NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

Care Management					
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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			
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 applicable standards of medical record confidentiality	**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			

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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			
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	Partial This requirement is addressed in the Care Management Program Description. File Review Results Sixteen (16) of 20 files reviewed included self-management strategies. One (1) file did not meet the requirement and 1 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. WellCare should 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. **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.	Full	The requirement is addressed in the Care Management Description Policy and in the 2019 Care Management Program Description. File Review Results Nineteen (19) of the 20 files reviewed included self-management strategies, and 1 file was not applicable. On site, the MCO discussed that if a member needs education, the MCO would first refer to Krames patient education material. Handouts from Krames are distributed and discussed with the member and / or their family members. For circumstances in which a member needs to be educated regarding self-performance of wound care or use of specific DMEs, the MCO staff works together with the member's primary care physician to provide the education to the member.	

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		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			
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 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	**Documents** Policy/procedure Program Description Evidence of educating CM staff about available community resources View community resource tool/directory onsite	Full			

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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.					
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			
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			
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 comprehensive care, treatment, and services to a member.	**Documents** Position descriptions for care coordinator and care manager Organizational chart for CM Department	Full			
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	**Documents** Policies/procedures	Full			

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institutional or community-based long-term supports and services that address the unique needs of these populations.					
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	Full	The requirement is addressed in the CAC agenda and minutes of the meetings conducted on 05/21/18, 08/15/18, 11/07/18, and 01/16/19. On site, the MCO discussed that CM staff receives ongoing trainings, which could be in-person, through online materials, or webinars. Monthly in-services and trainings are conducted, followed by evaluations, which serve as a post-test.	
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			
As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members potentially in need of CM services, including those who currently have or are likely to experience	**Documents** Policy/procedure Member handbook	Full			

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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	Provider Manual				
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. 10. General health and life goals.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full			

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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	Partial 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. 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 MCO should document the assigned risk stratification level 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.	Partial	The requirement is addressed in the Care Management Program Description. WellCare uses a proprietary ID Strat model to identify and stratify members for management. The model subjects all eligible members to a scoring algorithm which assigns a score (high, moderate, or low). File Review Results Nineteen (19) of 20 files reviewed included a risk stratification level, and 1 file did not meet the requirement. **Recommendation** The MCO should document the assigned risk stratification level in each care management file. It is important to stratify members into high, medium, and low risk. Sometimes a member can have multiple conditions but maintain a	

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		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.		very satisfactory level of health. WellCare should describe how its risk stratification model accounts for this. **MCO Response** WellCare transitioned to a new care management platform 3/25/19 which provides designated risk stratification level for each member. **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			
The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.	**Documents** Policy/procedure	Full			
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			
Behavioral Health Principles of Care The MCO must ensure that "active treatment" is	**Documents** Policy/procedure	Partial	Full	The requirement is addressed in the C7-CM-MD-1.2 and in the 2019 CM Program	

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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.	**Onsite File Review** CM file review results	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 1 file was not implemented until two months after the health risk assessment was completed. **Recommendation** The MCO should implement a plan of care in a timely manner 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 implementation of care plans is appropriately documented. **IPRO Final Findings** No change in review determination.		Description. File Review Results Twenty (20) of 20 files reviewed met this requirement.	
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	Partial 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	Full	The requirement is addressed in CM-C7-MD-1.2 and in the 2019 Care Management Program Description. File Review Result Fifteen (15) of 20 files reviewed met this requirement, and 5 files were not	

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		were not applicable, and 1 file lacked evidence of assistance. **Recommendation** MCO should ensure that, as needed, care management files 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** No change in review determination.		applicable.	
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	Partial 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 1 file lacked evidence of assistance. **Recommendation** The MCO should ensure that, as needed, care management files reflect assistance with accessing primary care, behavioral health, and 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**	Full	The requirement is addressed in C7-CM-MD-1.2 and in the 2019 Care Management Program Description. File Review Results Eighteen (18) of 20 files reviewed met this requirement, and 2 were not applicable.	

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		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			
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			
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	Partial 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 2 files lacked evidence of continuity of care. **Recommendation** MCO should ensure that, as needed, care management files 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.	Partial	The requirements are addressed in the 2019 CM Program Description on page 16 and in C7-CM-MD-1.2 on page 15. File Review Results Six (6) of 20 files reviewed met this requirement. Thirteen (13) were not applicable, and 1 file lacked evidence of continuity of care. **Recommendation** The MCO should ensure that, as needed, care management files 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.	

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		IPRO Final Findings No change in review determination.		**MCO Response** WellCare will provide a supplemental training to care managers addressing documentation of coordination of services/providers when a member transitions to a different level of care. **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			
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			
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	Full	Full	The requirement is addressed in C7-CM-MD-1.2, Care Management Program Description.	
2. A method to actively engage members in need of CM who are unresponsive to contact attempts or	**Documents** Policy/procedure	Full	Full	The requirement is addressed in the 2019 CM Program Description and in C7-CM-MD-	

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disengaged from CM.	Onsite discussion of methods used			1.2, Care Management Program Description.	
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	Full	The requirement is addressed in the 2019 CM Program Description and in C7-CM-MD-1.2, Care Management Program Description.	
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	Full	The requirement is addressed in C7-CM-MD-4.8, Individuals with special Health Care Needs, and in C7-CM-MD-1.2, Care Management Program Description.	
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	Full	The requirement is addressed in C7-CM-MD-4.8, Individuals with Special Health Care Needs, and in C7-CM-MD-1.2, Care Management Program Description.	
6. Results of the identification and assessment of any member with SHCNs to ensure that services and	**Documents** Policy/procedure	Full	Full	The requirement is addressed in C7-CM-MD-4.8, Individuals with special Health Care	

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activities are not duplicated and to identify any ongoing special conditions that require a course of treatment or regular care monitoring.				Needs.	
7. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.	**Documents** Policy/procedure	Non-compliant 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.	Full	The requirement is addressed in C7-CM-MD-1.2, Care Management Program Description.	
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	Full	The requirement is addressed in C7-CM-MD-1.2, Care Management Program Description, and in the 2019 NE Medicaid Provider Manual.	
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	Full	Full	The requirement is addressed in C7-CM-MD-1.22, Care Management Program Description, and in the 2019 NE Medicaid Provider Manual.	

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	record documentation				
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	Full	The requirement is addressed in the 2019 Nebraska Medicaid Provider Manual.	
11. A process that ensures continuity of care for members with SHCNs who are in CM.	**Documents** Policy/procedure	Full	Full	The requirement is addressed in C7-CM-MD-4.8, Individual with Special Health Care Needs.	
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	Partial 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** MCO should ensure that care management files 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** 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**	Full	This requirement is addressed in C7-CM-MD-1.2, Care Management Program Description. File Review Results Eight (8) of 20 files reviewed met this requirement, and 12 files were not applicable.	

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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			
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			
4. Develop speaking points and triggers for making emergency appointments.	**Documents** Policy/procedure Onsite discussion	Full			
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			
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			
2. Provide list of community resources (for referral).	**Documents**	Full			

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	Policy/procedure **Onsite File Review** CM file review results				
3 Plan for coordination and communication with State staff who are responsible for management of HCBS waivers.	**Documents** Policy/procedure	Full			
4. Develop a process to engage non-compliant members.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full			
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			
6. Identify providers with special accommodations (e.g., sedation dentistry).	**Documents** Policy/procedure Provider directory	Full			
7. Educate staff about barriers members may experience in making and keeping appointments.	**Documents** Evidence of staff education	Full			
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			
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	Full			

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	Onsite File Review CM file review results				
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. 4. Member discharges from inpatient and residential treatment levels of care, including State psychiatric hospitals.	**Documents** Policies/procedures	Full			
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	**Documents** Policy/procedure Onsite discussion	Full			

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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.					
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			
The MCO is responsible for ensuring coordination between its providers and the WIC program. Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.	**Documents** Policy/procedure	Full			
The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.	**Documents** Policy/procedure Onsite discussion	Full			
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			

Final Findings

Care Management					
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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			

Final Findings

Care Management					
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 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	Partial 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.	Full	The requirement is addressed in NE BH and PH Collaboration with Division of Children and Family Services Policy C7-BH-006, and in C7-BH-006-PR-001, Nebraska Behavioral and Physical Health Collaboration with Division of Children and Family Services.	

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

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**	**Prior Determination**	**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**
GRIEVANCES 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			
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			
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	**Documents** Policy/procedure Template acknowledgment notice	Partial This requirement is addressed in WellCare's Nebraska Medicaid Grievance Policy, page 4.	Partial	This requirement is addressed in WellCare's Medicaid Grievance Procedure, page 2; WellCare's Medicaid Member Appeal Policy, page 6; and WellCare's Member Handbook, page 98.	

Final Findings

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**	**Prior Determination**	**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 Grievances and appeals file review results	File Review Results: All appeals and grievances files contained acknowledgment letters. For the 20 grievances files, 1 file contained an acknowledgment letter that was dated more than 10 calendar days after receipt of the grievance. For the 10 appeals files, 2 files contained an acknowledgment letter that was dated more than 10 calendar days after receipt of the appeal. **Recommendation:** The MCO should ensure that timely (within 10 calendar days of receipt) acknowledgment letters are 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 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		File Review Results: Of the 20 grievance files reviewed, 15 files met the requirement, and the remaining 5 files did not meet the requirement. Four (4) of those 5 files were cases in which an acknowledgment letter was not sent to the member. WellCare indicated that staff has been trained to follow the process for timely acknowledgment. Of the 10 appeals files reviewed, 5 files were not applicable for this requirement, as they were expedited appeals. Of the remaining 5 standard appeals files, 4 files met the requirement, and 1 file did not meet the requirement. **Recommendation** The MCO should make a reasonable effort to ensure that acknowledgment letters for grievances and appeals are sent to members/providers within the required timeframe of 10 calendar days. This includes continuing to train staff on grievances and appeals policies and protocols for timely acknowledgment. **MCO Response** Both the Appeals and Grievance Department have several mechanisms in place to ensure appeals and grievances are acknowledged and processed within the applicable state contracted timeframes. The departments have a dashboard that runs daily to capture 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	

Final Findings

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**	**Prior Determination**	**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**
		missed elements of compliance. **IPRO Final Findings** No change in review determination.		business, compliance timeframe, and other pertinent information needed to manage the day-to-day operations of the departments. The department's sr. director, director, managers, and supervisors use the dashboards to prioritize work, monitor and manage volume of aging and open appeals and grievances approaching due dates. Team supervisors and team leads will discuss processing timeframe goals and metrics on an on-going basis, assuring that all team members take accountability for processing files within the compliance timeframe. Re-education will be given as needed up to and including performance management as necessary for files that miss compliance. The appeals and grievance teams will also report trends and processing timeframes goals to the quarterly UMAC and/or QIC Committee meetings. Although we have these processes in place to ensure we meet compliance timeframes, there are instances where the MCO has not been able to resolve certain cases timely. For instance, timeliness may be affected when a request for review does not reach the appeals department timely but instead is sent to other departments such as Claims, Customer Service or Utilization Management. Another instance is when a request for review is not identified accurately by internal staff. For those files that missed timely review due to misclassification, we have identified the individual appeals processor(s) and provided coaching and re-education on the classification of reviews and the	

Final Findings

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**	**Prior Determination**	**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**
				appeals process. For those files that missed timely review because they were sent to departments other than the Appeals Department, our department management team met with our centralized Intake Department to discuss the issues and opportunities for improvement. **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** Grievanced and appeald file review results	Full			
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			

Final Findings

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**	**Prior Determination**	**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			
A member may file a grievance with the MCO or the State at any time.	**Documents** Policy/procedure Member handbook	Full			
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			
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			
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			

Final Findings

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**	**Prior Determination**	**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**
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			
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			
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			
2. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member handbook Provider manual	Full			
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			

Final Findings

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**	**Prior Determination**	**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. 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			
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full			
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	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full			

Final Findings

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**	**Prior Determination**	**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**
than the date on which the extension expires.					
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. 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.	**Documents** Policy/procedure Template appeal resolution notice **Onsite File Review** Appeal file review results	Full			
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			
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 Provider manual	Full			

Final Findings

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**	**Prior Determination**	**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 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	Full	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 10, and in the member handbook, page 100. File Review Results Of the five expedited appeals files reviewed, all five files met the requirement.	
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	Partial	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 12, and in the member handbook, page 101. File Review Results Of the five expedited appeals files reviewed, four files met the requirement. The remaining one file did not meet the requirement. **Recommendation** WellCare should resolve each expedited appeal within the required timeframe of 72 hours after receipt. **MCO Response** Both the Appeals and Grievance Department have several mechanisms in place to ensure appeals and grievances are acknowledged and processed within the applicable state contracted timeframes. The departments have a dashboard that runs daily to capture 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	

Final Findings

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**	**Prior Determination**	**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, 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, director, managers, and supervisors use the dashboards to prioritize work, monitor and manage volume of aging and open appeals and grievances approaching due dates. Team supervisors and team leads will discuss processing timeframe goals and metrics on an on-going basis, assuring that all team members take accountability for processing files within the compliance timeframe. Re-education will be given as needed up to and including performance management as necessary for files that miss compliance. The appeals and grievance teams will also report trends and processing timeframes goals to the quarterly UMAC and/or QIC Committee meetings. Although we have these processes in place to ensure we meet compliance timeframes, there are instances where the MCO has not been able to resolve certain cases timely. For instance, timeliness may be affected when a request for review does not reach the appeals department timely but instead is sent to other departments such as Claims, Customer Service or Utilization Management. Another instance is when a request for review is not identified accurately by internal staff. For those files that missed timely review due to misclassification, we have identified the individual appeals processor(s) and provided coaching and re-	

Final Findings

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**	**Prior Determination**	**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**
				education on the classification of reviews and the appeals process. For those files that missed timely review because they were sent to departments other than the Appeals Department, our department management team met with our centralized Intake Department to discuss the issues and opportunities for improvement. **IPRO Final Findings** No change in review determination.	
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	Full	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 12, and in the member handbook, page 101. File Review Results Of the five expedited appeals files reviewed, all five files were not applicable for this requirement.	
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	Full	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 12, and in the member handbook, page 100. File Review Results Of the five expedited appeals files reviewed, all five files met the requirement.	
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			
If the MCO denies a request for expedited resolution of an appeal, it must:	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.					
Continuation of Benefits The MCO must continue a member's benefits if all of the following apply: 1. The appeal is filed timely, meaning on or before the later of the following: a. Within ten (10) calendar days of the MCO sending the Notice of adverse benefit determination; or b. The intended effective date of the MCO's proposed adverse benefit determination. 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 period covered by the authorization has not expired.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 14, and in the member handbook, page 103.	
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:	**Documents** Policy/procedure	Full	Full	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 14, and in the member handbook, page 103.	

Final Findings

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**	**Prior Determination**	**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**
6. The member withdraws the appeal or request for state fair hearing. 7. The member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the MCO sends the notice of an adverse resolution to the member's appeal. 8. The state fair hearing office issues a hearing decision adverse to the member. 9. The authorization expires or authorization service limits are met.					
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 to the extent that the services were furnished solely because of the requirements of this section.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in WellCare's Medicaid Appeal Procedure, page 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			
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	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
a hearing must be explained to the member or the member's representative (if any) by the MCO.					
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			
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			
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			
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			

Final Findings

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**	**Prior Determination**	**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			
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			

Final Findings

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**	**Prior Determination**	**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 Grievances System reports for grievances, appeals, expedited appeals, and state fair hearings submitted during the review period	Full			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

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**	**Prior Determination**	**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			
Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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			
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			

Final Findings

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**	**Prior Determination**	**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 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			
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				
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	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.					
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			
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			
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	**Documents** Policy/procedure Member materials for	Partial This requirement is partially addressed in WellCare's corporate policy "Updates to the WellCare Websites Policy," page 37, bullet d. There is a	Full	This requirement is addressed in the Updates to the WellCare Websites Policy on page 40 and in the Medicaid Post-Enrollment Member Materials Policy on page 26. The	

Final Findings

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**	**Prior Determination**	**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**
can find on the website and how to obtain written materials if the member does not have access to the website.	new members	discrepancy in the number of days within which the MCO must distribute member materials: the policy says within 30 days, and the state contract says within 10 days. On site, 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** MCO should 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.		member handbook includes a description of the MCO's website and the materials the members can find on the website on page 24. Also on this page, the members are given a number to call if they do not have access to the website.	
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			
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			
The MCO must make its written information available in the prevalent non-English languages in the State.	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.	Examples of member materials in English and Spanish, such as newsletters and other informational materials				
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			
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			
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			
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			
Member Handbook The MCO must develop, maintain, and post to	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Medicaid Post-enrollment Materials Policy on	

Final Findings

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**	**Prior Determination**	**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 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. 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.	Member handbook View website onsite Onsite discussion			pages 2, 4, 20, 21, and 26. On site, the MCO demonstrated the member portal where members can request written member handbook or provider directory or view/print these documents. When members choose to view/print, they are taken to the public website where the handbook is available for everyone under the Members→Medicaid→WellCare of Nebraska route and by scrolling down the page. The MCO should consider adding a direct link to download the handbooks in both languages under the Members tab on the public website, especially for those members who are not able to navigate websites comfortably.	
At a minimum, the member handbook must include: 1. A table of contents.	**Documents** Member handbook should address all sub-elements	Full			
2. A general description of basic features of how MCOs operate and information about the MCO in particular.		Full			
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		Full			

Final Findings

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**	**Prior Determination**	**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**
number, fax number, email address, and mailing 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			
5. Member rights/protections and responsibilities.		Full			
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			
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			
8. A description of the PCP selection process and the PCP's role as coordinator of services.		Full			
9. The member's right to select a different MCO or change providers within the MCO.		Full			
10. Any restrictions on the member's freedom of choice of MCO providers.		Full			
11. A description of the purpose of the Medicaid		Full			

Final Findings

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**	**Prior Determination**	**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**
and MCO ID cards, why both are necessary, and how to use them.					
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			
13. Procedures for obtaining benefits, including authorization requirements.		Full			
14. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.		Full			
15. Information about health education and promotion programs, including chronic care management.		Full			
16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full			
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			
18. Information about a member’s right to a free second opinion and how to obtain it.		Full			
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.		Full			

Final Findings

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**	**Prior Determination**	**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**
b. That prior authorization is not required for emergency services. 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			
21. How to obtain emergency and non-emergency medical transportation.		Full			
22. Information about the EPSDT program and the importance of children obtaining these services.		Full			
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			
24. Information about member copayments.		Full			
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			

Final Findings

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**	**Prior Determination**	**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**
26. How and where to access any benefits that are available under the Medicaid State Plan that 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.		Full			
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			
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		Full			

Final Findings

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**	**Prior Determination**	**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**
services furnished while the appeal is pending, if the final decision is adverse to the member.					
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			
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			

Final Findings

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**	**Prior Determination**	**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**
30. Information about how members can file a complaint with MLTC or the Division of Public Health about a provider's failure to comply with advance directive requirements.		Full			
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			
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			
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	Full	This requirement is addressed in the Medicaid Post-enrollment Materials Policy on page 24.	
Other Member Notifications The MCO must also provide the following	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Disenrollment Policy on pages 20 and 29, and	

Final Findings

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**	**Prior Determination**	**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**
information to each member: 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.	Evidence of member notification			in the member handbook on pages 108 and 109. On site, the MCO provided the member notification letter template, which explains the member's disenrollment rights. The MCO also provided the process for mailing this letter to members on August 1, and indicated that a report is run every day to capture all members until October 31 (the day before the current enrollment start date of November 1). This process logic was written for 2017, but was used in 2018 as well. This process shows 76,148 mailings on the initial August 1 pull of 2018, for example.	
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	Full	This requirement is addressed in the Medicaid Post-enrollment Materials Policy on page 24, and in the member handbook on pages 21 and 24. There is no mention that the members can request the provider directory at no cost. On site, the MCO confirmed that they do not charge for the provider directory when members request it. They also provided the member notification letter template, which clearly states that members can request an updated member handbook and the updated provider directory at any time at no cost. The MCO submitted evidence that this letter is mailed to members at least once a year.	
Member Newsletter The MCO must develop and distribute, a minimum of	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Medicaid Post-enrollment Materials Policy on page 41, which references quarterly member	

Final Findings

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**	**Prior Determination**	**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**
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.	Copies of member newsletters issued during the review period			newsletters. Location of the newsletter on the MCO's website is indicated in the member handbook on page 24. Availability for members to get a copy of the newsletter is detailed in the member handbook on page 111. The MCO also provided the four newsletters for the review period to evidence the implementation of this requirement.	
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	Full	This requirement is addressed in the Medicaid Post-enrollment Materials Policy on page 24. The MCO also provided provider directories for five regions for January 2019 and March 2019 as examples to evidence the implementation of this requirement. The online provider directory is searchable for members and the public. On site, the MCO and MLTC confirmed that the electronic file of the directory is submitted by the MCO to the MLTC on a weekly basis.	
The hard copy directory for members must be updated a minimum of monthly. The web-based	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.					
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 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).	**Documents** Policy/procedure Provider directory View website onsite	Full			
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.	**Documents** Policy/procedure View website onsite	Full			

Final Findings

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**	**Prior Determination**	**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 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.					
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.	**Documents** Policy/procedure View website onsite	Full			

Final Findings

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**	**Prior Determination**	**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. 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.					
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: 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	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.					

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

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**	**Prior Determination**	**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 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			
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			
There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.	**Documents** Policy/procedure	Full			
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			
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:** Appointment Availability Access Standards	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	Full	This requirement is addressed in the Provider Appointment Accessibility and After-Hours Coverage section of the provider manual on page 27. WellCare also provided the 2018 Q4 Geographical Access Report and the Provider Appointment Availability WHP 2018 Q4 Sample Report. Also, these requirements are communicated to the providers in the provider manual and in the provider contracts.	

Final Findings

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**	**Prior Determination**	**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**
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.					

Final Findings

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**	**Prior Determination**	**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**
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					

Final Findings

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**	**Prior Determination**	**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**
members (other than by mail order) to ensure convenient access to covered drugs. 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					

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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**	**Prior Determination**	**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 cannot be met because of a lack of behavioral health providers in 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			
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			
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	**Documents** Policy/procedure Template provider contract – one per provider type	Full			

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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**	**Prior Determination**	**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**
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.	Provider manual				
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			
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			
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			
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			
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			

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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**	**Prior Determination**	**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 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			
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	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full			

Final Findings

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**	**Prior Determination**	**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**
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. 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			
If the MCO identifies a problem involving	**Documents**	Full			

Final Findings

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**	**Prior Determination**	**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**
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.	Policy/procedure				
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			
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			

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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**	**Prior Determination**	**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 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 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.	**Documents** Policy/procedure				
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			
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			
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	**Documents** Policy/procedure Member handbook	Full			

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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**	**Prior Determination**	**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**
approved number of visits) as appropriate for the member's condition and identified needs.					
The MCO must ensure that its provider network includes sufficient numbers of network providers 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.	**Documents** Policy/procedure Onsite discussion	Full			
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	**Documents** Policy/procedure Examples of notification to MLTC	Full			

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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**	**Prior Determination**	**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**
covered services are not available within the required distance.					
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			
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** Geographical access reports Onsite discussion	Full	Full	This requirement is addressed in the Network Development Policy and in the 2018 and 2019 Network Development Plan.	
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	**Documents** Policy/procedure Network development plan Onsite discussion	Full	Full	This requirement is addressed in the Network Development Policy and in the 2018 and 2019 Network Development Plan.	

Final Findings

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**	**Prior Determination**	**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**
members, and whether the location provides physical access for members with disabilities. 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	Partial 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 requirements related to the 45-minute wait time.	Full	This requirement is addressed in the Network Development Policy. This is communicated to the members in the member handbook and to the providers in the provider manual.	

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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**	**Prior Determination**	**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 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			
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			
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 follow-up	Full			

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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**	**Prior Determination**	**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**
	actions				
The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, MLTC may require that they be implemented by the MCOs.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment "no-show" rate, including results and follow-up actions	Full			
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 follow-up actions	Full			
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	**Documents** Policy/procedure Requests for exception submitted to MLTC **Reports** Evidence of Geo access monitoring including	Full	Full	This requirement is addressed in the Q4 Geographical Access Report.	

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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**	**Prior Determination**	**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**
available to the non-Medicaid population.	results and f/u actions				
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 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.	**Documents** Policy/procedure Provider network availability plan	Full	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
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 follow-up actions	Full	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
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 must completely process credentialing applications from all provider types within 30	**Documents** Policy/procedure	Full			

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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**	**Prior Determination**	**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**
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 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.	Template denial letter				
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			
The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent	**Documents** Policy/procedure **Onsite file review**	Full	Full	This requirement is addressed in the Credentialing and Recredentialing Policy. **Credentialing File Review Results**	

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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**	**Prior Determination**	**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**
providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.	Credentialing file review results			Ten (10) of 10 files met all requirements.	
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	Full	This requirement is addressed in the Credentialing and Recredentialing Policy. **Recredentialing File Review Results** Four of four files met all requirements.	
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			
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	**Documents** Policy/procedure View network provider database onsite	Full			

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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**	**Prior Determination**	**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. 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 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			
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	**Documents** Policy/procedure Network development plan	Full	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	

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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**	**Prior Determination**	**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**
population.					
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 (age/gender/race/ethnicity) data, and the number of single case contracts by service type.	**Documents** Policy/procedure Network development plan	Full	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
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	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
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	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
A summary of network development efforts conducted during the prior year.	**Documents** Policy/procedure Network development plan	Full	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
Plans to correct any current material network	**Documents**	Full	Full	This requirement is addressed in the 2018	

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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**	**Prior Determination**	**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**
gaps and barriers to network development.	Policy/procedure Network development plan			and 2019 Network Development Plan.	
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	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
The participation of members, family members/caretakers, providers, including State- operated providers, and other community stakeholders in the annual network planning process.	**Documents** Policy/procedure Network development plan	Full	Full	This requirement is addressed in the 2018 and 2019 Network Development Plan.	
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			
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			
Evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full			
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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 area.					
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			
Process provisional credentials for behavioral health service providers.	**Documents** Policy/procedure	Full			
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			
Provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full			
Educate its provider network regarding appointment time requirements.	**Documents** Policy/procedure	Full			
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 follow-up actions	Full			
Provider-Patient Communication/Anti-Gag Clause Subject to the limitations described in 42 CFR 438.102(a)(2), the MCO must not prohibit or	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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 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.	Template provider contract – one per provider type Provider manual				
Confidentiality The MCO must establish and implement	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.	Template provider contract – one per provider type Provider manual				

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 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	Partial 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 should ensure its policies/procedures 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.	Full	This requirement is addressed in the Provider Complaint System Policy and in the Provider Customer Service Escalation Workflow Procedure. This requirement is conveyed to the providers in the provider manual.	
This system must be capable of identifying and tracking complaints received by telephone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.	**Documents** Policy/procedure **Reports** Provider complaint system reports produced during the review period	Partial Addressed in WHP-C6 GR-NE-30. The Grievance System Log provided includes, for example, type of issue (complaint, appeal), complaint type, date received, resolution date, outcome, and 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	Full	This requirement is addressed in the Provider Complaint Policy and in the Grievance System Log.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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'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. The policies and procedures must include, at a minimum:	**Documents** Policy/procedure Provider manual Template complaint resolution notice Complaint system standardized reports **Onsite File Review** Provider complaint file review **Onsite discussion:** Review complaint system metrics, including year-	Partial 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 in a timely manner. Nine (9) of 10 files included a resolution notice. **Recommendation** Provider complaints should be resolved within the MCO-defined timeframe. All files should include a copy of the resolution notice sent to the provider.	Partial	This requirement is addressed in the Nebraska Provider Complaint System Policy and is communicated to the providers in the provider manual. **Provider Complaint File Review Results** Seven (7) of 10 files were reviewed. All files included documentation of the substance of the complaint. Three (3) files were not completed in a timely manner and did not contain a Resolution Notice or an Explanation of Payment. For claims-related instances, WellCare sends an EOP to the provider rather than a resolution notice. On site, WellCare provided evidence that the provider was re-sent the EOP notification for the seven files that were claims-related.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	over-year comparisons of complaint volumes			**Recommendation** WellCare should ensure that all complaints are resolved within the MCO-defined timeframe. All files should contain a resolution notice or an explanation of payment. **MCO Response** We are conducting daily inventory meetings, including review of detailed reporting and focusing on open items/ anything that could possibly impact TAT. As demonstrated during the audit there are other resolutions that we offer including a letter, out-bound call to provider and new EOP generated upon claim payment. **IPRO Final Findings** No change in review determination.	
1. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the resolution timeframes.		Partial WHP-C6 GR-NE-30 provided. The policy inconsistently states the timeframe for providers to file a complaint. In one section, the policy states that providers may file a complaint at any time and, in another section, the policy states 30 days. An updated policy is awaiting MLTC approval. **Recommendation** WellCare should implement its updated policy addressing all requirements upon MLTC approval. **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.	Full	This requirement is addressed in the Nebraska Provider Complaint System Policy.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.		Non-compliant WHP-C6 GR-NE-30 provided. The policy does not address complaints that may be filed directly to MLTC. An updated policy is awaiting MLTC approval.	Full	This requirement is addressed in the Nebraska Provider Complaint System Policy.	
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.		Full WHP-C6 GR-NE-30 provided. 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.	Full	This requirement is addressed in the Nebraska Provider Complaint System Policy.	
4. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues.		Partial 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. **Recommendation** WellCare should update its provider handbook to include instructions for providers to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues. **MCO Response** Updates to the Provider Handbook regarding consolidating complaints and the opportunity to present complaints in person are currently in progress.	Full	This requirement is addressed in the Nebraska Provider Appeal Process for Dissatisfaction with Payment Procedure and in the Provider Complaint Form.	
5. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation.		Full Addressed in WHP-C6 GR-NE-30.	Full	This requirement is addressed in the Nebraska Provider Complaint System Policy.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.		Full 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.	Full	This requirement is addressed in the Nebraska Provider Complaint System Policy.	
7. A process for giving providers (or their representatives) the opportunity to present their cases in person.		Non-compliant The provider's opportunity to present in person was not found in policy, the provider handbook, or on the MCO website. **Recommendation** WellCare should ensure the provider's opportunity to present in person is documented in MCO policy and in the provider handbook.	Full	This requirement is addressed in the Nebraska Provider Complaint System Policy. This requirement is communicated to the providers in the provider manual.	
8. Identification of specific individuals who have authority to administer the provider complaint process.		Full Addressed in WHP-C6 GR-NE-30.	Full	This requirement is addressed in the Nebraska Provider Complaint System.	
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.		Full Addressed in WHP-C6 GR-NE-30. Complaints are captured in the MCO's grievance database. Associated documentation is maintained in the case file.	Full	This requirement is addressed in the Nebraska Provider Complaint System.	
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	Partial 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 Manual was also provided. Similarly, the	Full	This requirement is addressed in the provider handbook and in the Provider Complaint Form.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
		resolution timeframe stated is not consistent with the MCO policy. The manual references the provider complaint form provided on the website. The manual also refers to the Quick Reference Guide and provides a link for more information on how to contact the Grievance Department. **Recommendation** WellCare should implement an updated policy addressing all requirements upon MLTC approval. WellCare should ensure that the MCO website and provider manual are consistent with the updated policy. **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.			
The MCO must develop an internal claims dispute process for those claims that have been denied or underpaid. The process for appealing payment and service denial decisions must be included in the provider handbook.	**Documents** Policy/procedure Provider manual **Onsite File Review** Provider appeal of claim/service denial file review	New requirement	Full	This requirement is addressed in the Nebraska Provider Appeal Process for Dissatisfaction with Payment Procedure and in the Claims Provider Payment Disputes Timeframe for Requesting Adjustments to Denied-Underpaid Claims Policy. This requirement is conveyed to the providers in the provider manual. Provider Appeal File Review Results Ten (10) of 10 files met all requirements.	

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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. 5. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program.	**Documents** QM Program Description	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 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			
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			
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: 45 calendar days following 12th month of contract year	**Documents** QM Program Description	Full	Full	This requirement is addressed in WellCare's Quality Improvement (QI) Program Description.	
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. 3. Implementation of improvement actions, where applicable.	**Documents** QM Work Plan	Full	Full	This requirement is addressed in the 2019 QI Work Plan.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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. Individual accountability for each activity. QM work plan due date: 45 calendar days following 12th month of contract year					
Procedures for remedial action for deficiencies that are identified.	**Documents** QM Program Description Policy/procedure	Full			
Specific types of problems requiring corrective action.	**Documents** QM Program Description Policy/procedure	Full			
Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.	**Documents** QM Program Description Policy/procedure	Full			
Procedures for provider review and feedback about results.	**Documents** QM Program Description Policy/procedure	Full			
Annual QM evaluation that includes: 1. Description of completed and ongoing QM activities. 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	**Documents** QM Evaluation Onsite discussion	Full	Partial	This requirement is addressed in the QAPIC meeting minutes and partially addressed within the QI Program Evaluation; there is an opportunity to incorporate all Quality Performance Program (QPP) measure outcomes in the yearly QI Program Evaluation, and post this evaluation on the MCO's website. **Recommendation** WellCare should include all QPP measures in their QI Program Evaluation, and post this	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 service to members, and overall effectiveness of the QM program. QM Evaluation due date: 45 calendar days following 12th month of contract year Quality Performance Program Measures for Year 2 per Attachment 14 as per Amendment Three include: 1. Claims Processing Timeliness				evaluation to their website. **MCO Response** QPP measures will be added to the Annual QI Evaluation and to the website when complete. **IPRO Final Findings** No change in review determination.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
2. Encounter Data Acceptance Rate 3. Call Abandonment Rate 4. Appeal Time Resolution 5. PDL Compliance 6. Lead Screening in Children 7. Well Child Visits in the First 15 Months of Life 8. Childhood Immunization Status					
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			
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			
At a minimum, assess the quality and appropriateness of care furnished to members.	**Documents** QM Program Description	Full			
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			
Maintain a health information system that can support the QAPI program. The MCO's information system must support the QAPI process by collecting,	**Documents** QM Program Description	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
analyzing, integrating, and reporting data required by 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	Full	This requirement is addressed in the member handbook on page 111 and in the provider handbook on pages 44–49.	
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	Full	This requirement is evidenced within the QAPIC meeting minutes, as well as the Member Advisory Committee (MAC) meeting minutes.	
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	Full	This requirement is addressed in the QI Program Description on page 10.	
QAPIC The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.	**Documents** QM Program Description Description of QAPIC	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 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	Partial 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.	Full	This requirement is addressed in the QI Program Description on page 18, and evidenced within the QAPIC meeting minutes.	
The MCO's QAPIC must: 1. Review and approve the MCO's QAPI Program	**Documents** QM Program Description	Full	Full	This requirement is addressed in the QI Program Description, and evidenced within the QAPIC meeting minutes.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.	Agendas and meeting minutes for all committee meetings held during review period				
Additional required committees must include:	**Documents** Committee descriptions	Full	Full	This requirement is addressed in the QI Program Evaluation, and evidenced within the	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.	List of membership for each committee QM Work Plan QM Evaluation			QAPIC meeting minutes and agendas.	
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	Full	This requirement is addressed in the Adult and Child Core Measures summaries.	
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 must ensure that data received from providers is accurate and complete by:	**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	Full	Full	This requirement is addressed in the Quality Oversight Committee reports. The numerator and denominator for each rate reported by the MCO are evidenced within the Adult and Child Core Measures summaries. Trending of previous year's performance, as well as benchmarking, is evidenced within the QI Work Plan.	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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	**Reports** 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	Full	This requirement is evidenced by the timely submission of PIPs and performance measures, per the reporting requirements and deadlines outlined in Attachment 38 of the Heritage Health contract. This requirement is also evidenced within the QI Work Plan.	
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. Performance measures include, but are not limited to,	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS Final Audit Report	Full	Full	This requirement is evidenced within the three PIP interim reports submitted (for Tdap, 17p, and follow-up after ED visit for MHI/SUD), as well as within the Adult and Child Core Measures summaries and the HEDIS 2018 Annual Evaluation Workbook.	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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: June 30 **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) 14. Adherence to Antipsychotics for Individuals with Schizophrenia (SAA) 15. Controlling High Blood Pressure (CBP) 16. Comprehensive Diabetes Care: Hemoglobin A1c	and IDSS rates CAHPS Report Onsite discussion				

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
(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) 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)					

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 Medicaid and Children with Chronic Conditions Supplemental Items) (CPC) <u>HEDIS Measures</u> 1. Comprehensive Diabetes Care 2. Medication Management for People with Asthma (Adults) 3. Lead Screening in Children					

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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. 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 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.	**Reports** HEDIS Final Audit Report and IDSS rates	Full	Full	This requirement is evidenced within the HEDIS 2018 Annual Evaluation Workbook, and in the final audit report prepared by HealthcareData Company, LLC.	
The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that	**Reports** HEDIS Final Audit Report and IDSS rates	Full	Full	This requirement is addressed in the 2018 HEDIS Annual Evaluation and in the QI Work Plan, which demonstrates goals and the	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.	Trended performance measure results			performance measure rates from 2017 (2018 rates were not available for all measures at the time of this compliance review, but a column has been established as a placeholder for comparison purposes).	
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 Audit Report and IDSS rates Review of website Onsite discussion	Full	Full	WellCare provided interim PIP reports for each of the three topic areas. These topics were selected based on state priorities, and where opportunities were identified. HEDIS FUM and FUA measures are being used to evaluate the behavioral health PIP (Follow-Up After an ED Visit for Mental Health Illness/Substance Use Disorder). The other two PIPs (Tdap and 17p) rely on measures crafted by IPRO and MLTC. The PIPs are reported to and validated by IPRO annually, with updates provided quarterly. The MCO also provided as evidence the 17p and Tdap PIP Annual Reports.	
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	Full	Full	This requirement is evidenced within the Adult, Child and CCC final reports, prepared by SPH Analytics. This requirement is addressed in the 2018 HEDIS Annual Evaluation and in the QI Work Plan, which demonstrates goals and the performance measure rates from 2017 (2018 rates were not available for all measures at the time of this compliance review, but a column has been established as a placeholder for	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	benchmarks, including follow-up actions taken			comparison purposes).	
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	Full	WellCare provided interim PIP reports that reflect activity from CY 2018 for each of the three topic areas. These topics were selected based on state priorities, and where opportunities were identified. HEDIS FUM and FUA measures are being used to evaluate the behavioral health PIP (Follow-Up After an ED Visit for Mental Health Illness/Substance Use Disorder). The other two PIPs (Tdap and 17p) rely on measures crafted by IPRO and MLTC.	
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	Full	The Heritage Health MCOs collaborate on all three PIP topics identified by MLTC.	
PIPs must be addressed in the MCO's annual QM Program Description, Work Plan, and Program 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	**Documents** QM Program Description QM Work Plan QM Evaluation	Full	Full	PIPs are addressed in the Quality Oversight Committee Report, the QI Program Description, the QI Work Plan, and QI Program Evaluation. Each of the PIP interim reports that were submitted for review contained each of the necessary CMS requirements.	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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. 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	Full	This requirement is addressed in the QI Program Evaluation. PIP next steps are not detailed within the Work Plan or Program Description, however are appropriately detailed within the Program Evaluation. WellCare should include next steps in the work plan, as appropriate.	
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	Full	The 2018 PIPs are two years in duration, allowing for enough time to pilot interventions designed in response to barrier analysis, gather data to evaluate the success of these interventions, modify accordingly, and then apply more broadly.	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.	Onsite discussion	Full	Full	Amendment 3 to the Heritage Health contract included additional performance measures. These measures are reflected within the QI Work Plan.	
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	Full	WellCare contracted with SPH Analytics, an NCQA-certified vendor, to administer the CAHPS Adult and Child CCC surveys.	
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	Non-compliant	WellCare did not survey CHIP members for the CCC items, and thus were unable to report separate results. The MCO has crafted an action plan that accounts for this oversight, and will ensure these populations (CHIP and Medicaid) are accounted for separately in the report that is issued to MLTC in 2020. **Recommendation** WellCare should ensure both Title XIX (Medicaid) and Title XXI (CHIP) populations are surveyed and their results stratified. **MCO Response** The CAHPS survey for 2019 included all required categories as per the contract. Five data sets were received on 6/17/19 that include Title XIX (Child and Child with CCC, Title XXI (Child and Child with CCC), and the Adult data. **IPRO Final Findings**	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
				No change in review determination. The 2018 data reviewed as part of this compliance audit did not demonstrate stratification of Title XIX and Title XXI populations. The 2019 data sets will be reviewed as part of next year's compliance review.	
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	Full	SPH Analytics follows NCQA protocols to achieve a representative sample of the MCO's member population.	
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	Full	This requirement is addressed within the reports SPH Analytics prepared on behalf of WellCare.	
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: 45 calendar days following 12th month of contract year	**Reports** CAHPS Adult And Child Survey reports Onsite discussion	Full	Non-compliant	The reports SPH Analytics prepared on behalf of WellCare do not include stratified results for Medicaid children and CHIP children. **Recommendation** WellCare should ensure both Title XIX (Medicaid) and Title XXI (CHIP) populations are surveyed and their results stratified. **MCO Response** Final reports for 2019 CAHPS have not been made available. However, the raw data indicates that each of the populations was	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
				surveyed separately as is required per the contract. **IPRO Final Findings** No change in review determination. The 2018 data reviewed as part of this compliance audit did not demonstrate stratification of Title XIX and Title XXI populations. The 2019 data will be reviewed as part of next year's compliance audit.	
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	Full	This requirement is addressed in WellCare's 2018 Provider Satisfaction Survey Final Report, and in Policy C7-QI-038, Provider Satisfaction. SPH Analytics utilized a two-wave mail and Internet with phone follow-up survey methodology to administer the Provider Satisfaction Survey. Four hundred and sixty two (462) surveys were collected (225 mail, 68 Internet, and 169 phone) from the eligible provider population from July to October 2018. After adjusting for ineligible members, the mail/Internet survey response rate was 12.4%, and the phone survey response rate was 19.1%.	
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	**Documents** Provider Satisfaction Survey tool and methodology Onsite discussion	Full	Full	This requirement is addressed in Policy C7-QI-038, Provider Satisfaction, on page 5.	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
(neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.					
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: 45 calendar days following 12th month of contract year	**Reports** Provider satisfaction survey results, including follow-up actions taken	Full	Full	This requirement is addressed in WellCare's 2018 Provider Satisfaction Survey Final Report, and in Policy C7-QI-038, Provider Satisfaction. Opportunities for improvement are detailed within the NE NPS Market Action Log. The lowest scoring items on the 2018 survey, for respondents overall, were as follows: 1. Timeliness to resolve complaints 2. Variety of branded drugs on formulary 3. Consistency of the formulary over time The corresponding action plan for 2019 (per the QI Program Evaluation) includes: 1.Claims processing and operational efficiency 2. Provider call center satisfaction 3. Collaboration with care management 4. Relationship development This action plan is the same as last year (following the 2017 survey); however, finance issues, health plan call center staff, and provider relations declined by 6, 7.8, and 3.9 percentage points, respectively. WellCare indicated that they have a new approach this year to address provider satisfaction, which includes a cross-functional team that follows an account management approach. There have been several town hall meetings with providers, to better gauge	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
				satisfaction and create a platform for direct feedback. In addition, the provider relations team has partnered with call center staff and data analytics to better understand why providers are calling with complaints.	
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			
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			
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	Full	This requirement is addressed in the MAC Charter, the QI Program Description, and the MAC meeting minutes and agendas.	
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	Partial 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**	Full	This requirement is addressed within the MAC Charter, and within the MAC training deck. The last two trainings that were conducted took place December 6, 2018, and March 7, 2019. New members attended these trainings; there was one new member present for the December training and two for the March	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 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.		training.	
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	Partial	This requirement is partially addressed in the MAC Charter; there is an opportunity to include a more detailed meeting schedule (only "quarterly" is indicated). **Recommendation** The MCO should include a detailed meeting schedule within the MAC Charter, so that members can plan accordingly. **MCO Response** The MAC Charter will be updated to include a detailed meeting schedule. **IPRO Final Findings** No change in review determination.	
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	Full	Full	This requirement is addressed in the MAC meeting minutes and agendas.	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	review period				
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** Semiannual reports submitted during the review period	Full	Full	This requirement is addressed in the MAC Charter, and evidenced within the MAC reports and MAC membership roster submitted to MLTC.	
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	Full	This requirement is addressed in the Clinical Advisory Committee (CAC) Charter, the QI Program Description, and the CAC meeting minutes provided by the MCO.	
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 reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	Full	This requirement is evidenced within the CAC meeting minutes and agendas.	
The committee must include members who care for	**Documents**	Full			

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.	Clinical Advisory Committee membership				
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	Full	This requirement is evidenced within the CAC meeting minutes and agendas.	
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	Full	This requirement is addressed in the CAC Charter, and evidenced within the quarterly meeting minutes that were submitted.	
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 assessments, encounter data validation, focused studies, and other tasks requested by MLTC.	Onsite discussion	Full	Full	This requirement was addressed during the onsite audit held at WellCare in Lincoln, Nebraska, on May 16, 2019.	
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			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

Subcontracting Requirements					
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 Required for any new subcontractors annually	Full	Not applicable	This requirement is addressed in the Delegation Oversight Policy and in the 2018 Nebraska Audit Plan. WellCare provided contracts and agreements with 27 entities. Fourteen (14) of these were not applicable, as they were credentialing agreements with providers/provider groups. The remaining 13 contracts were indicated to be effective prior to the review period, and therefore, did not require a pre-delegation evaluation report.	
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 Required for any new subcontractors annually	Full	Full	Of the 13 contracts with subcontractors, 12 met all the requirements. The remaining 1 contract for University of Florida MTM did not include frequency of reporting or terms for revoking delegation or sanctions. On site, the MCO explained that they did the pre-delegation evaluation for MTM at the end of last year and were expected to go live at the end of last year; however, approval of MTM is still pending with MLTC. MTM's contract is not complete and should not have been provided for review. As a result, there are 12 applicable contracts that are live at the time	

Final Findings

Subcontracting Requirements					
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
				of the review for the review period, and all 12 satisfied the requirements.	
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 follow-up actions taken Also includes reviewer completion of subcontractor worksheet	Full			
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 follow-up actions taken Also includes reviewer completion of subcontractor worksheet	Full			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: WellCare

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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			
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	Full	This requirement is addressed in WellCare's 2018 UM Program Description, pages 12–20.	
Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, pages 22–24.	
Mechanisms to detect and document over- and under-utilization of medical services.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, page 28.	
Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, page 2.	
Availability of UM criteria to providers.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, page 5.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, pages 5–6.	
Availability of physician reviewers to discuss determinations by telephone with physicians who request them.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, page 5.	
Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, pages 3 and 20.	
A process and procedures to address disparities in health care.		Partial 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 entitled "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 individuals' needs. HEDIS results could also inform their analysis. Health risk assessments and CAHPS surveys identify special populations. One example is the partnership the MCO 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 health care. **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 support due to disparaging conditions	Full	This requirement is partially addressed in WellCare's 2018 UM Program Description on page 4, whereby the MCO mentions delivery of services that are culturally sensitive and medically necessary. This requirement is also addressed in the 2019 UM Program Description. The 2019 UM Program Description was submitted to MLTC February 28, 2019, and approved May 3, 2019. The review determination has been changed to full, since the MCO made the changes to the UM Program Description during the review period.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
		(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	Full	This requirement is addressed in WellCare's 2018 UM Program Description, page 28.	
A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, pages 13–20.	
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	Partial	This requirement is not explicitly addressed in the 2018 or 2019 UM Program Descriptions provided. The MCO has policies and procedures relating to prescribing pharmaceuticals and has submitted the template for the preferred drug list; however, the requirement states that these must be addressed in the MCO's written UM Program Description. **Recommendation** The MCO should include language pertaining to ensuring network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected MLTC's PDL and other state publications. **MCO Response** WellCare will revise the UM Program	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
				Description to include language pertaining to ensuring network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected MLTC's PDL and other state publications and a process for providing prescribers with members' drug utilization data from MLTC and the Nebraska DUR board to inform prescribing activity. This will be completed by October 1, 2019. **IPRO Final Findings** No change in review determination.	
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	Partial	This requirement is not explicitly addressed in the 2018 or 2019 UM Program Descriptions provided. The MCO has sample reports relating to drug utilization data sharing and has also submitted policies and procedures; however, the requirement states that these must be addressed in the MCO's written UM Program Description. **Recommendation** The MCO should include language pertaining to having a process for providing prescribers with members' drug utilization data from MLTC and the Nebraska DUR board to inform prescribing activity. **MCO Response** WellCare will revise the UM Program Description to include language pertaining to ensuring network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
				reflected MLTC's PDL and other state publications and a process for providing prescribers with members' drug utilization data from MLTC and the Nebraska DUR board to inform prescribing activity. This will be completed by October 1, 2019. **IPRO Final Findings** No change in review determination.	
A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 45 calendar days following the 12th month of the contract year.		Full	Full	This requirement is addressed in WellCare's 2018 UM Program Description, pages 26–27.	
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			
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			
Are adopted in consultation with participating health care professionals.	**Documents** Policy/procedure Evidence of participation of health care professionals	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
Are reviewed and updated a minimum of annually, as appropriate.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in WellCare's Provider Clinical Practice Guidelines Policy, page 15.	
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			
Are posted to the MCO's website.	**Documents** Policy/procedure View website onsite	Full			
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			
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			
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 follow-up actions taken	Full	Full	This requirement is addressed in WellCare's Provider Clinical Practice Guidelines Policy, page 15.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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	Full	This requirement is addressed in WellCare's Provider Clinical Practice Guidelines Policy, page 15.	
Service Authorization Procedures The MCO and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services	**Documents** Policies/procedures addressing all sub-elements	Full			
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			
2. Not require service authorization for emergency services.		Full			
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			
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			
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			
6. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization		Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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.					
7. Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth.		Full			
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			
9. Consult with the requesting network provider, when appropriate.	**Onsite File Review** Also includes UM file review results	Full			
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			
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			
Retrospective Utilization Review of Network Providers 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.	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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			
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			
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 follow-up actions taken	Full			
5. Provider reviews related to Medicaid compliance issues.	**Documents** Policy/procedure Example of a provider review related to compliance	Full			
6. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.	**Documents** Policy/procedure	Full			
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	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	follow-up actions taken				
The MCO must monitor for potential off-label drug usage.	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken	Full	Full	This requirement is addressed in WellCare's Drug Evaluation Review Procedure and in the tracking log provided of denials due to off-label drug 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 whether a prudent layperson would have requested such services. A prudent layperson is one who possesses an average knowledge of health and medicine.	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken	Full	Full	This requirement is addressed in WellCare's Decrease in Emergency Room Overuse Procedure, pages 1–2, and in the Decrease in Emergency Room Overuse Policy, page 2.	
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	**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	Full	This requirement is addressed in WellCare's Utilization Management Committee Charter and by the committee meeting minutes provided for June–December 2018.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
are identified and shared with provider network staff through this committee. 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			
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** UM file review results	Full			
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			
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			
1. The action the MCO or its subcontractor has taken or intends to take.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
2. The reason(s) for the action.	**Documents** Policy/procedure	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 UM file review results				
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** UM file review results	Full			
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
6. Procedures for exercising a member's rights to appeal or grieve a decision.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
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			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	UM file review results				
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** UM file review results	Full			
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. 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:	**Documents** Policy/procedure	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 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				

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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** UM file review results	Partial 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** 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.	Full	This requirement is addressed in WellCare's Adverse Benefit Determinations Policy, pages 41–42, and the Service Authorizations Decisions Policy, pages 37–38. File Review Results Of the five standard UM files reviewed, all five files met the requirement.	
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	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	Full	This requirement is addressed in WellCare's Service Authorizations Decisions Policy, page 37. File Review Results Of the five expedited UM files reviewed, all five files met the requirement.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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. 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.					
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			