured in the Member Newsletters.	
The MCO must provide an orientation and ongoing training for Member Advisory Committee members so that they have sufficient information and understanding of the managed care program to fulfill their responsibilities.	**Documents** Evidence of orientation and training including training materials	Substantial	This requirement is addressed in the MAC training dated July 2016 – Draft. However, the MCO noted the incorrect year (2016) is indicated on the PowerPoint training presentation. **Recommendation**	

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			The MCO should update the MAC PowerPoint training presentation to include the appropriate year, and further provide evidence of these trainings (such as attendance sheets). **MCO Response** WellCare offers this training whenever a new member joins the committee. The training was last completed in March 2018 and is planned again for September 2018. The committee minutes will reflect the training dates and provide evidence of training completion for the next audit period. The training deck has been updated and will be shared with IPRO at our next audit opportunity. **IPRO Final Findings** No change in review determination.	
The MCO must develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the Committee that must include, but is not limited to, members' perspectives about improving quality of care. This Plan must be submitted to MLTC for approval a minimum of 60 calendar days before the contract start date and annually thereafter.	**Documents** Member Advisory Committee Plan	Full	This requirement is addressed in the QI Program Description 2017 (page 23) and the MCO provided evidence of timely submission to MLTC.	
The MCO's Member Advisory Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in three MAC minutes held during the review period: 9/28/17, 12/21/17 and 3/21/18. Agenda/Topics are included in the minutes.	

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The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually. This report must include the membership of the committee (name, address, and organization represented), a description of any orientation and/or ongoing training activities for committee members, and information about Committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports must be submitted to MLTC according to the schedule described in Attachment 38 – Revised Reporting Requirements. Semi-annual reports due date: June 30 and Dec 31	**Documents** Semi-annual reports submitted during the review period	Full	Prior Results (2017) Substantial- WellCare submitted the MAC report to MLTC after the first 6 months of operation. It was not able to be determined from this report which individuals were members of WellCare, versus which were staff. Further, member addresses were not provided in this report, per contract requirements. Otherwise, all elements associated with this requirement were met within the report. MCO Response An attendance roster will be used for future meetings. Please see attached sample (note: sample removed to protect PHI). This requirement was addressed in the Member Advisory Committee Report dated 12/21/17. However, the MCO has not included the addresses of the committee members in the report. **Recommendation** The MCO should include member addresses in the report, per contract requirements. **MCO Response** The Member Advisory Committee Report includes the committee member addresses. This information is included in Attachment A_MAC Membership, which is an embedded attachment within the MAC Report. This document was submitted to IPRO in advance of the on-site audit. WellCare will continue to report all elements required by the contract.	

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			IPRO Final Findings Upon review of WellCare's response, and re-review of the MAC report provided pre-onsite, the determination has been changed from Substantial to Full.	
Clinical Advisory Committee The MCO must develop, establish, and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment, including diseases/chronic conditions common in the Medicaid population, disabilities, and mental health and/or substance use disorder treatment for adults, children, and adolescents in the State.	**Documents** Clinical Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the CAC agendas and minutes provided by the MCO dated 11/27/17 and 2/14/18. During the 2/14/18 meeting, the committee discussed was new practice guidelines for Child & Adolescent behavioral health, Frailty & special populations, Neonatal & infant health.	
The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with CM and utilization management functions, including clinical and practice guidelines, and utilization management criteria to ensure that they	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the CAC Agendas and Minutes provided by the MCO dated 11/27/17 and 2/14/18.	

Quality Management				
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reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State.				
The committee must include members who care for children, adolescents and adults in the State across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations and represent pharmacists, physical health providers, and behavioral health providers.	**Documents** Clinical Advisory Committee membership	Full	This requirement is addressed in the Nebraska Clinical Advisory Committee (CAC) Charter.	
The committee must review and approve initial practice guidelines. Any significant changes in guidelines must also be reviewed/approved by the Committee prior to adoption by the MCO.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the CAC Agendas and Minutes provided by the MCO dated 11/27/17 and 2/14/18. During the 2/14/18 meeting, the Committee discussed new practice guidelines: child & adolescent behavioral health, frailty & special populations, and neonatal & infant health. A motion was made to approve the guidelines with recommended changes.	
The committee must meet on an as-needed basis, but a minimum of twice a year and preferably quarterly.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the CAC Agendas and Minutes provided by the MCO dated 11/27/17 and 2/14/18.	
External Quality Review The MCO is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, services covered under the contract, per 42 CFR 438.350. The EQR is conducted by MLTC's contracted external quality review organization (EQRO) or other designee. The EQR will include, but is not be limited to, annual operational reviews, PIP	Onsite discussion	Full	This requirement was addressed during the onsite audit held at WellCare in Omaha, Nebraska on May 14, 2018 – May 15, 2018.	

Quality Management				
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assessments, encounter data validation, focused studies, and other tasks requested by MLTC.				
The MCO must provide the necessary information required for these reviews, provide working space and internet access for EQRO staff, and make its staff available for interviews.	Onsite discussion	Full	This requirement was addressed during the onsite audit held at WellCare in Omaha, Nebraska on May 14, 2018 – May 15, 2018.	

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Utilization Management **General Requirements** The MCO's UM activities must include the evaluation of medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided to members when they need them. The MCO's UM program must also focus on individual and system outliers to assess if individual members are meeting their health care goals and if service utilization across the system is meeting the goals for delivery of community-based services.				
The MCO must not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in the MCO's UM Program Description, page 11.	
UM Program Description The MCO must have a written UM Program description that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually and include, at a minimum: Criteria and procedures for the evaluation of medical necessity of medical services for members.	**Documents** UM Program Description should address all sub-elements	Full	This requirement is addressed in the MCO's UM Program Description, pages 11-19.	
Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.		Full	This requirement is addressed in the MCO's UM Program Description, pages 11-19.	
Mechanisms to detect and document over- and under-utilization of medical services.		Full	This requirement is addressed in the MCO's UM Program Description, page 4.	

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Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.		Full	This requirement is addressed in the MCO's UM Program Description on page 2. This requirement is also addressed in Policy C7CM MD-4.8 - Individuals with Special Health Care Need, which states that retrospective utilization reviews of hospitalization and other services are used to identify individuals with special needs. During the onsite review, examples of reporting or analysis that addressed assessment of quality of care for members with special health care needs were requested. The MCO stated that the Utilization team works closely with Case Management. The MCO also supplied examples of data mining for outliers in utilization. In future compliance reviews, the MCO could consider adding supporting documentation of the hand-off from Utilization Management staff to Care Management staff in the case of identified special needs members.	
Availability of UM criteria to providers.		Full	This requirement is addressed in the MCO's UM Program Description, page 5.	
Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.		Full	This requirement is addressed in the MCO's UM Program Description, page 7.	
Availability of physician reviewers to discuss determinations by telephone with physicians who request them.		Full	This requirement is addressed in the MCO's UM Program Description, page 22.	

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Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.		Full	This requirement is addressed in the MCO's UM Program Description, page 3.	
A process and procedures to address disparities in health care.		Substantial	This requirement is not explicitly addressed in the UM Program Description. Some references are made to social and psychosocial needs and co-morbidities. The MCO also provided a word document titled "Community Activities Addressing Health Care Disparities". This has a paragraph on risk algorithms and social determinants. During the onsite review, the MCO indicated that they look at factors during care management based on individual's needs. HEDIS results could also inform their analysis. Health risk assessments and CAHPS surveys identify special populations. One example is the partnership the Plan has with Project Air – addressing asthma associated risk for members living in older homes. **Recommendation** The MCO should incorporate the required language in the UM Program Description and create policies and procedures to address disparities in healthcare. **MCO Response** WellCare will update the UM Program Description to reflect the process for addressing disparities in health care. WellCare's UM staff identify members in need of care management	

Utilization Management				
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			support due to disparaging conditions (complex discharges/catastrophic diagnoses, etc.) during the authorization review process. If identified, UM staff refer these member to the Care Management team for follow up and collaborative management of member needs. **IPRO Final Findings** No change in review determination. WellCare's response to compliance findings, if implemented, would potentially address the issue raised. IPRO will review the UM Program Description during the next compliance audit.	
A process for identifying and analyzing clinical issues by appropriate clinicians and, when necessary, developing corrective actions to improve services.		Full	This requirement is addressed in the MCO's UM Program Description, page 25.	
A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR.		Full	This requirement is addressed in the MCO's UM Program Description, pages 11-18.	
Reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the MLTC's Preferred Drug List and other State publications.		Full	This requirement is partially addressed in the MCO's UM Program Description, page 14. This requirement is also addressed in the MCO's policy C20RX-136 - Preferred Drug List. Further, the MCO provided a template of letters that go out to providers when changes are made to the Preferred Drug list as well as references to the Provider Handbook where updated website information can also be found.	

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A process for providing prescribers with members' drug utilization data obtained from MLTC and the Nebraska DUR board to inform prescribing activity. As part of this effort, the MCO must: 1. Work to improve collaboration across prescribers, to reduce conflicting or duplicate prescribing. 2. Provide reports to PCPs and other network providers about the patterns of prescription utilization by members, in an effort to increase collaboration and reduce inappropriate prescribing patterns.		Full	The MCO provided policy C20RX-077 - Corporate Policy and Procedures, Pharmacy Area, Pharmacy and C20RX-077-PR-003 - Corporate Policy and Procedures, Pharmacy Area, Pharmacy which together address this requirement. The MCO also shared examples of letters sent to providers with clinical advisory related to Drug Utilization.	
A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 30 calendar days after its completion.		Full	This requirement is addressed in the MCO's UM Program Description, page 24.	
Practice Guidelines The MCO must develop practice guidelines that: Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	**Documents** Policy/procedure List of practice guidelines developed/adopted by MCO Examples of practice guidelines	Full	This requirement is addressed in Policy C7QI-026 – Provider Clinical Practice Guidelines. The MCO also provided a library of 50 specific guidelines ranging from ADHD to TBI.	
Consider the needs of the MCO's members, including children with serious emotional disorders and adults with serious and persistent mental illness.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines. During the onsite review, the MCO stated that the Behavioral Health Utilization Management team in Tampa works closely with the local Nebraska team on addressing members with serious mental health illness. Inpatient nurses	

Utilization Management				
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			work with providers on discharge plans and needed support systems. Local team members work on transitions back into the community. Clinical rounds also play a part in managing the care of members affected by mental illness.	
Are adopted in consultation with participating health care professionals.	**Documents** Policy/procedure Evidence of participation of health care professionals	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines. The MCO also provided the Clinical Advisory Committee charter and committee meeting minutes which satisfy the evidence of participation.	
Are reviewed and updated a minimum of annually, as appropriate.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines.	
Are disseminated, by the MCO, to all affected providers and, on request, to members and enrollees.	**Documents** Policy/procedure Evidence of dissemination to providers Member Handbook	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines, Provider Manual, Member Handbook and provider website.	
Are posted to the MCO's website.	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines. The MCO's provider website contains the guidelines.	
Provide a basis for consistent decisions for utilization management, member education, service coverage, and any other areas to which the guidelines apply.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines.	

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The MCO must provide affected network providers with technical assistance and other resources to implement the practice guidelines.	**Documents** Policy/procedure Evidence of offering/providing technical assistance and other resources	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines. The MCO states that tracking of provider assistance goes through provider relations and it is recorded in SalesForce.com.	
The MCO must monitor the application of practice guidelines annually through peer review processes and collection of performance measures for review by the MCO's QAPIC.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines. QAPIC and CAC minutes were reviewed, however there was no reference to monitoring of practice guidelines within the review period. During the onsite review the MCO stated that when it comes to clinical practice guidelines and compliance, the shared services group in Tampa sees data first and then they subsequently see reporting locally. Monitoring of the local providers is accomplished through Medical Record Review. Performance Measure review is accomplished through the annual HEDIS reporting process which is ongoing.	
Using information acquired through its QM and UM activities, the MCO must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into care management and UR activities.	**Documents** Policies/procedures **Reports** Most recent written recommendations and evidence of transmittal to MLTC	Full	This requirement is addressed in the MCO's policy C7QI-026 - Provider Clinical Practice Guidelines.	
Service Authorization Procedures The MCO and its subcontractors must have in place, and follow, written policies and procedures	**Documents** Policies/procedures addressing all sub-elements	Full	This requirement is addressed in the MCO's UM Program Description, pages 12-17.	

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for processing requests for initial and continuing authorizations of services				
The MCO must: 1. Incorporate the definition of medical necessity for covered services, inclusive of service definitions and levels of care, into MCO documents, where applicable.		Full	This requirement is addressed in the MCO's UM Program Description, page 12.	
2. Not require service authorization for emergency services.		Full	This requirement is addressed in the MCO's UM Program Description, page 14.	
3. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose.		Full	This requirement is addressed in the MCO's UM Program Description, page 12.	
4. Not arbitrarily deny a required service solely because of the member's diagnosis, type of illness, or condition. This also applies to the MCO's subcontractors.		Full	This requirement is addressed in the MCO's policy C7UM MD-2.1 - Service Authorization Decisions.	
5. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.	**Reports** Also includes evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the MCO's UM Program Description, page 24.	
6. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization requirements.		Full	This requirement is also covered by the MCO's policy C20RX-136 - Preferred Drug List Evidence of this requirement can be found on WellCare's website as well.	
7. Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth.		Full	The MCO provided evidence from its internal review system with a process called Nebraska Medicaid Psychotropic Drugs and Youth Initiative Process.	

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8. Have written policies and procedures for prescribers to request peer review and peer-to-peer consultations on prior authorizations. Peer-to-peer review or peer consultation must be conducted by a State-licensed prescriber.		Full	This requirement is addressed in the MCO's UM Program Description, page 15. The MCO also provided a process document from their internal authorization system called Completing Peer to Peer Requests with description of how to initiate pharmacy peer to peer consultations.	
9. Consult with the requesting network provider, when appropriate.	**Onsite File Review**	Full	This requirement is addressed in the MCO's UM Program Description, page 15. File Review Results Ten (10) files were reviewed, and were not applicable, as none (0) of the 10 required consultation with the requesting provider.	
Concurrent Review The MCO must develop a system of concurrent review for inpatient services to monitor the medical necessity of the need for a continued stay. The concurrent review system must include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one (1) day, based on the medical necessity determination.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's UM Program Description, page 17.	
An important feature of concurrent review is the evaluation of each hospital case against established criteria, including national clinical guidelines. The MCO must use published and commercially available criteria for hospital case reviews to facilitate evaluation by UR nurses.	**Documents** Policy/procedure Identification of criteria used	Full	This requirement is addressed in the MCO's UM Program Description, page 17. WellCare is using InterQual criteria.	
Retrospective Utilization Review of Network Providers	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's UM Program Description, page 18.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
The MCO must develop and implement retrospective UR functions for examining trends, issues, and problems in utilization, particularly over- and under-utilization that may need to be addressed including: 1. A system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services.	**Reports** Evidence of monitoring including results and f/u actions taken		The MCO also provided Policy C7UM-5.1-Retrospective Review and C7UM-1.2 - Under and Over Utilization of Services. The MCO provides trend reports and drill downs. Reports go to leadership multiple times a week. If there are questions, UM staff partner with Provider Relations and the Medical Director and discuss how some population health issues might have impacted results, as well as talking to providers.	
2. A reasonable appeal process that includes: standard communication with reasonable timelines, UR criteria that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims.	**Documents** Policy/procedure	Full	This requirement is addressed in Policy C7-AP-043 - Nebraska Member Appeal Policy and Procedure - C7-AP-043-PR-001 - Nebraska Member Appeal Procedure.	
3. Written policies and procedures through which the prescriber of pharmacy services is able to submit additional information for special consideration and additional review of denied prior authorization requests that do not meet criteria.	**Documents** Policy/procedure	Full	This requirement is addressed in C20RX-137-PR-001 - Pharmacy Appeals Procedure (Medicaid).	
4. Retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to members, were appropriate and medically necessary, and were authorized and billed in accordance with the MCO's requirements.	**Documents** Policy/procedure **Reports** Evidence of retrospective and peer reviews including results and f/u actions taken	Full	WellCare provided their 2018 Error Rate Measurement Audit and an Excel report on results from a six month sample. This addresses claims, quality assurance procedures for billing accuracy, and a review of medical necessity. Sample corrective action plans and follow-up were provided.	

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5. Provider reviews related to Medicaid compliance issues.	**Documents** Policy/procedure Example of a provider review related to compliance	Full	WellCare provided their 2018 Error Rate Measurement Audit and an Excel report on results from a six month sample. This addresses claims, quality assurance procedures for billing accuracy, and a review of medical necessity. The MCO also provided its Q1 2018 Service Verification Report.	
6. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.	**Documents** Policy/procedure	Full	WellCare provided their 2018 Error Rate Measurement Audit and an Excel report on results from a six month sample. This addresses claims, quality assurance procedures for billing accuracy, and a review of medical necessity.	
7. Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) for each provider that monitor and report under-and over- utilization of services at all levels of care, including monitoring providers' utilization of services by race, ethnicity, gender, and age.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	WellCare provided their 2018 Error Rate Measurement Audit and an Excel report on results from a six month sample. This addresses claims, quality assurance procedures for billing accuracy, and a review of medical necessity. The MCO also provided minutes from the QAPIC which address the follow through on this topic.	
The MCO must monitor for potential off-label drug usage.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	WellCare provided Procedure C20RX-077-PR-003 - Drug Utilization Review Program. The MCO also provided a sample retrospective utilization report specifically targeted at identifying off-label usage.	
The MCO must monitor emergency services utilization by provider and member and have routine methods for addressing inappropriate utilization. For UR, the test for appropriateness of the request for emergency services must be	**Documents** Policy/procedure **Reports**	Full	This requirement is addressed in policy C7CM MD-6.0 - Decrease in Emergency Room Overuse and procedure C7CM MD-6.0-PR-001 - Decrease in Emergency Room Overuse Procedure.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
whether a prudent layperson would have requested such services. A prudent layperson is one who possesses an average knowledge of health and medicine.	Evidence of monitoring including results and f/u actions taken		The MCO stated that is has Care Management protocols that address this requirement. Further, the MCO has an active PIP that utilizes alerts when members are in ED departments so they can monitor and follow-up with these members to ensure appropriate care after discharge.	
Utilization Management Committee The MCO must establish an internal UM Committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The UM Committee must be chaired or co-chaired by the Medical Director and must report its findings to the QAPIC. The UM Committee must review, at a minimum: 1. The need for and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan. 2. Grievances and appeals (including expedited appeals and state fair hearings) related to UM activities to determine any needed policy changes. 3. Information from UM operations relevant to system gaps are identified and shared with provider network staff through this committee.	**Documents** UM Committee description List of membership Agendas and meeting minutes for all committee meetings held during review period **Reports** UM reports for review period UM Program Evaluation	Full	This requirement is addressed in the Utilization Management Committee (UMC) Charter, (description and membership) as well as meeting agendas and minutes.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
4. Results from internal audits of UM (e.g., live call monitoring and documentation reviews), to effect changes in policies and procedures and plan training activities.				
Service Authorizations and Notices of Action **Service Authorization** The MCO must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in the MCO's UM Program Description, page 12.	
The MCO must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's UM Program Description, page 16. File Review Results Ten (10) files were reviewed. Two (2) of the 10 were administrative denials that did not require clinical decisions. All of the remaining 8 files had evidence of an appropriate reviewer for clinical decisions.	
Notice of Adverse Action The MCO must notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.	**Documents** Policy/procedure Template notice of action	Full	This requirement is addressed in the MCO's UM Program Description, page 12 and policy C7UM MD-2.1 - Service Authorization Decisions.	
The MCO must give the member written notice of any action (not just service authorization actions) within the timeframes required for each type of action. The notice must explain:	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's policy C7UM MD-2.1 - Service Authorization Decisions.	
1. The action the MCO or its subcontractor has taken or intends to take.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 46.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Onsite File Review		File Review Results Ten (10) of 10 files met this requirement.	
2. The reason(s) for the action.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 46. File Review Results Ten (10) of 10 files met this requirement.	
3. The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 46. File Review Results Ten (10) of 10 files met this requirement.	
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 46. File Review Results Ten (10) of 10 files met this requirement.	
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review**	Full	Prior Results (2017) Substantial-7 of 10 UM files reviewed met this requirement. The notice of action template appears to have changed after 4/1/17, to include notice about the member's right to obtain copy of their documents and records, as well as their right to state fair hearing. Prior to 4/1/17, the letter did not allude to member's right to request a state fair hearing, and thus the 3 files	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			that were reviewed within this timeframe did not meet this requirement. MCO Response WellCare agrees, and the State Fair Hearing language was added. This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 46. File Review Results Ten (10) of 10 files met this requirement.	
6. Procedures for exercising a member's rights to appeal or grieve a decision.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7 AP-043-PR-001- Nebraska Member Appeal Procedure, and in the Member Handbook. File Review Results Ten (10) of 10 files met this requirement.	
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 47. File Review Results Ten (10) of 10 files met this requirement.	
8. The member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 47. File Review Results Ten (10) of 10 files met this requirement.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
The notice must be in writing and must meet the language and format requirements. [The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency. The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC.]	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 46. File Review Results Ten (10) of 10 files met this requirement.	
Timeframes for Notice of Action The MCO must provide notice to the member a minimum of ten (10) days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 49.	

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The period of advanced notice required is shortened to five (5) days if probable member fraud has been verified. The MCO must give notice by the date of the action under the following circumstances: 1. The death of a member. 2. A signed written member statement requesting service termination or giving information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services. 3. The member's admission to an institution where he or she is ineligible for further services. 4. The member's address is unknown and mail directed to him/her has no forwarding address. 5. The member has been accepted for Medicaid services by another state. 6. The member's physician prescribes the change in the level of medical care. 7. An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1989. 8. The safety or health of individuals in the facility would be endangered, the resident's health				

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 calendar days (applies only to adverse actions for nursing facility transfers).				
The MCO must provide notice on the date of action when the action is a denial of payment.	**Documents** Policy/procedure	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations.	
Standard Service Authorization Denial The MCO must give notice as expeditiously as the member's health condition requires, and within State-established timeframes, that may not exceed 14 calendar days following receipt of the request for service. The timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCO extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The MCO must issue and carry out its determination as expeditiously as the member's health condition requires and in any event no later than the date the extension expires.	**Documents** Policy/procedure **Onsite File Review**	Substantial	Prior Results (2017) Substantial-9 of 10 UM files reviewed met the timeliness standard. None (0) of the 10 files required an extension. MCO Response WellCare respectfully agrees. We have implemented a retro review process as well as reporting to ensure TATs are met. This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations on page 48. File Review Results Nine (9) of 10 files met this requirement. File #8 contained evidence that the request was received on 11/16/17 and the decision to deny was sent 17 days later on 12/3/17. None of the 10 files required an extension. **Recommendation** The MCO should implement a process to assess ability to comply with the timeliness standard. **MCO Response**	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			WellCare's UM Team has implemented daily inventory meetings with UM leadership to assess current inventory and ensure timely processing of authorization requests. WellCare ensures determinations are made within required timeframes by closely monitoring various systems and reports throughout the day, including Authorization Inventory Reports. These reports allow authorization staff and UM Leadership to closely monitor and view the status of all authorization requests to ensure determinations are rendered and appropriate notices are given within required timeframes. **IPRO Final Findings** No change in review determination. WellCare's process will be re-evaluated during next year's compliance audit.	
Expedited Service Authorization Denial For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCO may extend the time period by up to 14 calendar days if the member requests an extension or if the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 48. File Review Results Ten (10) files were reviewed; none (0) were applicable since they did not require an expedited authorization.	

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Untimely Service Authorization Decisions The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and, therefore constitutes an adverse action.	**Documents** Policy/Procedure	Full	This requirement is addressed in the MCO's policy C7-UM-MD-2.2 - Adverse Benefit Determinations page 49.	

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Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Grievance and Appeals **General Requirements** The MCO must have a grievance system for members that meet all Federal and State regulatory requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The MCO must distinguish between a grievance, grievance system, and grievance process, as defined below: 1. A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of actions. 2. The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system, not just to the grievance process. 3. A grievance process is the procedure for addressing members' grievances.	**Documents** Policy/procedure UM Program Description in place during the review period	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, Pages 2-3.	
The MCO must: 1. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 3.	
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	**Documents** Policy/procedure Template acknowledgement notice **Onsite File Review**	Substantial	Prior Results (2017) Substantial-8 of 10 appeal files contained the acknowledgement letters. Two (2) of 10 appeals files were resolved within 10 days	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Grievance and appeal file review results		and thus the acknowledgement letter was not applicable. Seventeen (17) of 20 grievance files contained the required information. Acknowledgement letters were not found in 3 grievance files. WellCare responded by stating a request for information (i.e. phone number, address) would replace acknowledgement letters. WellCare received direction from the State that members whose grievance was filed between January and July 2017 did not require the full grievance response. MCO Response WellCare agrees that grievance files should contain acknowledgement letters. Should there be a need for additional information, the State approved letter requesting additional information will be used. This letter also acknowledges the grievance, and it includes the date the grievance was received and the subject of the grievance. In addition, this letter includes language regarding information needed to process the member's grievance. This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 4. File Review Results: All appeals and grievance files contained acknowledgement letters. For the grievance files, there was 1 out of the 20 files for which the acknowledgement letter was dated more than 10 calendar days after receipt of the grievance.	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			For the appeals files, there were 2 out of the 10 files for which the acknowledgement letter was dated more than 10 calendar days after receipt of the appeal. **Recommendation:** IPRO recommends that timely (within 10 calendar days of receipt) acknowledgement letters be provided to all members filing a grievance or appeal. **MCO Response** Both the Appeals and Grievance Departments have several mechanisms in place to ensure appeals and grievances are processed within the applicable state contracted timeframes. The Departments have a dashboard that runs daily to capture the department's daily inventory and lists all files that require acknowledgment and closure. The dashboard captures all expedited, pre-service, retrospective appeals and grievances, the date of receipt, status of grievance, reason for appeal and grievance, line of business, compliance timeframe, and other pertinent information needed to manage the day-to-day operations of the departments. The Department's Sr. Director, Managers, and Supervisors use the dashboards to prioritize work and manage the inventory throughout the day to ensure cases are addressed and resolved according to established timeframes. Team Supervisors and Team leads, will discuss processing timeframe goals and metrics on an	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			on-going basis, assuring that all team members take accountability for processing files within the compliance timeframe. Re-education will be given as needed for files that are nearing compliance timeframes. In addition, a quality auditing process reviews and monitors missed elements of compliance. **IPRO Final Findings** No change in review determination.	
3. Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: a. The denial of service is based on lack of medical necessity. b. Because of the member's medical condition, the grievance requires expedited resolution. c. The grievance or appeal involves clinical issues.	**Documents** Policy/procedure **Onsite File Review** Grievance and appeal file review results	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 4. File Review Results: Ten (10) out of 10 appeals files contained the required information. This requirement was not applicable for all 20 grievance files, as all of the files were a first level review and did not involve a medical issue.	
4. Take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 4. File Review Results: Ten (10) out of 10 appeals files contained the required information.	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Complaint and Grievance Processes A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 5.	
A member may file a grievance with the MCO or the State at any time.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 5.	
The MCO must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes and not to exceed 90 calendar days from the day on which the MCO receives the grievance.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Grievance file review results	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 4. File Review Results: Twenty (20) out of 20 grievance files demonstrated timely notice.	
MLTC will establish the method the MCO must use to notify a member of the disposition of a grievance.	**Documents** Policy/procedure Template grievance resolution notice **Onsite File Review** Grievance file review results	Full	This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 5. File Review Results: Twenty (20) of 20 grievance files demonstrated an appropriate method by which the MCO notified members of the disposition of a grievance.	
Appeal Processes A member may file a MCO-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 4.	
Following receipt of a notification of an adverse benefit determination by the MCO, the member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 3.	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 3.	
The MCO must: 1. Ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 3. File Review Results: This requirement is not applicable for 10 out of the 10 appeals files, as all inquiries were made in writing.	
2. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 3.	
3. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full	Prior Results (2017) Substantial-10 appeal files were reviewed. Of the 10 files, 7 were standard appeals. Zero (0) of 7 standard appeal files contained evidence that the member was given the opportunity to present evidence in person as well as in writing. MCO Response The WellCare Appeals Department has several mechanisms in place to ensure members are informed of their rights and the timeline to submit additional information with their request for appeal. Members are informed that information may be provided in writing and/or in person. Currently, members are made aware of this right through the web portal and the Member Handbook. Additionally, our Customer Service	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Department informs members of this right when a request for appeal is received verbally. Nonetheless, to add an additional level of notification, the Appeals Acknowledgment letter has been updated to inform members of their right to submit additional information during the appeals process. In addition, the Utilization Management Notice of Adverse Benefit Determination letter has been updated to notify members of their right to submit additional information on appeal and of the limited time to submit additional information for an expedited appeal request. Both letters are now pending State submission, review and approval. This requirement is addressed in WellCare's Member Appeal Procedure, page 4. File Review Results: Ten (10) out of 10 appeals files met this requirement.	
4. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 4. File Review Results: Ten (10) out of 10 appeals files met this requirement.	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 4.	
The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must: 1. Make reasonable efforts to give the member prompt verbal notice of the delay. 2. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision. 3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 8. File Review Results: Ten (10) out of 10 appeal files demonstrated evidence that the appeal was resolved within 30 days. There were no files in the sample that represented an extension.	
The MCO must provide written notice of disposition, which must include: 1. The results and date of the appeal resolution; and 2. For decisions not wholly in the member's favor: a. The right to request a state fair hearing. b. How to request a state fair hearing.	**Documents** Policy/procedure Template appeal resolution notice **Onsite File Review** Appeal file review results	Full	Prior Results (2017) Substantial-1 of 10 files did not contain the results and date of the appeal resolution. Three (3) of 10 files contained all required elements for decisions not wholly in the member's favor. 7 of 10 files were not applicable.	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
c. The right to continue to receive benefits pending a hearing. d. How to request the continuation of benefits. e. If the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.			MCO Response Upon the completion of an appeal, WellCare of Nebraska provides written notice of the appeals determination to the member and/or the member's representative. All appeal letters are dated; however, the appeals determination notices have been updated to list the actual date of the appeal decision. This requirement is addressed in WellCare's Member Appeal Procedure, page 9. File Review Results: Ten (10) out of 10 appeals files contained the results and date of the appeal resolution. Ten (10) out of 10 appeals files were not applicable for the requirements pertaining to decisions not wholly in the member's favor requirements, as all were overturned.	
Expedited Appeals Process The MCO must establish and maintain an expedited review process for appeals that the MCO determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, pages 9-10.	
The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 10.	

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Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Provider Manual			
The MCO must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.	**Documents** Policy/procedure Member Handbook Template notice of action **Onsite File Review** Appeal file review results	Full	Prior Results (2017) Substantial- This was not applicable in 7 of the 10 appeal files reviewed, as they were standard appeals. For the remaining 3 files that were expedited appeals, 1 of 3 met this requirement. MCO Response The WellCare Appeals Department has several mechanisms in place to ensure members are informed of their rights and the timelines to submit additional information with their request for appeal. Members are informed that information may be provided in writing and/or in person. Currently, members are made aware of this right through the web portal and the Member Handbook. Additionally, our Customer Service Department informs members of this right when a request for appeal is received verbally. Nonetheless, to add an additional level of notification, the Appeals Acknowledgment letter has been updated to inform members of their right to submit additional information during the appeals process. In addition, the Utilization Management Notice of Adverse Benefit Determination letter has been updated to notify members of their right to submit additional information on appeal and of the limited time to submit additional information for an expedited appeal request.	

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Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Both letters are now pending State submission, review and approval. This requirement is addressed in WellCare's Member Appeal Procedure, page 10. File Review Results: Ten (10) out of 10 appeals files for this requirement were not applicable, as they were not expedited appeals.	
The MCO must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than 72 hours after the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 12. File Review Results: Ten (10) out of 10 appeals files for this requirement were not applicable, as they were not expedited appeals.	
For any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 12. File Review Results: This requirement is not applicable for 10 of 10 appeals files, as an extension was not requested.	
In addition to written notice, the MCO must also make reasonable efforts to provide verbal notice of resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 12. File Review Results: Ten (10) out of 10 appeals files for this requirement were not applicable, as they were not expedited appeals.	

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Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
The MCO must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 10.	
If the MCO denies a request for expedited resolution of an appeal, it must: 1. Transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCO receives the appeal with a possible extension of 14 calendar days. 2. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 12.	
Continuation of Benefits The MCO must continue a member's benefits if any one of the following apply: 1. The appeal is filed timely, meaning on or before the later of the following: a. Ten (10) calendar days after the MCO mailing the Notice of Action; or b. The intended effective date of the MCO's proposed action. 2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. 3. The services were ordered by an authorized provider. 4. The authorization period has not expired.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 14.	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
5. The member requests an extension of benefits.				
If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: 6. The member withdraws the appeal or request for state fair hearing. 7. The member does not request an appeal within ten (10) calendar days from when the MCO mails an adverse resolution to the member's appeal. 8. A state fair hearing decision adverse to the member is made. 9. The authorization expires or authorization service limits are met.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 14.	
The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, pages 14-15.	
Access to State Fair Hearings A member may request a state fair hearing. The provider may also request a state fair hearing if the provider is acting as the member's authorized representative. A member or his/her representative may request a state fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.	**Documents** Policy/procedure Member Handbook Provider Manual Template appeal resolution notice-upheld decision	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 13.	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
If the MCO takes action and the member requests a state fair hearing, the State must grant the member a state fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's representative (if any) by the MCO.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 14.	
The member or the member's representative (if any) may request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.	**Documents** Policy/procedure Template appeal resolution notice-upheld decision	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 14.	
The parties to the State fair hearing include the MCO, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 14.	
Reversed Appeals If the MCO or the state fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but in no event later than 72 hours from the date the MCO receives notice reversing the determination.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 15.	
The MCO must pay for disputed services if the MCO or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 15.	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Grievance and Appeal Recordkeeping Requirements The MCO must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date the grievance or appeal was received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance process, as applicable. e. Date of resolution at each level of the appeal or grievance process, as applicable. f. Name of the covered person by or for whom the appeal or grievance was filed. The MCO is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.	**Documents** Policy/procedure	Full	This requirement is addressed in WellCare's Member Appeal Procedure, pages 15-16; and WellCare's Nebraska Medicaid Grievance Policy, page 6.	
Information to Providers and Subcontractors The MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract: a. The member's right to a State fair hearing, how to obtain a hearing and representation rules at a hearing. b. The member's right to file grievances and appeals and the requirements and timeframes for filing them.	**Documents** Provider Manual Template provider contract Template subcontractor agreement	Full	This requirement is addressed in WellCare's Provider Handbook, pages 81-89.	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings. d. The toll-free number(s) to use to file verbal grievances and appeals. e. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending. f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.				
Reporting of Complaints, Grievances, and Appeals The MCO is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals Member Grievance System reports due date: 15th day of following calendar month for 1st 6 months than 45 calendar days following most recent quarter	**Documents** Policy/procedure **Reports** Member Grievance System reports for grievances, appeals, expedited appeals and state fair hearings submitted during the review period	Full	This requirement is addressed in WellCare's Member Appeal Procedure, page 15.	