State of Georgia

Department of Community Health (DCH)

EXTERNAL QUALITY REVIEW OF COMPLIANCE WITH STANDARDS

for

WELLCARE OF GEORGIA, INC.

February 2016

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1. Overview

Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations (MCOs), referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. The State refers to its managed care program as Georgia Families and to its CHIP program as PeachCare for Kids®. *Georgia Families* refers to all Medicaid and CHIP members enrolled in managed care, approximately 1.3 million beneficiaries.[1-1]

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR 438.358, the state, an agent that is not a Medicaid MCO, or its external quality review organization (EQRO) must conduct a review to determine a Medicaid MCO's compliance with standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. These standards must be at least as stringent as the federal Medicaid managed care standards described in 42 CFR 438—Managed Care.

To comply with the federal requirements, DCH contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance reviews of the Georgia Families CMOs. The DCH uses HSAG to review one-third of the full set of standards each year over a three-year cycle.

Description of the External Quality Review of Compliance With Standards

The DCH requires its CMOs to undergo annual compliance reviews that cover a third of the federal standards each year. This ensures that within a three-year period, a full comprehensive assessment is conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2014–June 30, 2015, and marked the second year of the current three-year cycle of external quality reviews.

HSAG performed a desk review of WellCare of Georgia, Inc.'s (WellCare's) documents and an on-site review that included reviewing additional documents, conducting interviews with key WellCare staff members, and conducting file reviews. HSAG evaluated the degree to which WellCare complied with federal Medicaid managed care regulations and the associated DCH contract requirements in seven performance categories. Six of the seven review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR 438.213–438.230, while the seventh area focused specifically on noncompliant standards from the prior review period. The standards HSAG evaluated included requirements that addressed the following areas:

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 08/2015."

- Provider Selection, Credentialing, and Recredentialing
- Subcontractual Relationships and Delegation
- Member Rights and Protections
- Member Information
- Grievance System
- Disenrollment Requirements and Limitations
- Re-review of all *Not Met* elements from the prior year's review.

Following this overview (Section 1), the report includes:

- Section 2—A summary of HSAG's findings regarding WellCare's performance results, strengths, and areas requiring corrective action.
- Section 3—A description of the process and timeline WellCare followed for submitting to DCH its corrective action plan (CAP) addressing each requirement for which HSAG scored WellCare's performance as noncompliant.
- Appendix A—The completed review tool HSAG used to:
  - Evaluate WellCare's compliance with each of the requirements contained within the standards.
  - Document its findings, the scores it assigned to WellCare's performance, and (when applicable) corrective actions required to bring its performance into compliance with the requirements.
- Appendix B—The completed review tool HSAG used to evaluate WellCare's performance in each of the areas identified as noncompliant from the prior year's review.
- Appendix C—The dates of the on-site review and a list of HSAG reviewers, DCH observers, and all WellCare staff members who participated in the interviews that HSAG conducted.
- Appendix D—A description of the methodology HSAG used to conduct the review and to draft its findings report.
- Appendix E—A template for WellCare to use in documenting its CAP for submission to DCH within 30 days of receiving the draft report.

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

HSAG determined findings for the compliance review from its:

- Desk review of the documents WellCare submitted to HSAG prior to the on-site review.
- On-site review of additional documentation provided by WellCare.
- Interviews of key WellCare administrative and program staff members.
- File reviews during the on-site review.

HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix D—Review Methodology. If a requirement was not applicable to WellCare during the period covered by the review, HSAG used a *Not Applicable* designation. HSAG then calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards as well as the follow-up review.

Table 2-1 presents a summary of WellCare's performance results.

Table 2-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Provider Selection, Credentialing, and Recredentialing	**10**	**10**	**9**	**1**	**0**	**90.0%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**7**	**0**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**6**	**0**	**0**	**100.0%**
IV	Member Information	**20**	**20**	**20**	**0**	**0**	**100.0%**
V	Grievance System	**47**	**47**	**43**	**4**	**0**	**91.5%**
VI	Disenrollment Requirements and Limitations	**10**	**10**	**10**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**17**	**17**	**12**	**5**	**0**	**70.6%**
	Total Compliance Score	**117**	**117**	**107**	**10**	**0**	**91.5%**

*** Total # of Elements**: The total number of elements in each standard.

**** Total # of Applicable Elements**: The total number of elements within each standard minus any elements that received a designation of *NA*.

***** Total Compliance Score**: Elements that were *Met* were given full value (1 point).The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

The remainder of this section provides a high-level summary of WellCare's performance noted in each of the areas reviewed. In addition, the summary describes any areas that were not fully compliant with the requirements and the follow-up corrective actions recommended for WellCare.

Standard I—Provider Selection, Credentialing, and Recredentialing

Performance Strengths

WellCare monitored its recredentialing practices to ensure the CMO did not discriminate against any providers in the network. Additionally, WellCare monitored its credentialing practices to ensure the CMO did not discriminate against any providers requesting to become part of the network. The CMO also maintained its policies and procedures for exclusion monitoring, querying the National Practitioner Data Bank (NPDB), the System for Award Management (SAM), and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Cumulative Sanctions report. WellCare also used the Medicaid sanctioned providers list developed by the State. WellCare monitored its providers to ensure the provision of quality care and when quality issues were identified, implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status.

HSAG reviewed 10 credentialing case files and found that eight of the 10 files reviewed were 100 percent compliant with all case review elements. HSAG also reviewed 10 recredentialing case files and noted that all files were compliant with all case review elements. Recredentialing decisions were completed within 36 months of the initial or most recent credentialing/recredentialing decision, and the CMO used primary sources, OIG and State licensure boards, to verify licensure, credentialing, and exclusion as a Medicaid provider.

Areas Requiring Corrective Action

Although WellCare's policy demonstrated compliance with the 120-day credentialing decision standard, the reported practice conflicted with this policy. Credentialing staff identified that the standard time frame for credentialing decisions followed the National Committee for Quality Assurance (NCQA) standard, which is 180 days. HSAG also noted that two of the 10 credentialing files reviewed did not meet the 120-day standard for credentialing decisions.

As of August 1, 2015, via its centralized credentialing verification organization, DCH assumed most credentialing and recredentialing activities, which were previously performed by the CMOs. Therefore, WellCare will no longer be responsible for credentialing and recredentialing the majority of providers in its network. The CMO should work with DCH to identify any needed actions based on HSAG's findings.

Standard II—Subcontractual Relationships and Delegation

Performance Strengths

WellCare delegated functions based on quality, efficiency, and cost-effective healthcare solutions with a focus on enhancing members' health and quality of life. The CMO maintained its policies and procedures to ensure compliance with industry and State standards. WellCare monitored delegate

performance through ongoing assessment of individual delegate functions and took corrective action when deficiencies were identified.

HSAG reviewed delegation files for three of WellCare's identified delegates. All files were found to be compliant with the case review elements. Each file contained a written agreement that specified delegated activities and reporting responsibilities, performance expectations, and WellCare's options for addressing any deficiencies identified during annual reviews. HSAG noted that the CMO had reviewed all delegates and that an additional disaster recovery and global delegation oversight audit had been completed for each delegate.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required WellCare to implement corrective actions for this standard.

Standard III—Member Rights and Protections

Performance Strengths

WellCare submitted several policies, procedures, and the member handbook as evidence that the CMO and its providers took into account member rights while providing care. All of the member rights included in both the federal regulations and the State contract were included in these documents. WellCare trained its associates on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and discrimination policies, acts, and regulations.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required WellCare to implement corrective actions for this standard.

Standard IV—Member Information

Performance Strengths

WellCare provided materials to members within the contractually required time frame. The CMO maintained oversight of the vendor that mailed member materials to ensure there were no delays in the member receiving the information. Materials were available in alternative languages when needed and at a reading level appropriate for the member. The online provider directory was easy to use and contained the mandated information.

Standard V—Grievance System

Performance Strengths

WellCare provided detailed grievance, administrative review, and administrative law hearing policies and procedures. During the on-site audit both corporate and local staff demonstrated knowledge of grievance and appeal processes. WellCare informed members and providers of the grievance and appeal processes via the member and provider handbooks.

During the on-site audit, HSAG reviewed 10 grievance files and 10 administrative review (appeal) files. With regard to timeliness, all appeal files met the applicable timeliness requirements for standard and expedited cases and all grievance resolution letters were mailed within 90 days.

Areas Requiring Corrective Action

WellCare provided detailed policies and procedures; however, HSAG noted that descriptions of contract requirements were not always consistent with actual practice or did not include all contractually required information. For example, WellCare's Administrative Review procedure did not include the intended effective date of the proposed action in its timely filing description, when the proposed action was to terminate, reduce, or suspend services. In addition, WellCare's Notice of Proposed Action form letter did not indicate that the member must exhaust WellCare's internal administrative review process.

During the file review for grievances and appeals, it was noted that appeal resolution letters were not always written in easily understood language. In some cases, procedure codes and advanced medical terminology were used. In addition, three grievance acknowledgement letters were not mailed to members within 10 days.

As a result of these findings:

- The Administrative Review procedure should be revised to include the "intended effective date of the proposed action" in its timely filing description when the proposed action is to terminate, reduce, or suspend previously authorized services.
- The Notice of Proposed Action form letter should be revised to indicate that the member must exhaust WellCare's internal administrative review process.
- The Georgia Medicaid Grievance procedure should be revised to include the provision that the member acknowledgment letter must be available in the member's primary language.
- WellCare must acknowledge all grievances within 10 working days.
- WellCare must ensure that appeal resolution letters are written in a manner that is understandable to members.

Standard VI—Disenrollment Requirements and Limitations

Performance Strengths

The disenrollment policies, procedures, work flows, and processes were well structured and easily understood. WellCare ensured that members were not discriminated against on the basis of religion, gender, race, color, national origin, health, health status, pre-existing conditions, or the need for healthcare services. The possible reasons for disenrollment, either for cause or without cause, were appropriately documented. WellCare staff understood the processes and assisted members with disenrollment paperwork if needed.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required WellCare to implement corrective actions for this standard.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

Twelve of the 17 elements that were assessed during the follow-up review received a *Met* status. All elements related to Coordination and Continuity of Care, and Coverage and Authorization of Services received a *Met* score.

Areas Requiring Corrective Action

The five reevaluated elements (within the Furnishing of Services, Practice Guidelines, and Quality Assessment and Performance Improvement standards) that will require continued corrective action are as follows:

- WellCare needs to address timely access issues to ensure providers return calls after hours within appropriate time frames. Urgent calls must be returned within 20 minutes and other calls within one hour.
- WellCare must meet the geographic access standards for both urban and rural areas for primary care physicians (PCPs), specialists, dental subspecialty providers, and pharmacies.
- WellCare must ensure that 90 percent of its providers use the clinical practice guidelines.
- WellCare must meet all DCH-established performance measure targets.
- WellCare should continue to incorporate DCH feedback on its Quality Assessment and Performance Improvement (QAPI) plan. The CMO should also ensure it measures the effectiveness of the quality initiatives on the care provided to its membership.

3. Corrective Action Plan Process

WellCare is required to submit to DCH its CAPs addressing all requirements receiving an HSAG finding of *Not Met*. WellCare must submit its CAPs to DCH within 30 calendar days of receipt of HSAG's final External Quality Review of Compliance With Standards report. WellCare should identify, for each requirement that requires corrective action, the interventions it plans to implement to achieve compliance with the requirement (including how the CMO will measure the effectiveness of the intervention), the individuals responsible, and the timelines proposed for completing the planned activities.

The DCH, in consultation with HSAG, will review, and when deemed sufficient, approve WellCare's CAPs to ensure they sufficiently address the interventions needed to bring performance into compliance with the requirements.

Appendix A. **Review of the Standards**

Following this page is the completed review tool that HSAG used to evaluate WellCare's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring WellCare's performance into full compliance.

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Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Note about the Citations: Unless otherwise specified, the federal Medicaid managed care references for the following requirements are those contained in 42 CFR §438, which describes requirements applicable to Medicaid Managed Care Organizations (MCOs).

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
1. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1)* and *42CFR438.214(c)*	◆ Documented Process: C7CR-049 Non-Discrimination Policy ◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure, p.22 ◆ Materials: Credentialing Committee Minutes January 2015 ◆ Materials: Denial Letter Sample January 2015 ◆ Materials: PCP Agreement - RTR Medical Group, p.41	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided its corporate policy that addressed nondiscrimination of providers. The CMO completed one periodic review of practitioner complaints to determine if any complaints alleging discrimination had been submitted, and two annual state-specific reviews and evaluations of the credentialing program which included a review of the Credentialing Committee's decisions for nonclean files that may have suggested potential discriminatory practice in the selection of practitioners.		
Required Actions: None.		
2. The Contractor does not employ or contract with providers excluded from participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (requires a policy and must be in provider subcontracts). The Contractor is responsible for routinely checking the exclusions list and shall immediately terminate any provider found to be excluded and notify the member per the requirements outlined in this contract. *42CFR438.214(d)* *Contract: 4.8.1.4*	◆ Documented Process: C7CR-024 Medicare & Medicaid Eligibility Policy ◆ Documented Process: C7CR-046 Ongoing Monitoring Policy ◆ Documented Process: C7CR-046-PR-001 Ongoing Monitoring Procedure ◆ Materials: Exclusion Monitoring Logs July 2014 – March 2015 ◆ Materials: Exclusion Term Letter Sample ◆ Materials: Exclusion Term Letter Template ◆ Materials: PCP Agreement - RTR Medical Group, p.14	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided its monitoring policy which indicated that the CMO verified whether a provider had been sanctioned by querying the National Practitioner Data Bank (NPDB), reviewing the HHS OIG Cumulative Sanctions report, and determining if the State has a Medicaid sanctioned providers list. For providers in a practice, the CMO reviewed the System for Award Management (SAM). During the on-site interviews, staff reported that the CMO completed an		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
initial background check on all employees to ensure that they were not excluded providers, and checked current staff, subcontractors, and providers against the federal list of excluded individuals and entities monthly.		
Required Actions: None.		
3. If the Contractor declines to include individuals or groups of providers in its network, the Contractor gives the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* *Contract: 4.8.1.7*	◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure, p.24 ◆ Documented Process: C7CR-009-PR-001 Assessment of Organizational Providers Procedure, p.10 ◆ Materials: Credentialing Committee Minutes January 2015, p.8-10 ◆ Materials: Denial Letter Sample January 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided a sample denial letter along with policies and procedures that outlined the process for providing written notice to providers when the CMO declined to include them in the network. The Credentialing and Recredentialing Procedure and Assessment of Organizational Providers Procedure indicated that credentialing and recredentialing notifications were sent to providers within 60 days of the Credentialing Committee's decision.		
Required Actions: None.		
4. The Contractor shall maintain written policies and procedures for the credentialing and recredentialing of network providers using standards established by the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), or URAC. *Contract: 4.8.15.1*	◆ Documented Process: C7CR-009 Assessment of Organizational Providers Policy ◆ Documented Process: C7CR-009-PR-001 Assessment of Organizational Providers Procedure, p. 2, 13 ◆ Documented Process: C7CR-001 Credentialing & Recredentialing Policy ◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure, p.29 ◆ Materials: NCQA Credentialing & Recredentialing Standards	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided corporate policies and procedures that met all aspects of this element. During the on-site review staff reported that the credentialing process began when the CMO received the provider's application packet and that each packet was tracked electronically. As part of the verification process the credentialing department reviewed the application/documentation for completeness. Staff reported that recredentialing of providers was completed every 36 months and that the credentialing department initiated the recredentialing process four months prior to the provider's credentialing expiration date.		
Required Actions: None.		
5. The Contractor has written policies and procedures for the credentialing and recredentialing of network providers that include:		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
(a) The verification of the existence and maintenance of: ◆ Credentials. ◆ Licenses. ◆ Certificates. ◆ Insurance coverage. *Contract: 4.8.15.2*	◆ Documented Process: C7CR-041 Maintenance of Expiring Documents Policy ◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure, p.13-20 ◆ Documented Process: C7CR-009-PR-001 Assessment of Organizational Providers Procedure, p.2, 7-9	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided policies and procedures that met all aspects of this element. During credentialing and recredentialing file review, all cases reviewed had documented verification of the provider's credentials, licensure, insurance coverage, and certificates.		
Required Actions: None.		
(b) Verification using primary sources. *Contract: 4.8.15.2*	◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure, p.12-20 ◆ Documented Process: C7CR-009-PR-001 Assessment of Organizational Providers Procedure, p. 2, 7-9	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare's Credentialing & Recredentialing Procedure stated that "documents, diplomas, and certificates or transcripts provided directly by the applicant are not acceptable as primary or secondary source verified documentation" and staff reported during the on-site interview that only primary sources are used in the verification process. During the credentialing and recredentialing file reviews, HSAG noted that all of the files reviewed contained provider information gathered from primary sources (i.e., OIG and State licensure boards).		
Required Actions: None.		
(c) The methodology and process for recredentialing providers. *Contract: 4.8.15.2*	◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure ◆ Documented Process: C7CR-009-PR-001 Assessment of Organizational Providers Procedure ◆ Materials: Credentialing Program Description ◆ Materials: Credentialing Committee Minutes November 2014	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare's policies and procedures outlined the process for recredentialing providers. During the on-site interviews staff reported that the recredentialing process was initiated four months prior to the due date. The credentialing department mailed an initial notice indicating that it was time for the provider to be recredentialed with the CMO. The credentialing staff worked with the provider representatives to obtain the necessary information to complete the recredentialing process.		
Required Actions: None.		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
(d) A description of the initial quality assessment of private practitioner offices and other patient care settings. *Contract: 4.8.15.2*	◆ Documented Process: C7CR-027-PR-001 Site Inspection Evaluation Policy ◆ Documented Process: C7CR-027-PR-001 Site Inspection Evaluation Procedure ◆ Materials: Provider Site Visit Tool Template ◆ Materials: Unaccredited Facility Site Visit Tool Template ◆ Materials: Provider Site Visit Sample ◆ Materials: Unaccredited Facility Site Visit Sample	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare's Site Inspection Evaluation policy and procedure indicated that site inspections were completed in accordance with federal, State, and accreditation requirements. WellCare provided examples of templates used during the assessment of providers' offices and other patient care settings. During the on-site interviews staff reported that complaints were monitored, and that if at least three complaints concerning the provider's office were submitted, the credentialing staff completed a scheduled, on-site inspection of the provider's office. In egregious situations—anything that posed a risk to the member—an unannounced visit was completed.		
Required Actions: None.		
(e) Procedures for disciplinary action, such as reducing, suspending, or terminating provider privileges. *Contract: 4.8.15.2*	There have been no instances of reduction, suspension or termination of providers in Georgia due to quality of care or conduct issues. ◆ Documented Process: C7CR-007 Corrective Action Policy ◆ Documented Process: C7CR-007-PR-001 Corrective Action Procedure ◆ Documented Process: C7CR-020 Hearing & Appellate Policy ◆ Documented Process: C7CR-020-PR-001 Hearing & Appellate Procedure	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare staff stated that provider complaints were monitored, and that when an issue was identified, an investigation was initiated and completed within 24 to 48 hours of receiving the complaint. When the CMO conducted an investigation or actions were considered to be detrimental to a member's safety or impacting the quality of care, a corrective action was initiated. WellCare's Corrective Action policy stated that recommendations from the Credentialing Committee could include rejection of the corrective action; issuance of a "letter of warning, letter of admonition, letter of reprimand, the imposition of a retrospective review of practice, requirement to participate in continuing education"; required supervision; placement on a CAP; and/or suspension or termination of provider participation.		
Required Actions: None.		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
6. The Contractor makes credentialing decisions on all completed application packets within 120 calendar days of receipt. *Contract: 4.8.15.1*	◆ Documented Process: C7CR-001-PR-001 Credentialing & Recredentialing Procedure, p.21 ◆ Report: Credentialing Turn-Around-Time Report	☐ **Met** ☒ **Not Met** ☐ **NA**

Findings: The Credentialing & Recredentialing Procedure identified the time frame for credentialing decisions as 120 days. During the on-site interviews credentialing staff reported that the time frame for credentialing decisions was 180 days, as this was the NCQA standard. During the credentialing file review, two cases reviewed had credentialing decisions that were made beyond 120 calendar days from receipt of the application. The application for Case 5 was received on 02/03/2015, and the credentialing decision was made on 06/08/2015, which was 126 days after receipt of the application. The application for Case 6 was received on 06/08/2014, and the credentialing decision was made on 10/27/2014, which was 142 days after receipt of the application. Staff provided documented outreach and facilitated communication between the credentialing staff and the provider requesting the necessary documentation.

Required Actions: As of August 1, 2015, via its centralized credentialing verification organization, DCH assumed most credentialing and recredentialing activities, which were previously performed by the CMOs. Therefore, WellCare will no longer be responsible for credentialing and recredentialing the majority of providers in its network. The CMO should work with DCH to identify any needed actions based on HSAG's findings.

Standard I—Provider Selection, Credentialing, and Recredentialing					
Met	=	9	X 1.00	=	9
Not Met	=	1	X .00	=	1
Not Applicable	=	0	***NA***		***NA***
Total Applicable	=	10	**Total Score**	=	9
Total Score ÷ Total Applicable				=	**90%**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: 16.1.3*	◆ Documented Process: C7QI-023 Delegation Oversight Policy, p.2 ◆ Documented Process: Delegation Oversight Procedure C12AO-023-PR-001, p. 5 ◆ Documented Process: Delegation Oversight Department Description 2014, p.2, 16-18, 20, 26-28, 30-31 ◆ Report: GA Medicaid Q3 2014 QIC Minutes, p. 25-27 ◆ Report: GA Medicaid Q4 2014 QIC Minutes, p. 32-35 ◆ Report: QIC Q3 DOC Presentation, p.3 ◆ Report: QIC Q4 DOC Presentation, p.3 ◆ Report: QIC Scorecard Dashboard Presentation Q3 2014, p.2 ◆ Report: QIC Scorecard Dashboard Presentation Q4 2014, p.2	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: According to the Delegation Oversight Policy, WellCare "delegates functions based on quality, efficiency and costs. Delegation is permitted to enhance member health and quality of life and to partner with vendors, providers, and other suppliers to provide quality cost-effective healthcare solutions." During the on-site interview staff reported that the delegation department conducted daily monitoring of delegates that included updating data in the CMO's health information system (C360), identifying pending audits, and reviewing corrective action plans for timeliness. This process was also outlined in WellCare's Delegation Oversight Department Description.		
Required Actions: None.		
2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: 16.1.3*	◆ Documented Process: C7QI-023 Delegation Oversight Policy, p.2 ◆ Documented Process: C7QI-023 PR-001 Delegation Oversight Procedure, p. 4-5 ◆ Report: (CR) Kaiser Delegation Audit Tool, p.1-7 ◆ Materials: (CR) Kaiser Delegation Addendum, p.1-2, 7-10 ◆ Materials: (CR) Kaiser Pre-del Results Memo, p. 1 ◆ Materials: (CR) Kaiser Pre-del Results Letter, p. 1	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided policies and procedures that outlined the steps to evaluate prospective subcontractors and an example of the audit tool used to determine performance abilities. During the on-site interviews staff members stated that the review process began when they received the predelegation application from the contract owner, which outlined the specific delegate scope of work for each line of business. Completed evaluations were part of the subcontractor's delegation case file that was reviewed during the delegation case file review.		
Required Actions: None.		

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
3. There is a written delegation agreement with each delegate that: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. *42CFR438.230(b)(2)* *Contract: 16.1.2*	◆ Documented Process: Delegation Oversight Policy C7QI-023, p.2-3 ◆ Documented Process: Delegation Oversight Procedure C7QI-023 PR-001, p. 5-9 ◆ Materials: (CR) Kaiser Delegation Addendum, p.1-2, 7-11 ◆ Materials: (UM) Carecore Delegation Addendum, p.1-2, 5-6 ◆ Materials: (NM) HearUSA Delegation Addendum, p.1 ◆ Materials: (UM) Carecore National Agreement, p.1, 35-36	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare's delegation oversight policy indicated that a written agreement was accomplished for each delegate. During the on-site review HSAG reviewed three delegate files and determined that all three files were compliant with this element.		
Required Actions: None.		
4. The Contractor implements written procedures for monitoring the delegate's performance on an ongoing basis. The Contractor subjects the subcontractor to a formal review according to a periodic schedule established by the State, consistent with industry standards or state CMO laws and regulations. *42CFR438.230(b)(3)* *Contract: 16.1.3*	◆ Documented Process: Delegation Oversight Policy C7QI-023, p.2 ◆ Documented Process: Delegation Oversight Procedure C7QI-023 PR-001, p. 6-9 ◆ Materials: (CR) 2014 Albany Area Primary Care Audit Tool ◆ Materials: (CR) 2014 Albany Area Primary Care Results Memo ◆ Materials: (CR) 2014 Albany Area Primary Care Initial File Review ◆ Materials: (CR) 2014 Albany Area Primary Care Recredentialing File Review ◆ Materials: (CR) 2014 Albany Area Primary Care DOC Results Letter ◆ Report: 2014 Delegation Audit Schedule (GA), p.1-3 ◆ Report: 12.09.14 DOC Online (Adhoc) Review Minutes for Albany, p. 1-2 It is the policy of WellCare to implement and maintain a robust process for ongoing monitoring of compliance of all contracted delegates. Entity Scorecards have been developed and include all applicable federal, state, and accreditation requirements. Each entity will be required to complete the scorecard and to submit all data to the Delegation Reporting Mailbox. ◆ Materials: (ALL) 2014 Delegate Scorecard Template ◆ Report: (UM) 2014 Carecore (GMD) Scorecard Jan-Dec ◆ Report: (ALL) 2014 Avesis Dental (GMD) Scorecard Jan-Dec ◆ Report: GA Medicaid Q3 2014 QIC Minutes, p. 25-27	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Report: GA Medicaid Q4 2014 QIC Minutes, p. 32-35	
Findings: WellCare provided policies and procedures that met all aspects of this element. During the on-site interview, WellCare staff stated that the CMO completed an annual assessment for each delegate based on the delegated functions; copies of the annual assessments were provided to HSAG during the case file review. Additionally, the CMO completed a disaster recovery and global delegation oversight audit for each delegate. Staff also reported that the CMO will transition to a risk-based assessment schedule. Implementation will begin during fourth quarter 2015, and full implementation is projected for first quarter 2016.		
Required Actions: None.		
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: 16.1.3*	◆ Documented Process: Delegation Oversight Policy C7QI-023, p.2 ◆ Documented Process: Delegation Oversight Procedure C7QI-023-PR-001, p. 6-9 ◆ Materials: (NM) 2014 HearUSA Results Memo ◆ Materials: (NM) 2014 HearUSA DOC Results Letter – Combined wCAP ◆ Materials: (NM) 2014 HearUSA CAP Extension Memo ◆ Materials: (NM) 2014 HearUSA DOC Results Letter – CAP Extension ◆ Materials: (NM) 2014 HearUSA CAP Extension Memo1 ◆ Materials: (NM) 2014 HearUSA DOC Results Letter – CAP Extension1 ◆ Materials: (NM) 2014 HearUSA CAP Completion Memo ◆ Materials: (NM) 2014 HearUSA DOC CAP Completion Results Letter ◆ Report: (NM) 2014 HearUSA CAP ◆ Report: (NM) 2014 HearUSA CAP Update ◆ Report: (NM) 2014 HearUSA CAP Update1 ◆ Report: (NM) 2014 HearUSA CAP Satisfied ◆ Report: (NM) 2014 HearUSA CAP Evidence_FedEx Tracking ◆ Report: 12.09.2014 DOC Online Review Minutes, p.27	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: During the on-site review HSAG reviewed three delegate files and noted that annual reviews were completed for all of the reviewed delegates. Staff reported that when no deficiencies were identified during the review, information was sent to the delegation oversight committee for review and approval, and the delegate was then sent a notification of the review's outcome. When deficiencies were noted, the delegation oversight staff provided recommendations to the delegation oversight committee for review and approval. After the CAP or performance improvement project (PIP) recommendation was approved, the delegate was sent a letter and the contract owner worked with the delegate to initiate and implement the findings. In review of delegate files, HSAG noted that		

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
two of the three delegates reviewed were placed on CAPs after their annual reviews, both delegates had initiated and implemented recommended changes, and the CAPs were closed out.		
Required Actions: None.		
6. The Contractor must provide a listing, including detailed contract information, for all of its subcontractors involved in the execution of the contract, including description of the subcontractor's organization and the responsibilities that are delegated. *Contract:16.1.7*	◆ Report: Delegate List and Delegated Responsibilities_GA	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided a listing of delegates that detailed contact information, a description of the subcontractor's organization, and delegated responsibilities.		
Required Actions: None.		
7. The Contractor must not contract or permit the performance of any work or services by subcontractors without prior written consent of DCH. *Contract: 16.1.1*	◆ Documented Process: C7QI-023 Delegation Oversight Policy, p.17 ◆ Documented Process: Subcontractor Agreements Step Action_rev 6.16.15 ◆ Report: Subcontractor Agreement and Monitoring Information Report Jul-Dec 2014 ◆ Report: List of Subcontractors Approved by DCH 7.1.14 - 6.30.15 ◆ Materials: Transaction Application Services (TAG) Agreement - DCH Approval ◆ Materials: Blackhawk Color Corporation Agreement - DCH Approval ◆ Materials: Curant Health Agreement - DCH Approval ◆ Materials: Cobalt Therapeutics, LLC Agreement - DCH Approval ◆ Materials: CVS Caremark Agreement - DCH Approval	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided policies and procedures that met all aspects of this element. Staff reported that consent from DCH could be obtained verbally but that written confirmation was then obtained and placed in the delegate's file.		
Required Actions: None.		

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Subcontractual Relationships and Delegation						
Met	=	7	X	1.00	=	7
Not Met	=	0	X	.00	=	0
Not Applicable	=	0		***NA***		***NA***
Total Applicable	=	7	**Total Score**		=	7
Total Score ÷ Total Applicable					=	100%

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor has written policies regarding member rights. *42CFR438.100(a)(1)* *Contract: 4.3.4.1*	WellCare of Georgia, Inc. (WCGA) distributes the Member Rights and Responsibilities statement via the Member Handbook, which is sent to all members upon enrollment. ◆ Documented Process: C6CS-116 Medicaid Customer Service Rights Disclosure of Rights and Responsibilities, p.13-15 ◆ Documented Process: C6MMO-002 Medicaid Post Enrollment Materials, p.2 ◆ Materials: Member Handbook, p.74-76	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided its Medicaid Customer Service Disclosure of Rights and Responsibilities policy as evidence of compliance. Member rights were also included in the member handbook.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members. *42CFR438.100(a)(2)*	◆ Documented Process: C6CS-116 Medicaid Customer Service Rights Disclosure of Rights and Responsibilities, p.1, 2, 13-15 ◆ Materials: Site Inspection Evaluation Survey Tool for Unaccredited Facilities, p.3 ◆ Materials: Site Inspection Evaluation Survey Tool for All Specialties, p.4 ◆ Materials: Site Evaluation FAQs ◆ Materials: Provider Handbook, p.28-32	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided its Medicaid Customer Service Disclosure of Rights and Responsibilities policy, its site inspection evaluation survey tool, and its provider handbook. WellCare staff stated that the provider handbook was used to inform providers about member rights and responsibilities. In addition, this information was discussed during provider education sessions. Rights and responsibility issues were monitored through the grievance process, and rights-related grievances were reviewed by the grievance and appeals committee. Rights were also covered during customer service representative (CSR) initial training and reinforced in periodic CSR training sessions and small group meetings.		
Required Actions: None.		
3. The Contractor ensures that these rights are included in the member handbook and at a minimum specifies the member's right to: ◆ Receive information in accordance with information requirements (42CFR438.10).	◆ Documented Process: C6CS-116 Medicaid Customer Service Rights Disclosure of Rights and Responsibilities, p.13-15 ◆ Documented Process: C12PD-004 Medicaid Member Handbook, p.4 ◆ Documented Process: C13HIP.01.002 HIPAA Records and Safeguards Policy, p.2-3	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Have all records and medical and personal information remain confidential. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records pursuant to 45CFR160 and 164, subparts A and E, and request that they be amended or corrected as specified in 45CFR164.524 and 164.526. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). ◆ Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated. ◆ Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the covered services provided to the member for which DCH does not pay the Contractor; not be held liable for covered services provided to the member for which DCH or the CMO plan does not pay the health care provider that furnishes the services; and not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the Contractor provided the services directly.	◆ Documented Process: C13HIP.01.005 HIPAA Member Rights Standard, p.2 ◆ Documented Process: C13HIP.03.002 HIPAA Corporate Compliance Sanction and Reports of Misconduct Standard, p. 2-3 ◆ Materials: HIPAA Privacy and Security at WellCare Training 0714 ◆ Materials: HIPAA Training Log_GA ◆ Materials: Member Handbook, p.74-76 ◆ Materials: Provider Handbook, p.28-31	

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ Only be responsible for cost sharing in accordance with 42CFR447.50 through 447.60 and Attachment K of the contract. *42CFR438.100(b)(2) & (3)* *Contract: 4.3.4.1*		
Findings: A comprehensive list of member rights and responsibilities was included in the member handbook.		
Required Actions: None.		
4. The Contractor shall ensure that members are aware of their rights and responsibilities, the role of primary care physicians (PCPs), how to obtain care, what to do in an emergency or urgent medical situation, how to request a grievance, appeal, or Administrative Law Hearings, and how to report suspected fraud and abuse. The Contractor shall convey this information via written materials and via telephone, internet, and face-to-face communications that allow the members to submit questions and receive responses from the Contractor. *Contract: 4.3.1*	◆ Documented Process: C6MMO-002 Medicaid Post Enrollment Materials, p.2 ◆ Documented Process: C6CS-116 Medicaid Customer Service Rights Disclosure of Rights and Responsibilities, p.13-15 ◆ Documented Process: C13HIP.01.005 HIPAA Member Rights Standard ◆ Materials: NPP WellCare Notice of Privacy Practices_2014 ◆ Materials: GA MOC 2.0 Documentation Templates_Updated 12.31.14 ◆ Materials: Website Screenshot ◆ Materials: Member Handbook, p.6, 9, 13, 32-34, 59-60, 63, 72, 74-76	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The information contained in this element was included in the member handbook, which was posted on WellCare's website. The information included the CMO's telephone numbers such that a member could submit questions and receive responses from WellCare. During the interview staff indicated that member services representatives were trained on all contents of the member handbook.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45CFR part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. *42CFR438.100(d)* *Contract: General Program Requirements*	◆ Documented Process: Associate Handbook p.8-9 ◆ Documented Process: Cultural Competency Plan, p.10-12 ◆ Materials: Cultural Competency Training 2014, p.17-18 ◆ Materials: Member Handbook, p.82 ◆ Materials: Provider Handbook, p.19, 27, 96	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The Associate Handbook included HIPAA information, an Equal Employment Opportunities section, and discrimination summaries for WellCare employees. Member rights, which included information on member expectations related to privacy and confidentiality, were included in the member handbook.		
Required Actions: None.		
6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.224*	◆ Documented Process: C13HIP.01.004 HIPAA Handbook Procedure, p.9-10 ◆ Documented Process: C13HIP.01.006 HIPAA Use and Disclosure of Protected Health Information, p.2 ◆ Materials: HIPAA Privacy and Security at WellCare Training 0714 ◆ Materials: HIPAA Training Log GA ◆ Materials: HIPAA Authorization Form ◆ Materials: HIPAA Revocation of Authorization Form	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided its HIPAA handbook procedure and its Use and Disclosure of Protected Health Information standard. The member handbook cited the expectation that personal information included in medical records would be kept confidential.		
Required Actions: None.		

Standard III—Member Rights and Protections					
Met	=	6	X 1.00	=	6
Not Met	=	0	X .00	=	0
Not Applicable	=	0	***NA***		***NA***
Total Applicable	=	6	**Total Score**	=	6
Total Score ÷ Total Applicable				=	100%

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor provides all newly enrolled members the member handbook within ten (10) calendar days after receiving notice of the enrollment from DCH or the State's agent and every other year thereafter unless requested sooner by the member. *42CFR438.10(f)(3)* *Contract: 4.3.3.1*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.4 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The WellCare Medicaid Post-Enrollment Member Materials policy, which was submitted prior to the on-site audit, indicated that the member handbook was provided within 10 calendar days after the CMO received the enrollment file from DCH and annually thereafter unless requested sooner by the member. In addition, WellCare staff stated that a vendor produced the enrollment materials and mailed them to the member. When asked about oversight of the vendor, staff provided a sample ID card and member mailing oversight spreadsheet that demonstrated supervision over the process, ensuring members received the materials within the required time frame.		
Required Actions: None.		
2. The Contractor provides all newly enrolled members the provider directory within ten (10) calendar days of receiving the notice of enrollment from DCH or the State's Agent. *42CFR438.10(f)(3)* *Contract: 4.3.5.1*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.6 ◆ Materials: DCH Approval to Mail Provider Directories on an Ad-Hoc Basis 11/15/2012 ◆ Materials: Provider Directory, Q2 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The DCH granted WellCare a waiver from providing a hard copy provider directory to newly enrolled members. The WellCare member handbook directed members to the CMO's website, which contained the provider directory. The website also advised the member to contact member services to request a provider directory and/or for assistance with provider selection.		
Required Actions: None.		
3. The Contractor makes all written information available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The Contractor notifies all members and potential members that information is available in alternative formats and how to access those formats. *42CFR438.10(d)(1) & (2)* *Contract: 4.3.2.1*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.1-2 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.1 ◆ Materials: GA Caid & PeachCare for Kids ID Card Welcome Letter, p.1 ◆ Materials: Member Handbook, p.9 ◆ Materials: Example of Large Print – OTC Catalog ◆ Materials: Alternate Format Request	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Materials: Medicaid Alternate Format Process	
Findings: The Medicaid Post-Enrollment Member Materials policy indicated that materials were available in alternative formats and in a manner that considered the member's special needs, including visual impairment or those members with limited reading proficiency. The member handbook included notification to members and potential members that information was available in alternative formats and provided the customer service phone number. Staff members indicated that once such a call was received, the call was transferred to outreach staff members who fulfilled the member's request.		
Required Actions: None.		
4. The Contractor makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH. All written materials include a language block, printed in Spanish and all other prevalent non-English languages, that informs the member that the document contains important information and directs the member to call the Contractor to request the document in an alternative language, or to have it orally translated. *42CFR438.10(c)(3)* *Contract: 4.3.2.2 and 4.3.2.3*	The following documents demonstrate WCGA's evidence to make all written information available in English, Spanish, and all other prevalent non-English languages as defined by DCH as well as ensuring that all written materials include a language block, printed in Spanish and all other prevalent non-English languages. 42 CFR 438.10 (c) (1) states that each state must establish a methodology for identifying the prevalent non-English languages spoken by members and potential members in the State. Georgia Families contract sections 2.5.1, 4.3.2.2, and 4.3.10.1 do not specify the threshold for Georgia. Further, neither the Georgia state Medicaid manuals nor the O.C.G.A, specify the threshold for Georgia. ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.4 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.1-2 ◆ Documented Process: Member Understanding Assessment Campaign Program Description ◆ Materials: GA Caid & PeachCare for Kids ID Card Welcome Letter, p.1-2 ◆ Materials: Member Handbook, p. 1:1, 9 ◆ Materials: WellCare GA Website Screenshot ◆ Materials: PCP Reminder Insert ◆ Materials: NOA Template Letter_ENG_GA_01_15 ◆ Materials: GA Newsletter English_State Approved 08042014 ◆ Materials: GA Newsletter Spanish_State Approved 09172014	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The Medicaid Post-Enrollment Member Materials policy indicated that materials were available in English, Spanish, and all other prevalent, non-English languages, as defined by DCH. The member handbook included a language block in Spanish that informed the member of the telephone number to call to request the document in Spanish or to access translation services.		
Required Actions: None.		
5. All written materials are worded such that they are understandable to a person who reads at a fifth (5th) grade reading level. The Contractor must use one of the following reference materials to determine the reading level: ◆ Fry Readability Index. ◆ PROSE The Readability Analyst (software developed by Education Activities, Inc.). ◆ Gunning FOG Index. ◆ McLaughlin SMOG Index. ◆ The Flesch-Kincaid Index. ◆ Other word processing software approved by DCH. *42CFR438.10(b)(1)* *Contract: 4.3.2.4*	All member written materials are further approved by DCH prior to distribution as stated in contract section 4.3.2.6. To ensure that all written materials are worded such that they are understandable to a person who reads at a fifth (5th) grade reading level, WCGA utilizes The Flesch-Kincaid Index through Microsoft Word to establish the required reading level which is evidenced by the documents below: ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.4, 6, 7 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Email - 5th Grade Reading Level & Request for DCH Approval	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medicaid Post-Enrollment Member Materials policy indicated that materials were worded in a way to be understandable to someone reading at a fifth-grade reading level. WellCare used the Flesch-Kincaid Index to verify the reading level requirement and included a screenshot of the index when it sent materials to DCH for approval.		
Required Actions: None.		
6. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: 4.3.10.1*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.1-2 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p.9 ◆ Materials: WellCare GA Website Screenshot ◆ Materials: Step Action - Phone Translations Services ◆ Reports: GA_Requests for Translations Services July 2014-April 2015	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The Medicaid Post-Enrollment Member Materials policy included information pertaining to oral interpretation services. The member handbook indicated that oral interpretation services were available at no cost to the member and indicated the telephone number to call to obtain the service.		
Required Actions: None.		
7. The Contractor has in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan. *42CFR438.10(b)(3)*	◆ Documented Process: C6MMO-022 Medicaid Post Enrollment Materials, p.1 ◆ Materials: GA Caid & PeachCare for Kids ID Card Welcome Letter ◆ Materials: Member Handbook ◆ Materials: WellCare Means Better Care_ENG_GA_01_14 ◆ Materials: WellCare Offers More Benefits_ENG_GA_03_14 ◆ Materials: CAREconnects Member New Hire General Systems Overview	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare's Medicaid Post-Enrollment Member Materials policy indicated that the "member handbook, provider directories, newsletters, member education materials, and identification (ID) cards" were methods used to help members understand the requirements and benefits of the CMO. The member handbook contained member rights and responsibilities, information related to covered and noncovered services, extra benefits, and other information about benefits.		
Required Actions: None.		
8. The provider directory shall include names, locations, office hours, telephone numbers of, and non-English languages spoken by, current contracted providers. This includes, at a minimum, information on PCPs, specialists, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals. The provider directory also identifies providers that are not accepting new patients. *42CFR438.10(f)(6)* *Contract: 4.3.5.2*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.6 ◆ Materials: Provider Directory, Q2 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The provider directory included names, locations, office hours, telephone numbers, and languages spoken by the provider. The member had the ability to sort by provider, including PCP and specialty, dentist, pharmacy, federally qualified health centers (FQHCs), rural health clinics (RHCs), mental health providers, substance abuse providers, and hospitals. The provider directory also indicated those providers accepting or not accepting new patients.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
9. The member handbook includes a table of contents. *Contract: 4.3.3.2*	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p. 1:3	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included a table of contents.		
Required Actions: None.		
10. The member handbook includes information about the roles and responsibilities of the member (this information to be supplied by DCH), and what to do when family size changes. *Contract: 4.3.3.2*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p.9, 74, 76	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included information about roles and responsibilities of the member and what to do if a change in family size occurred.		
Required Actions: None.		
11. The member handbook includes information about the role of the PCP and information about choosing a PCP. *Contract: 4.3.3.2*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p.6-7 ◆ Materials: PCP Reminder Insert	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included information about the role of the PCP, how to access the provider directory, and information about choosing or changing PCPs.		
Required Actions: None.		
12. The member handbook includes: ◆ Information on benefits and services, including a description of all available Georgia Families (GF) benefits and services. ◆ Information on how to access services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, non-emergency transportation services (NET), maternity, and family planning services. ◆ An explanation of any service limitations or exclusions from coverage.	Information on benefits and services, including a description of all available Georgia Families (GF) benefits and services. ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Materials: Member Handbook, p.18-28 Information on how to access services, including Health Check (EPSDT) services, non-emergency transportation services (NET), and maternity and family planning services.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ A notice stating that the Contractor shall be liable only for those services authorized by the Contractor. ◆ Information on how and where members may access benefits not available from or not covered by the Contractor. ◆ Cost sharing. ◆ The policies and procedures for disenrollment. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	◆ Materials: Member Handbook, p.23, 31, 36, 44-45, 47-48 An explanation of any service limitations or exclusions from coverage. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p.40 A notice stating that the Contractor shall be liable only for those services authorized by the Contractor. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p.32 Information on how and where members may access benefits not available from or not covered by the Contractor. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.2 ◆ Materials: Member Handbook, p.30 Cost sharing. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.16 The policies and procedures for disenrollment. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Materials: Member Handbook, p.68-69	

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The member handbook included information about benefits and services, and how to access services including EPSDT, nonemergency transportation, maternity, and family planning services. It also included an explanation of exclusions, how and where members could access benefits not covered by WellCare, information on copays, and policies and procedures for disenrollment.		
Required Actions: None.		
13. The member handbook includes: ◆ The medical necessity definition used in determining whether services will be covered. ◆ A description of all pre-certification, prior authorization, or other requirements for treatments and services. ◆ A description of utilization review policies and procedures used by the Contractor. ◆ The policy on referrals for specialty care and for other covered services not furnished by the member's PCP. ◆ Information on how to obtain services when the member is out of the service region. ◆ Geographic boundaries of the service region. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	The medical necessity definition used in determining whether services will be covered. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.1 A description of all pre-certification, prior authorization, or other requirements for treatments and services. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.30 A description of utilization review policies and procedures used by the Contractor. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.31 The policy on referrals for specialty care and for other covered services not furnished by the member's PCP. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.30 Information on how to obtain services when the member is out of the service region.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.34 Geographic boundaries of the service region. ◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.15	
Findings: The member handbook contained all of the information described in this element.		
Required Actions: None.		
14. The member handbook includes: ◆ A statement that additional information, including information on the structure and operation of the CMO plan and physician incentive plans, shall be made available on request. ◆ A notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including the Contractor's toll-free telephone line and Web site. *42CFR438.10(f)(2) and 42CFR438.10(f)(6)* *Contract: 4.3.3.2*	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p. 3, 9, 10, 70	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included information regarding how a member could obtain a summary of the structure and operations of WellCare, including the CMO's physician incentive plans. The handbook also included WellCare's mailing address, toll-free telephone numbers, and its website information. WellCare staff indicated that the CMO escalated requests for structure and operations information to an "offline" customer service team for fulfilment. The provider relations team was consulted for requests dealing with provider incentive plans.		
Required Actions: None.		
15. The member handbook includes a description of member rights and responsibilities as described in Section 4.3.4 of the Contract and 42CFR438.100. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.74-76	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The member handbook included a description of member rights and responsibilities as described in the CFR and the contract.		
Required Actions: None.		
16. The member handbook information on advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care including the right to accept or refuse medical or surgical treatment. ◆ The contractor's policies on respecting the implementation of those rights, including a statement of any limitation regarding the implementation of the Advance Directives as a matter of conscience. ◆ Information must inform members that complaints may be filed with the State's Survey and Certificate Agency. *42CFR438.10(g)* *Contract: 4.3.3.2, 4.6.12.1.1, 4.6.12.1.2, and 4.6.12.3*	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Materials: Member Handbook, p.56-57	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included the required advance directive information described in this element.		
Required Actions: None.		
17. The member handbook includes: ◆ The extent to which and how after hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and post-stabilization services with reference to the definitions in 42CFR438.114(a). ▪ The fact that prior-authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent.	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Materials: Member Handbook, p.31, 33, 34	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)* *Contract: 4.3.3.3*		
Findings: The member handbook explained what constituted an emergency medical condition, and emergency and poststabilization services. It stated that prior authorization was not required for emergency services and provided a summary of the process to obtain emergency and poststabilization services, including use of the 911 telephone number. The member handbook indicated that if the member needed these services, he or she should go to the nearest emergency room or hospital and that prior authorization was not required.		
Required Actions: None.		
18. The member handbook information on the Grievance System includes: ◆ The right to file a grievance or an appeal with the Contractor. ◆ The requirements and timeframes for filing grievances and appeals. ◆ The availability of assistance in filing a grievance or an appeal with the Contractor. ◆ The toll free numbers the member may use to file a grievance or an appeal by phone. ◆ The right to a State Administrative Law hearing, the method to obtain a hearing, and the rules that govern representation at the hearing. *42CFR438.10(g)* *Contract: 4.3.3.4*	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Materials: Member Handbook, p.58-59, 61, 63-64, 74	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included information on the grievance system including the right to file, the requirements and time frames, availability of assistance when filing, and the toll-free numbers to file a grievance or appeal by phone. The member handbook also included the right to a State administrative law hearing, the method to obtain a hearing, and the rules that governed representation at the hearing.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
19. The member handbook information on the Grievance System includes: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for the State Administrative Law hearing is filed within the timeframes specified for filing. ◆ Notice that if the member files an appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, 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. *42CFR438.10(g)* *Contract: 4.3.3.4*	◆ Documented Process: C6MMO-023 Georgia Medicaid Member Handbook, p.3 ◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Materials: Member Handbook, p.64-65	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The appeals section of the member handbook indicated that when requested by a member, benefits may continue if the appeal or administrative law hearing was filed within appropriate time frames and that the member may be required to pay the cost of services furnished during the appeals or administrative law hearing process if the final decision was adverse to the member. The Georgia Medicaid Member Handbook policy also ensured that WellCare included these provisions in the member handbook.		
Required Actions: None.		
20. The Contractor gives written notice to DCH of any significant change in information to members at least 30 calendar days before the effective date of the change. *42CFR438.10(f)(4)* *Contract: 4.3.2.5*	◆ Documented Process: C6MMO-022 Medicaid Post-Enrollment Member Materials, p.2 ◆ Materials: Benefit Change Insert ◆ Materials: Member Newsletter ◆ Materials: Screen prints from the Web	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medicaid Post-Enrollment Member Materials policy indicated that WellCare provided written notice to DCH of any changes to written materials provided to the member. The written notice was provided to DCH at least 30 days prior to the intended date of the change.		
Required Actions: None.		

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard IV—Member Information						
Met	=	20	X	1.00	=	20
Not Met	=	0	X	.00	=	0
Not Applicable	=	0		***NA***		
Total Applicable	=	20	**Total Score**		=	20
Total Score ÷ Total Applicable					=	100%

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor has a system in place that includes a grievance process, an appeal (administrative review) process, and access to the State Administrative Law hearing process. The contractor's appeal process shall include an internal process that must be exhausted by the member prior to accessing an Administrative Law Hearing. *42CFR438.402(a)* *Contract: 4.14.1.1*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.3 ◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.2 ◆ Materials: Grievance System Workflow Process ◆ Materials: State Approved Grievance Department Georgia Training Module	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Medicaid Grievance procedure and Georgia Administrative Review policy and procedure demonstrated that WellCare had a system in place that included a grievance process, an administrative review process, and access to the State's administrative law hearing process. WellCare's appeals process included an internal process that the member must exhaust prior to accessing the administrative law hearing.		
Required Actions: None.		
2. The Contractor has written Grievance System and appeal process policies and procedures that detail the operation of the Grievance System and appeal process. The Contractor's policies and procedures shall be available in the member's primary language. The Grievance System and appeal process policies and procedures shall be submitted to DCH for review and approval as updated. *42CFR438.400(a)(3)* *Contract: 4.14.1.2*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.3 ◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.3	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: WellCare provided its Georgia Administrative Review policy and Georgia Medicaid Grievance procedure which detailed the operation of the grievance system and appeals process. The Georgia Administrative Review policy indicated that the policies and procedures were available in the member's primary language, and that policies and procedures related to the grievance system and appeals process were submitted to DCH for review and approval. WellCare staff members confirmed the DCH approval process, that WellCare conducted an annual internal review of these documents, and that any changes as a result of this annual review process were submitted to DCH for review and approval.		
Required Actions: None.		
3. The Contractor defines action (proposed action) as: ◆ The denial or limited authorization of a requested service, including the type or level of service.	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.1-2 ◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.1-2	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the timeframes for resolution of grievances and appeals specified at 438.408(b). *42CFR438.400(b)* *Contract: 1.4*	◆ Materials: Provider Handbook, p.85	
Findings: The Georgia Administrative Review policy indicated that WellCare defined a "proposed action" as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for services; the failure to provide services in a timely manner; or the failure of WellCare to act within the time frames provided in 42 CFR 438.408(b).		
Required Actions: None.		
4. The Contractor defines appeal (administrative review) as a request for review of an action, as action is defined in 42 C.F.R. §438.400. *42CFR438.400(b)* *Contract: 1.4*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.1 ◆ Materials: Member Handbook, p.60 ◆ Materials: Provider Handbook, p.85	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that WellCare defined an "administrative review" as the formal reconsideration, as a result of the proper and timely submission of a provider's or member's request, by WellCare, which has proposed an adverse action.		
Required Actions: None.		
5. The Contractor defines grievance as an expression of dissatisfaction about any matter other than an action. ◆ Possible subjects for grievances include but are not limited to, the quality of care or services provided or aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member's rights. *42CFR438.400(b)* *Contract: 1.4*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.2 ◆ Materials: Member Handbook, p.58 ◆ Materials: Provider Handbook, p.131	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Medicaid Grievance Procedure indicated that WellCare defined a "grievance" as an expression of dissatisfaction about any matter other than a proposed adverse action. The member handbook indicated that grievances could be filed about the quality of care or the way the provider or others behaved, and that a grievance could be filed when the member had any concerns about WellCare or the provider.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
6. The Contractor has provisions for who may file a grievance: ◆ A member or member's authorized representative may file a grievance, either orally or in writing. ◆ A Grievance may be filed about any matter other than a proposed action. ◆ A provider cannot file a grievance on behalf of the member. *42CFR438.402(b)(1) and 42CFR438.402(b)(3)* *Contract: 4.14.2.1,*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.5 ◆ Materials: Member Handbook, p.59 ◆ Materials: Provider Handbook, p.84	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Medicaid Grievance procedure indicated that a member or the member's authorized representative may file a grievance either verbally or in writing, a grievance may be filed about any matter other than a proposed action, and the provider cannot file a grievance on behalf of the member.		
Required Actions: None.		
7. The contractor shall ensure that the individuals who make decisions on grievances that involve clinical issues are health care professionals who have the appropriate clinical expertise as determined by DCH, in treating the member's condition or disease and who were not involved in any previous level of review or decision-making. *Contract: 4.14.2.2*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.4-5	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Medicaid Grievance procedure indicated that WellCare ensured that none of the decision makers on a clinical grievance were involved in any of the previous levels of review or decision making and that all decision makers were healthcare professionals with clinical expertise in the treatment of the member's condition or disease.		
Required Actions: None.		
8. Contractor shall provide written notice of the disposition of the grievance as expeditiously as the member's health condition requires but must be completed within 90 days but not to exceed 90 calendar days of the filing date. *Contract: 4.14.2.3*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.6-7 ◆ Materials: State Approved Grievance Department Georgia Training Module ◆ Materials: Member Handbook, p.59 ◆ Materials: Provider Handbook, p.84	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The Georgia Medicaid Grievance procedure indicated that a decision was made as quickly as the member's condition required, but no more than 90 calendar days from the day WellCare received the initial grievance request. The procedure also indicated that the grievance resolution letter was sent to the member and included the date, member information, grievance file number, receipt date of the grievance, substance of the grievance and actions taken, the decision, and the reason for the decision. All 10 grievance disposition letters reviewed during the on-site audit met the timeliness requirement of 90 calendar days. All letters were sent to members between 76 and 90 days of the filing date.		
Required Actions: None.		
9. The member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent may file an appeal (administrative review) of a proposed action either orally or in writing within 30 calendar days from the date of the notice of "proposed action." A written request must be provided when an oral request has been made, unless the request is for expedited resolution. *42CFR438.402(b)(3)* *Contract: 4.14.4.1 and 4.14.4.2*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5 ◆ Materials: Member Handbook, p.60 ◆ Materials: Provider Handbook, p.86-87	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that the member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent may file an administrative review either orally or in writing within 30 calendar days of the date of the notice of proposed action. The policy also indicated that an oral request must be followed by a written request unless the request was for expedited resolution.		
Required Actions: None.		
10. An appeal (administrative review) shall be filed directly with the contractor or its delegated representatives. The Contractor may delegate this authority to an administrative review committee, but the delegation must be in writing. *Contract: 4.14.4.3*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that administrative reviews must be filed directly with WellCare. The policy also indicated that WellCare may delegate this authority to an administrative review committee, but the delegation must be in writing. At the time of this review, WellCare did not delegate this activity.		
Required Actions: None.		
11. For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following:	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ Within ten (10) days of the Contractor mailing the notice of action, or ◆ The intended effective date of the proposed action. For all other actions, 30 calendar days from the date of the notice of proposed action. *42CFR438.402(b)(2) and 438.420(a)* *Contract: 4.14.4.2 and 4.14.7.1*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.15	
Findings: The Georgia Administrative Review Procedure indicated that WellCare "allows at least 10 calendar days following an action to terminate, suspend, or reduce services" for the member to file a request for administrative review; however, it did not address the fact that timely filing includes the later of either 10 days or the intended effective date of the proposed action.		
Required Actions: WellCare must include in its policy and procedure the fact that the member may file a request for administrative review by the later of either 10 days after the NOA is mailed or the intended effective date of the proposed action.		
12. The individuals who make the decisions on the administrative reviews are individuals who were not involved in any previous level or review of decision-making and will have the appropriate clinical expertise in treating the member's condition or disease when deciding the following: ◆ An administrative review of a denial that is based on lack of medical necessity. ◆ An administrative review that involves clinical issues. *Contract: 4.14.4.4*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.3 ◆ Materials: Provider Handbook, p.85 ◆ Reports: 2015 QI Program Description, p.5-6	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that WellCare ensured that the individuals who made decisions on administrative reviews were not involved in any previous level of review or decision making; and were healthcare professionals who were licensed and board certified in treating the member's condition or disease if deciding an administrative review of a denial based on lack of medical necessity, or any administrative review involving clinical issues. The 10 administrative review (appeal) files reviewed all complied with this element.		
Required Actions: None.		
13. A member must exhaust the Contractor's appeal (administrative review) process before requesting a State Administrative Law hearing. The member may request the State Administrative Law	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.3 ◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.15	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
hearing 30 days from the date of the notice of appeal resolution (notice of adverse action). *42CFR438.402(b)(3)* *Contract: 4.14.3.3 and 4.14.6.3*	◆ Materials: Member Handbook, p.63 ◆ Materials: Provider Handbook, p.89-90	
Findings: The Georgia Administrative Review policy indicated that WellCare members must exhaust the CMO's administrative review process before requesting a State administrative law hearing. The Georgia Administrative Review procedure indicated that a member may request in writing to WellCare an administrative law hearing within 30 calendar days of the date WellCare mailed the notice of adverse action.		
Required Actions: None.		
14. Notices of proposed action must be in writing and meet the language and format requirements of 42CFR438.10 and Contract Section 4.3.2 to ensure ease of understanding and be sent in accordance with the timeframes described in Section 4.14.3.4. *42CFR438.404(a)* *Contract: 4.14.3.2*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.5-10 ◆ Materials: UM Notice of Proposed Action	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that all adverse determination notices were in writing and met the language and format requirements. The notice of proposed action was available in English and in each prevalent, non-English language; was written in easy-to-understand language for a person reading at the fifth-grade level; and was available in other formats if needed. The Adverse Determinations Proposed Actions policy addressed and met all of the required NOA time frames.		
Required Actions: None.		
15. All proposed actions are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member's condition or disease. *Contract: 4.14.3.1*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.6-7 ◆ Reports: 2015 QI Program Description, p. 5-6, 11-12 ◆ Materials: Provider Handbook, p.47	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that all adverse determinations were made by a physician or other peer review consultant who had appropriate clinical expertise in treating the member's condition or disease.		
Required Actions: None.		
16. Notices of proposed action must contain: ◆ The action the Contractor has taken or intends to take, including the service or procedure that is subject to the action. ◆ Additional information, if, any that could alter the decision.	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.7-8 ◆ Materials: UM Notice of Proposed Action	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ The specific reason used as basis for the action (the reasons must have a factual basis and a legal/policy basis). ◆ The member's right to file an appeal (administrative review) through the Contractor's internal Grievance System and how to do so. ◆ The provider's right to file a provider complaint under the Contractor's provider complaint system. ◆ The requirement that a member exhaust the Contractor's internal administrative review process. ◆ The circumstances under which expedited review is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal (administrative review) and how to request that benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services if benefits are continued during the administrative review process. *42CFR438.404(b)* *Contract: 4.14.3.3*		
Findings: The Adverse Determinations Proposed Actions policy indicated that all adverse determination notices included the requirements listed in this element. WellCare supplied the Notice of Proposed Action form letter, and it did not contain the notice that the member must exhaust WellCare's internal administrative review process.		
Required Actions: WellCare must change its Notice of Proposed Action form letter to include a notice that the member must exhaust WellCare's internal administrative review process.		
17. The contractor shall mail the Notice of Proposed Action within the following timeframes: *Contract: 4.14.3.4*		
(a) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the Notice of Proposed Action must be mailed at least 10 calendar days	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.9	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
before the date of the proposed action except in the event of one of the following exceptions: ◆ The Contractor has factual information confirming the death of a member. ◆ The Contractor receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates he or she understands that this must be the result of supplying that information. ◆ The member's whereabouts are unknown and the post office returns the Contractor's mail directed to the member indicating no forwarding address. ◆ A change in the level of medical care is prescribed by the member's physician. *42CFR438.404(c)* *Contract: 4.14.3.4.1*		
Findings: The Adverse Determinations Proposed Actions policy indicated that in the event of terminations, suspensions, or reduction of previously authorized covered services, WellCare mailed the notice of proposed action at least 10 calendar days before the date of the proposed action or in the case of the exceptions listed in this element.		
Required Actions: None.		
(b) The Contractor may shorten the period of advance notice to five (5) calendar days before the date of the proposed action if the Contractor has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources. *Contract: 4.14.3.4.3*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.9	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that WellCare may shorten the period of advance notice to five calendar days before the date of action if WellCare had facts indicating that action should be taken because of probable member fraud and the facts had been verified, if possible, through secondary sources.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
(c) For denial of payment, at the time of any proposed action affecting the claim. *42CFR438.404(c)(2)* *Contract: 4.14.3.4.5,*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.9	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that for denials of payment, the notice was provided at the time of any proposed action affecting the claim.		
Required Actions: None.		
(d) For standard service authorization decisions that deny or limit service, within 14 calendar days of the receipt of the request for service. *42CFR438.404 (c)(3)* *Contract: 4.11.2.5.1 and 4.14.3.4.6*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.8	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that for standard service authorization decisions, the notice would be provided as expeditiously as the member's health condition required and it would not exceed 14 calendar days following receipt of the requested service.		
Required Actions: None.		
(e) For expedited service authorization decisions, within 24 hours. *42CFR438.404 (c)(6)* *Contract: 4.11.2.5.2*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.9	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that for expedited/urgent service authorization decisions, the notice was provided within 24 hours.		
Required Actions: None.		
(f) For authorization decisions not reached within the timeframes required in Section 4.11.2.5, on the date the timeframes expire, as this constitutes a denial and is thus a proposed action. *42CFR438.404 (c)(5)* *Contract: 4.14.3.4.8*	◆ Documented Process: C7UM MD 2.2 Adverse Determinations Proposed Actions, p.10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determinations Proposed Actions policy indicated that if WellCare failed to render an authorization decision within the required time frames, WellCare would mail a notice of proposed action within the required time frame. The Service Authorization Decisions policy indicated that WellCare would prepare an extension notification letter explaining the need for the extension, how it would benefit the member, and when the final determination would be		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
made. It further indicated that the decision would be carried out as expeditiously as the member's health condition required and no later than the date the extension expired.		
Required Actions: None.		
18. If the Contractor extends the timeframe for authorization decisions and issuance of the notice of proposed action according to Section 411.2.5, it provides the member: ◆ Written notice of the reason for the decision to extend the timeframe. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires. *Contract: 4.14.3.4.7*	◆ Documented Process: C7UM MD 2.1 Service Authorization Decisions, p.8, 11 ◆ Materials: Template GA Extension Letter	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Service Authorization Decisions policy indicated that if WellCare extended the time frame for authorization decisions, the extension notification letter would explain the need for the extension, that the member had the right to file a grievance, and that the decision would be made as expeditiously as the member's health condition required.		
Required Actions: None.		
19. In handling grievances and appeals (administrative reviews), the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* *Contract: 4.14.1.4*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.3 ◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.3	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that WellCare would give members reasonable assistance in completing forms and taking other procedural steps for both grievances and administrative reviews. This included, but was not limited to, providing interpreter services and toll-free numbers that had adequate TTY/TTD and interpreter capabilities.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
20. The Contractor acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language. *42CFR438.406(a)(2)* *Contract: 4.14.1.5*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.3-4 ◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.3 Materials: Member Handbook, p.59, 61	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that WellCare acknowledged receipt of each filed administrative review in writing within 10 calendar days of receipt and that the acknowledgment letter was available in the member's primary language. The Georgia Medicaid Grievance Procedure indicated that WellCare mailed the acknowledgment letter within 10 business days; however, the procedure did not address that the letter would be available in the member's primary language. Three of the 10 grievance acknowledgement letters reviewed during the on-site review were not sent to the member within 10 working days. All 10 administrative review (appeal) files met the acknowledgement timeliness requirement.		
Required Actions: WellCare must revise its Georgia Medicaid Grievance procedure to include the provision that the acknowledgment letter would be available in the member's primary language. WellCare must acknowledge all grievances within 10 working days.		
21. The Contractor must resolve each administrative review and provide written notice of the disposition as expeditiously as the member's health condition requires, not to exceed: ◆ For standard resolution of appeals, 45 calendar days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal. *42CFR438.408(b)* *Contract: 4.14.4.8*	Grievance ◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.6-7 ◆ Materials: State Approved Grievance Department Georgia Training Module ◆ Materials: Member Handbook, p.59 ◆ Materials: Provider Handbook, p.84 Appeals ◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5 ◆ Materials: Member Handbook, p.62 ◆ Materials: Provider Handbook, p.86	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that, for standard resolutions of an appeal, the notice of appeal decision was mailed no later than 30 days from receipt of the administrative review request, exceeding the DCH requirement. WellCare followed the more stringent NCQA standard. The 10 administrative review (appeal) files reviewed met all applicable timeliness requirements, both the NCQA requirement for standard appeals and the State standard for expedited appeals.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
22. The Contractor's appeal (administrative review) process must provide:		
(a) Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. *42CFR438.406(b)(1)*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5 ◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.2	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that when oral requests for an appeal were received, the appeal must be followed by a written, signed statement from the member. If the member did not send the written statement within 10 calendar days, WellCare sent the member an acknowledgement letter requesting the written, signed statement.		
Required Actions: None.		
(b) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's consent, must be given a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) *42CFR438.406(b)(2)* *Contract: 4.14.4.5*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5 ◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.3	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that members were given an opportunity to present evidence and allegations of fact or law either in person or in writing. The Georgia Administrative Review policy indicated that WellCare informed the member of the limited time available to provide this in case of an expedited review.		
Required Actions: None.		
(c) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent, must be given an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the administrative review process. *42CFR438.406(b)(3)*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Contract: 4.14.4.6		
Findings: The Georgia Administrative Review policy indicated that the member, the member's authorized representative, or the provider acting on behalf of the member with written consent was given the opportunity to examine the member's case file, including medical records and any other documents and records considered during the administrative review process.		
Required Actions: None.		
(d) Included, as parties to the appeal: ◆ The member and his or her representative. ◆ The provider, acting on behalf of the member with the member's written consent. ◆ The legal representative of a deceased member's estate. *42CFR438.406(b)(4)* *Contract: 4.14.4.7*	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.5 ◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.6	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review policy indicated that parties to the appeal included the member, the member's authorized representative, the provider acting on behalf of the member with the member's written consent, or the legal representative of a deceased member's estate.		
Required Actions: None.		
23. The Contractor has an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the timeframe for standard resolution, and ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two (2) calendar days with a written notice.	◆ Documented Process: C7AP-002 Georgia Administrative Review Policy, p.4-5 ◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.8 ◆ Materials: Member Handbook, p.61 ◆ Materials: Provider Handbook, p.86-87	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.410* *Contract: 4.14.4.8*		
Findings: The Georgia Administrative Review policy indicated that WellCare maintained an expedited administrative review process when the CMO determined or the provider indicated 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. The policy also indicated that WellCare's expedited review process included assurances that no punitive action would be taken against either a provider who requested an expedited resolution or a provider who supported a member's appeal. The Georgia Administrative Review procedure indicated that if WellCare denied a request for expedited resolution of an appeal, then WellCare notified the member via letter within two days, and automatically transferred and processed the request using the 30-calendar-day time frame for standard administrative reviews. The policy also stated that WellCare provided oral notification with 24 hours regarding a denial of the request for administrative expedited review.		
Required Actions: None.		
24. The Contractor may extend the timeframes for resolution of the appeal (administrative review) (both expedited and standard) by up to 14 calendar days if: ◆ The member, member's authorized representative, or the provider acting on behalf of the member requests the extension, or ◆ The Contractor shows (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the member's interest. *42CFR438.408(c)* *Contract: 4.14.4.9*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.5, 14 ◆ Materials: Member Handbook, p.62 ◆ Materials: Provider Handbook, p.86	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that WellCare may extend the time frame for standard or expedited resolution of the administrative review by up to 14 calendar days if the member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent requested the extension, or WellCare demonstrated to DCH's satisfaction that additional information was needed and how the delay was in the member's interest.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
25. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *Contract: 4.14.4.9*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.5, 14 ◆ Materials: Provider Handbook, p.86	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that if WellCare extended the time frame, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.		
Required Actions: None.		
26. If the Contractor upholds the proposed action in response to an administrative review filed by the member, the contractor shall issue a notice of adverse action within the timeframes described in Section 4.14.4.8 and 4.14.4.9. *Contract: 4.14.5.1*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.5, 9, 14	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative review procedure indicated that if WellCare upheld a proposed action in response to an administrative review filed by the member, then WellCare issued a notice of adverse action no later than 30 calendar days from the receipt of the administrative review request, which is the more-stringent NCQA standard. For expedited review, the notice of adverse action letter was issued no later than 72 hours from receipt of the administrative expedited review request.		
Required Actions: None.		
27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes: ◆ The results and date of the adverse action including the service or procedure that is subject to the action. ◆ Additional information, if any, that could alter the decision. ◆ The specific reason used as the basis of the action. ◆ The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing is date stamped. ◆ The right to continue to receive benefits pending a State Administrative Law hearing.	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.5-6, 9, 14-15 ◆ Materials: Appeal Template Closure Letter	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ How to request continuation of benefits. ◆ Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State Administrative Law hearing. ◆ Circumstances under which expedited resolution is available and how to request it. *42CFR438.408(e)* *Contract: 4.14.5.2*		
Findings: The Georgia Administrative Review procedure indicated that the notice of adverse action met the language and format requirements specified in the contract and included the requirements listed in this element. The Administrative Review Determination Final Denial Notice contained the required information. Five of the 10 administrative review (appeal) resolution letters reviewed during the on-site audit did not meet the fifth-grade reading/understandability level. In these cases procedure codes and medical terminology were used, which raised the reading level.		
Required Actions: WellCare must ensure that all administrative review resolution letters are written in easily understood language.		
28. The Contractor continues the member benefits if:		
(a) The member, member's authorized representative, or the provider files a timely appeal—defined as on or before the later of the following: ◆ Within ten (10) days of the Contractor mailing the notice of action. ◆ The intended effective date of the proposed action. *42CFR438.420(b)(1)* *Contract: 4.14.7.1*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.15 ◆ Materials: Member Handbook, p.64 ◆ Materials: Provider Handbook, p.89	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that the member, the member's authorized representative, or the provider acting on behalf of the member with written consent could request an administrative review. The element received a *Met* score; however, HSAG recommends a review of the procedure to ensure language is consistent throughout the document. For example, page 1 of this procedure mentioned that the provider acting on behalf of the member with written consent may request the administrative review; however, on page 15 the provider was not listed.		
Required Actions: None.		
(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. *42CFR438.420(b)(2)*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.15 ◆ Materials: Member Handbook, p.64	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Contract: 4.14.7.2	◆ Materials: Provider Handbook, p.89	
Findings: The Georgia Administrative Review procedure indicated that WellCare continued the member benefits if the appeal involved the termination, suspension, or reduction of a previously authorized course of treatment.		
Required Actions: None.		
(c) The services were ordered by an authorized provider. *42CFR438.420(b)(3)* *Contract*: 4.14.7.2	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.16 ◆ Materials: Member Handbook, p.64 ◆ Materials: Provider Handbook, p.89	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that WellCare continued the member benefits if the services were ordered by an authorized provider.		
Required Actions: None.		
(d) The original period covered by the original authorization has not expired. *42CFR438.420(b)(4)* *Contract: 4.14.7.2*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.16 ◆ Materials: Member Handbook, p.64 ◆ Materials: Provider Handbook, p.89	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that WellCare continued the member benefits if the original authorization had not expired.		
Required Actions: None.		
(e) The member requests an extension of benefits. *42CFR438.420(b)(5)* *Contract: 4.14.7.2*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.16 ◆ Materials: Member Handbook, p.64 ◆ Materials: Provider Handbook, p.89	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that WellCare continued the member benefits if the member requested extension of the benefits.		
Required Actions: None.		
29. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten (10) calendar days pass after the Contractor mails the notice of action providing the resolution of the appeal against	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.16 ◆ Materials: Member Handbook, p.65 ◆ Materials: Provider Handbook, p.89	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
the member, unless the member (within the 10-day timeframe) has requested a State Administrative Law hearing with continuation of benefits until a State Administrative Law hearing decision is reached. ◆ A State Administrative Law hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *Contract: 4.14.7.3*		
Findings: The Georgia Administrative Review procedure indicated that if WellCare continued or reinstated the benefits while the administrative review or administrative law hearing was pending, then the benefits were continued until one of the following occurred: (1) the member withdrew the appeal, (2) 10 calendar days passed after WellCare mailed the notice of adverse action, unless the member, within 10 calendar days, requested an administrative law hearing with continuation of benefits until an administrative law hearing decision was reached, (3) an administrative law judge issued a hearing decision adverse to the member, or (4) the time period or service limits of the previously authorized service were met.		
Required Actions: None.		
30. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section (contract section 4.14.7). *42CFR438.420(d)* *Contract: 4.14.7.4*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.16	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that if the final resolution of the administrative review was adverse to the member, that is, upheld WellCare's action, then WellCare may recover from the member the cost of the services furnished to the member while the administrative review was pending, to the extent they were furnished solely because of the requirements of the contract.		
Required Actions: None.		
31. If the Contractor or the State Administrative Law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending:	Between July 1, 2014 and June 30, 2015, there were no situations where the state Administrative Law Judge reversed the plan's original decision.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. ◆ The Contractor must pay for those services. *42CFR438.424* *Contract: 4.14.7.5and 4.14.7.6*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.16 ◆ Materials: Member Handbook, p.65 ◆ Materials: Provider Handbook, p.89	
Findings: The Georgia Administrative Review procedure indicated that if WellCare or the administrative law judge reversed a decision to deny, limit, or delay services that were not furnished while the administrative review or administrative law hearing was pending, WellCare authorized or provided the disputed services promptly and as expeditiously as the member's health condition required. The procedure also indicated that WellCare paid for those services.		
Required Actions: None.		
32. The Contractor logs and tracks all grievances, proposed actions, appeals, and Administrative Law hearing requests as described in Section 4.18.4.5. *42CFR438.416* *Contract: 4.14.8.1*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.7-8 ◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.17 ◆ Documented Process: Member ALH Step Action ◆ Documented Process: Provider ALH Step Action	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Medicaid Grievance procedure described WellCare's logging and tracking of grievances. The Georgia Administrative Review procedure described WellCare's appeals and administrative law logging and tracking mechanism. WellCare provided its Member ALH [Administrative Law Hearing] Step Action document as an example of its tracking of an administrative law hearing request.		
Required Actions: None.		
33. The Contractor shall maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the grievance, date of the decision, and the disposition. *Contract: 4.14.8.2*	◆ Documented Process: C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, p.7-8	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Medicaid Grievance procedure indicated that WellCare maintained a file on each grievance, which included a copy of the grievance and member information. The file also included dates associated with the grievance, decision, and disposition.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
34. The Contractor shall maintain records of appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. *Contract: 4.14.8.3*	◆ Documented Process: C7AP-002-PR-001 Georgia Administrative Review Procedure, p.17	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia Administrative Review procedure indicated that WellCare kept a file on each administrative review, which included a copy of the administrative review and member information. The file also included dates related to the appeal, decision, and resolutions.		
Required Actions: None.		
35. The Contractor must provide the information about the member Grievance System specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. *42CFR438.414*	◆ Materials: PCP Agreement - RTR Medical Group, p. 9, 36, 37 a) The right to file grievances ▪ Materials: Provider Handbook, p.83 b) The right to file appeals ▪ Materials: Provider Handbook, p.85 c) The right to a State Administrative Law hearing ▪ Materials: Provider Handbook, p.90 d) The requirements and timeframes for filing grievances and appeals ▪ Materials: Provider Handbook, p.87 e) The method for obtaining a State Administrative Law hearing ▪ Materials: Provider Handbook, p.90 f) The rules that govern representation at the State Administrative Law hearing ▪ Materials: Provider Handbook, p.90	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	g) The availability of assistance filing a grievance, an appeal, or requesting a State Administrative Law hearing ▪ Materials: Provider Handbook, p.84 h) The toll free numbers the member may use to file a grievance or an appeal by phone ▪ Materials: Provider Handbook, p.84 i) The fact that, when requested by the member, benefits will continue if the appeal or request for State Administrative Law hearing is filed within the timeframes specified for filing ▪ Materials: Provider Handbook, p.89 j) The fact that, if benefits continue during the appeal or State Administrative Law hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member ▪ Materials: Provider Handbook, p.89 k) Appeal rights available to providers to challenge the failure of the Contractor to cover a service ▪ Materials: Provider Handbook, p. 88, 90 ▪ Materials: PCP Agreement - RTR Medical Group, p.40	
Findings: The Georgia Medicaid Provider Handbook provided information about the member grievance system in accordance with 42CFR438.10(g)(1). The provider handbook was repeatedly mentioned in the Participating Provider Agreement, and the provider handbook was available on the WellCare website. The Participating Provider Agreement also included a notice about the dispute resolution process and time frames.		
Required Actions: None.		

Standard V—Grievance System						
Met	=	43	X	1.00	=	43
Not Met	=	4	X	.00	=	0
Not Applicable	=			***NA***		***NA***
Total Applicable	=	47	**Total Score**		=	43
Total Score ÷ Total Applicable					=	91.5%

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor shall accept all individuals for enrollment without restrictions. The Contractor shall not discriminate based on: ◆ Religion ◆ Gender ◆ Race ◆ Color ◆ National origin Contractor will not use any policy or practices that have the effect of discriminating on the above basis or on the basis of health, health status, pre-existing condition or need for health care services. *Contract: 4.1.1.4*	◆ Documented Process: C6EN MD-007 Enrollment Policy, p.4	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Enrollment policy indicated that WellCare did not discriminate based on religion, gender, race, color, national origin, health, health status, pre-existing conditions, or the need for healthcare services.		
Required Actions: None.		
2. A member may request disenrollment from a CMO for the following reasons: ◆ For cause at any time. ◆ Without cause: ▪ During 90 calendar days following the date of their initial enrollment or the day DCH or its agent sends the member notice of enrollment—whichever is later. ▪ Every 12 months thereafter. ▪ Upon automatic enrollment. *42CFR438.56(c)(i-iii)* *Contract: 4.2.1.1*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.3 ◆ Documented Process: Workflow - GA Disenrollment Process Flow ◆ Materials: Call Tool - GA Medicaid Member Services Disenrollment Guide ◆ Materials: Training - GA Medicaid New Hire ◆ Materials: Member Handbook, p.67	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated the a member may request disenrollment without cause during the 90 calendar days following the date of initial enrollment or the date DCH sent the member notice of enrollment, whichever is later. The policy also indicated that a member could request disenrollment without cause every 12 months thereafter.		
Required Actions: None.		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
3. The following constitutes cause for disenrollment requested by the member: ◆ The member moves out of the service area. ◆ The Contractor does not, because of moral or religious objections, provide the covered service the member seeks. ◆ The member needs related services performed at the same time and not all the related services are available within the network. A provider has determined that providing the services separately would subject the member to unnecessary risk. ◆ The member requests to be assigned to the same Contractor as family members. ◆ The member's Medicaid eligibility category changes to ineligible for GF. ◆ Other reasons include but are not limited to poor quality of care, lack of access to services covered under the Contract, or lack of providers experienced in dealing with the member's mental health care needs. *42CFR438.56(d)(2)(i-iv)* *Contract: 4.2.1.2*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.3 ◆ Documented Process: Workflow - GA Disenrollment Process Flow ◆ Materials: Call Tool - GA Medicaid Member Services Disenrollment Guide ◆ Materials: Training - GA Medicaid New Hire ◆ Records: Case Example of GA Out of Service Letter ◆ Records: Case Examples - Print Screen of GA Out of Service Area Members ◆ Materials: Member Handbook, p.67	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy included all of the causes for disenrollment that were described in this element.		
Required Actions: None.		
4. The Contractor provides assistance to members seeking to disenroll. Assistance consists of providing forms to the member and referring the member to DCH or its agent who makes disenrollment determinations. *Contract: 4.2.1.3*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.3 ◆ Materials: Call Tool - GA Medicaid Member Services Disenrollment Guide ◆ Materials: Step Action – Disenrollment, p.1	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated that WellCare provided assistance to members who were seeking disenrollment. The CMO provided forms and referred the member to DCH or its agent who made disenrollment determinations.		
Required Actions: None.		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
5. For disenrollment initiated by the Contractor, the Contractor notifies DCH or its agent upon identification of a member who it knows or believes meets the criteria for disenrollment, as defined in Contract Section 4.2.3. and completes all disenrollment paperwork for members it is seeking to disenroll. *Contract: 4.2.2.1 and 4.2.2.2*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.3-4 ◆ Documented Process: Workflow - GA Disenrollment Process Flow ◆ Documented Process: Workflow- GA Involuntary Disenrollment ◆ Materials: Training - GA Medicaid New Hire ◆ Materials: Step Action- GA Involuntary Disenrollment Requests, p.1 ◆ Materials: Step Action – Disenrollment ◆ Records: Case Example of GA Out of Service Letter ◆ Records: Case Examples - Print Screen of GA Out of Service Area Members ◆ Report: GA Disenrollment Report October 2014 ◆ Report: GA Disenrollment Report January 2015 ◆ Report: GA Disenrollment Report February 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated that WellCare notified DCH upon identification of a member who it knew or believed met the criteria for disenrollment. WellCare also completed all disenrollment paperwork for a member who was seeking disenrollment.		
Required Actions: None.		
6. The Contractor may request disenrollment if: ◆ The member's utilization of services is fraudulent or abusive; ◆ The member has moved out of the service region; ◆ The member is placed in a long-term care nursing facility, State institution, or intermediate care facility for the mentally retarded; ◆ The member's Medicaid eligibility category changes to a category ineligible for GF and/or the member otherwise becomes ineligible to participate in GF; ◆ The member has any other condition as so defined by DCH; or ◆ The member has died, been incarcerated, or moved out of State, thereby making them ineligible for Medicaid. *Contract: 4.2.3*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.4 ◆ Materials: Disenrollment Codes Document ◆ Materials: Step Action- GA Involuntary Disenrollment Requests ◆ Materials: Training - GA Medicaid New Hire ◆ Materials: Member Handbook, p.69 ◆ Records: Case Example of GA Out of Service Letter ◆ Records: Case Example – Print Screen of GA Out of Service Area Members ◆ Report: GA Disenrollment Report October 2014 ◆ Report: GA Disenrollment Report January 2015 ◆ Report: GA Disenrollment Report February 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated that WellCare may request disenrollment for the acceptable reasons listed in this element.		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
7. Prior to requesting Disenrollment of a member, the Contractor shall document: ◆ At least three (3) interventions over a period of ninety (90) calendar days that occurred through treatment, case management, and care coordination to resolve any difficulty leading to the request. ◆ Provide at least one (1) written warning to the member, certified return receipt requested, regarding implications of his or her actions. DCH recommends that this notice be delivered within ten (10) business days of the member's action. *Contract: 4.2.2.3*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.4 ◆ Documented Process: Workflow- GA Involuntary Disenrollment ◆ Materials: Training - GA Medicaid New Hire ◆ Records: Case Example of GA Out of Service Letter	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated that WellCare documented at least three interventions over a period of 90 calendar days that occurred through treatment, case management, and care coordination to resolve any difficulties leading to the disenrollment request. WellCare also provided at least one written warning to the member, certified return receipt requested, regarding implications of his/her actions. The notice was delivered within 10 business days of the member's action.		
Required Actions: None.		
8. The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for disenrollment outlined in Section 4.2.3 before requesting disenrollment of the member. *Contract: 4.2.2.4*	◆ Documented Process: C6EN MD-008 Disenrollment Policy, p.4 ◆ Documented Process: Workflow - GA Disenrollment Process Flow ◆ Documented Process: Workflow- GA Involuntary Disenrollment ◆ Materials: Training - GA Medicaid New Hire ◆ Materials: Step Action- GA Involuntary Disenrollment Requests ◆ Materials: Step Action – Disenrollment ◆ Report: GA Disenrollment Report October 2014 ◆ Report: GA Disenrollment Report January 2015 ◆ Report: GA Disenrollment Report February 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated that WellCare cited, to DCH, at least one acceptable reason before requesting disenrollment of the member.		
Required Actions: None.		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
9. The Contractor may not request disenrollment of a member for discriminating reasons, including: ◆ Adverse changes in a member's health status; ◆ Missed appointments; ◆ Utilization of medical services; ◆ Diminished mental capacity; ◆ Pre-existing medical condition; ◆ Uncooperative or disruptive behavior resulting from his or her special needs; or ◆ Lack of compliance with the treating physician's plan of care. ◆ Member attempts to exercise his/her rights under the Grievance System. *Contract: 4.2.4.1 and 4.2.4.2*	◆ Documented Process: Policy - C6EN MD-008 Disenrollment, p.5 ◆ Materials: Step Action- GA Involuntary Disenrollment Requests, p.1 ◆ Materials: Training - GA Medicaid New Hire ◆ Materials: Member Handbook, p.69	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The WellCare Disenrollment policy indicated that the CMO would not request disenrollment of a member for any of the reasons listed in this element.		
Required Actions: None.		
10. The request of one PCP to have a member assigned to another provider is not sufficient cause for the Contractor to request the member be disenrolled from the plan. The Contractor shall utilize its PCP assignment process to assign the member a new PCP. *Contract: 4.2.4.3*	◆ Documented Process: Policy - C6EN MD-008 Disenrollment, p.5 ◆ Documented Process: Policy - C6EN MD-006 Provider Auto-Assignment, p.2 ◆ Documented Process: Policy – C6CS- 075 Provider Requests to Transfer a Member	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment policy indicated that the request of one PCP to have a member assigned to a different provider was not sufficient cause for WellCare to request the member's disenrollment. Rather, WellCare used its PCP assignment process to assign the member to a different PCP.		
Required Actions: None.		

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard VI—Disenrollment Requirements and Limitations					
Met	=	10	X 1.00	=	10
Not Met	=	0	X .00	=	0
Not Applicable	=	0	***NA***		***NA***
Total Applicable	=	10	**Total Score**	=	10
Total Score ÷ Total Applicable				=	100%

Appendix B. **Follow-Up Review Tool**

Following this page is the completed follow-up review tool that HSAG used to evaluate WellCare's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring WellCare's performance into full compliance.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(b) **Provider Appointments—Office Wait Times:** *Contract 4.8.14.3*

The CMO informs providers and has processes to ensure that wait times for appointments do not exceed the following:

- Scheduled Appointments—Sixty (60) minutes. After 30 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.
- Work-in or Walk-in Appointments—Ninety (90) minutes. After 45 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.

Findings: The CMO informed providers on the office wait times outlined in this element via its provider handbook. WellCare monitored these requirements; however, the CMO's providers did not meet the wait time standards.

Required Actions: WellCare must ensure its providers meet the wait time standards in this element.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As a result of reviewing the finding of the HSAG EQRO audit, WellCare determined that a possible failure point in the Office Wait Time standard was the lack of a specific question regarding the amount of time a member has to wait in the provider office. Although providers were educated on the standards of office wait times via the web portal and PR rep outreach, the audit initially failed to monitor that standard in enough detail. Although the audit was asking if patients with scheduled appointments were seen within 60 minutes and work-ins or walk-in patients were seen within 90 minutes, the audit did not ask if at the midpoint of the wait time, if the patient was being given an update on the waiting time with the option of waiting or	WellCare believes that additional monitoring of the wait times will increase provider compliance to the standard. The script was changed in time to be in effect for the Q4 audit, and the preliminary results are trending in a positive direction, indicating that the intervention is working. Once the Q1 audit results are in (expected Q2 2015), WellCare will continue to monitor the findings to determine if new or additional interventions are required. If providers still do not meet the wait time standards, a new intervention considering face to face PR interaction, as well as, Senior Medical Director involvement will be implemented.	Joshua Luft	6/30/15

Standard II—Furnishing of Services			
rescheduling the appointment. In an effort to increase compliance with the wait time standard, in October 2014, WellCare was successful in amending the script used by The Myers Group to monitor provider adherence to appointment timeliness and wait times.			
Other Evidence/Documentation: Timely Access New Standards Q1-Q4 2013_2014_ 2015_Market Reporting 7.15.15.xlsx			
July 2015 Re-review Findings: The Timely Access survey reporting document indicated that providers were compliant with the element for quarter 4, 2014, quarter 1, 2015, and quarter 2, 2015.			
July 2015 Required Actions: None.			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*
The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(f) **Timelines—Returning Calls After-Hours:** *Contract 4.8.14.4*
The CMO ensures that provider response times for returning calls after-hours do not exceed the following:

- Urgent Calls—Twenty minutes
- Other Calls—One hour

Findings: WellCare monitored providers returning calls after hours. The CMO staff indicated that when providers were not compliant with either of these standards, they would receive a letter indicating the deficiency. The CMO staff also explained the provider corrective action process.

Required Actions: The CMO must ensure that 90 percent of its providers address urgent calls within 20 minutes and other calls within one hour.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As a result of reviewing the finding of the HSAG EQRO audit, WellCare acknowledges that Returning Calls After-Hours is a standard some providers struggle to meet. There is a current audit and education effort in place for this standard, which currently includes: 1. The Myers Group, on WellCare's behalf, conducts quarterly monitoring of after-hours return call times. TMG calls a statistically valid random sample of providers each quarter to specifically find out if urgent after-hours calls are being returned within 20 minutes and if other after-hours calls are being returned within an hour. The audit results are sent back to WellCare, along with voice recordings for all provider calls that failed the compliance standard. 2. Providers that fail the compliance testing are notified by letter of the failure which specifically includes the	Review Timely Access All Standards Report.	Interventions 1-4: Amy Carr Interventions 1-2: Amy Carr Intervention 3: Amy House	Interventions 1-4: 9/30/15 Interventions 1-2: 9/30/15 – Remediate "failure points" 1 & 2. Intervention 3: 6/30/15 – Remediate "failure point" 3.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
wait time standards as well as suggested remediation for after-hours calls. The expectation is that the "failed providers" will amend their procedure to adhere to the after-hours call back standard and that when they are re-audited the following quarter, they will meet these standards. 3. WellCare re-audits ALL failed providers the following quarter to determine if the education efforts have been successful in changing the behavior of the provider in such a way that they are now meeting members' medical after-hours needs in a timely manner. 4. Any provider that fails the re-audit is notified by letter, and the Senior Medical Director makes recommendation for further action, if necessary. It is important to note that in reviewing the current process, we discovered 3 possible failure points that will be addressed in our future interventions: 1. The first failure point is a lack of personal interaction for providers who fail the first audit. ◆ Beginning with the Q1 2015 audit results, the provider relations representatives will personally deliver the first "fail" letter to the PCPs who require remediation. The PR rep will educate the staff on the standards and explain that they are contractually bound to adhere to the standard because it is in place to ensure that our members' medical needs are being met. The PR rep will also talk to the provider group to determine the root			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
cause for the failure and work with the office to remove barriers to meeting the standards. 2. The second failure point is the same lack of personal interaction for failure of the second audit. ◆ Beginning with the Q1 2015 audit results, the provider relations representatives will personally deliver the second "fail" letter to the PCPs who require remediation. The PR rep will educate the staff on the standards and explain that they are contractually bound to adhere to the standard because it is in place to ensure that our members' medical needs are being met. The PR rep will also talk to the provider group to determine the root cause for the failure and work with the office to remove barriers to meeting the standards. ◆ In addition, the Senior Medical Director will communicate with the second audit failure providers via written or verbal communication to enforce the importance of returning after-hours calls in a timely manner, emphasizing the importance of PCP-centric care and avoidance of unnecessary ER visits, which can be an unintended consequence of untimely after-hours return calls. 3. The last failure point is a possible lack of understanding of the standards as they are currently provided. ◆ WellCare will re-vamp the Access Standards into a new, user-friendly job aid for distribution via the web portal as well as in personal remediation efforts with the providers.			
Other Evidence/Documentation:			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

Element 1f - Failed Letter_Dr. Daniel Marcadis
Element 1f - Salesforce Screenshot_follow-up with provider
Element 1f - Timely Access All Standards Q1-Q4 2013-2014, Q1 2015_Market Reporting 4.7.15
Element 1f, #3 - draft-New Appointment Access Standards Job Aid May 2015
Element 1f, #3 - Submission of Draft Job Aid to WC Communications Dept 5.19.15

July 2015 Re-review Findings: WellCare continued to monitor providers returning calls after hours. WellCare provided example letters it sent to noncompliant providers when the provider did not meet the call-back time frames in this element. Specifically, during quarter 4, 2014, pediatric providers achieved 88 percent success rate when addressing after-hours returned calls. During quarter 1, 2015, 88 percent of PCPs returned nonurgent calls within the one-hour requirement.

July 2015 Required Actions: WellCare must continue to apply current and new interventions with providers until the goal of 90 percent of its providers addressing urgent calls within 20 minutes and other calls within one hour is met.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

5. Geographic Access: *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

Findings: The CMO provided its corrective action reports for each quarter of the review period. WellCare did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCP
- Specialists
- Dental Subspecialty Providers
- Pharmacies

Required Actions: The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As a result of reviewing the finding of the HSAG EQRO audit, WellCare acknowledges that member	Review GEO Access CAP Report.	Intervention 1: Amy Carr	Intervention 1: 1/21/15 – Staff training

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
access to care in both the urban and rural areas of the State is of the utmost importance and that in areas where deficiencies exist, Network Development is a primary focus. There are 2 possible failure points that we have identified which, if improved upon, could lead to compliance with the geo access standards and ultimately increase member access to care. 1. The first failure point has been the schedule of the Network Development team's review of the network. In the past, the team has reviewed geo access on a quarterly basis. We believe that additional training and more frequent review of network deficiencies will help to identify opportunities where additional providers are needed and could be recruited in to the network. The additional training of the network development team was completed in February 2015 and included the expectation that the geo access report be used as a tool to conduct daily business. In addition, the network development team will begin using an internal tool, produced on a monthly basis, called The Georgia Medicaid Access Compliance Snapshot. Because this report is produced more frequently, the expectation is that deficiencies will be identified more quickly and recruitment of new providers to the network can occur to meet access needs quickly after they are identified. The network development team will continue to work with the PR team to learn about new providers who move in to an area, and they will also continue to assist case managers and		Intervention 2: Amy House	completed Intervention 2: 5/19/15 – Press release about Appling Co. Health Dept. telemedicine partnership emailed to WellCare Communications Dept. Intervention 2: 6/30/15 – Pilot Programs fully implemented.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
member outreach in contracting providers who are needed for specific member care. 2. WellCare has been working with Georgia Partnership for Telehealth since February 2013 in an effort to expand telemedicine access to our members. In reviewing our telemedicine utilization, a possible failure point has been the use of specialized programs promoting the utilization of telemedicine to close access gaps, particularly in rural areas of the state. WellCare is currently in the process of developing pilot programs that promote telemedicine in a school setting, as well as, a partnership with a public health department. The expectation is that broadening the scope of current telemedicine utilization will create access in areas where there is a shortage of either PCPs and/or specialists.			
Other Evidence/Documentation: Element 5 - 0654GEOAccessCAPReportQ115 Element 5 - 0654GEOAccessCAPReportQ314_revised Element 5 - 0654GEOAccessCAPReportQ414 Element 5, Intervention 1 - 4.20.15 GEO Access Meeting Element 5, Intervention 1 - 4.21.15 GEO Access Meeting Element 5, Intervention 1 - 4.22.15 GEO Access Meeting Element 5, Intervention 1 - GA Medicaid Access Compliance Snapshot Report_February 2015 Element 5, Intervention 1 - GMD ACS April 2015 Element 5, Intervention 1 - Staff Training-Geo Access_1.21.15 Element 5, Intervention 1 - Training Agenda-Geo Access_1.20.15 Element 5, Intervention 2 - Echols Co. Health Department (Telemedicine Effort)			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

July 2015 Re-review Findings: WellCare provided its GeoAccess Deficiencies CAP Reports for three quarters during the review period. WellCare did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCP
- Specialists
- Dental subspecialty providers
- Pharmacies

July 2015 Required Actions: WellCare must meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.

Standard III—Cultural Competence

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

4. Provides Plan Summary to Providers: *Contract 4.3.9.3*
The CMO provides a summary of its cultural competency plan to its in-network providers, which includes information on how the providers (i) may access the full plan on the CMO's Web site and (ii) can request a hard copy from the CMO at no charge to the provider.

Findings: WellCare provided its 2013–2014 cultural competency plan for review, and a summary of the cultural competency plan was included in the provider handbook. The 2011–2012 Cultural Competency Plan was available on WellCare's Web site, not the 2013–2014 version.

Required Actions: WellCare must provide the most current edition of the cultural competency plan on the CMO Web site for providers.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Update the version of the Cultural Competency Plan on the Georgia WellCare provider website. 2. Update the Cultural Competency Policy and Procedure documents to include a quality assurance step that confirms the updated plan is submitted to the WellCare Web Team for posting on the provider website following the DCH approval of the updated Plan. 3. Erroneously posted materials will be escalated to the Web Team for immediate correction.	Conduct monthly website audits to ensure all required materials are accurately posted on the website. The WellCare web site is updated daily with new content and materials. Monthly auditing will ensure that required materials are not mistakenly removed as a result of manual changes or system updates. Monthly audits are conducted by Janise Smith and began on 3/1/15.	Intervention 1: Felicia Thomas – updates the plan at least once per year Intervention 2: Janise Smith – maintains the Policy and Procedure document Intervention 3: Christine Stewart – updates website content	Intervention 1: 12/5/14 – Replaced the outdated Cultural Competency Plan on our Website with the current Plan. Intervention 2: 2/15/15 – Updated the Cultural Competency Policy and Procedure Document Intervention 3: Updated as needed

Other Evidence/Documentation:
Element 4, Intervention 1_ga_caid_culturalcompplan_eng_2014
Element 4, Intervention 1_Screenshot - Cultural Competency Plan
Element 4, Intervention 1_Screenshot2 - Cultural Competency Plan
Element 4, Intervention 2_GOV18PD-007 Cultural Competency Plan
Element 4_GA Website Audit Checklist 032015

July 2015 Re-review Findings: The WellCare website included the most current version of the cultural competency plan for providers.

July 2015 Required Actions: None.

Standard IV—Coordination and Continuity of Care

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

7. Protects Member Privacy: *45 CFR 160 and 164, subparts A and E; Contract 4.8.17.6*
The CMO implements procedures to ensure that in the process of coordinating care, each member's privacy is protected, consistent with the confidentiality requirements.

Findings: WellCare provided policies and procedures that met all requirements of this element. All WellCare procedures ensured that member privacy was protected in a telephonic setting. It was noted during the file review that a case manager met with a member in a public setting. While the case manager documented that she asked the member all privacy-related questions to verify the member's identity, HSAG found no clear documentation that the case manager protected the member's privacy during the discussion, i.e., sitting away from people, meeting in a closed room, etc.

Required Actions: When the case manager meets with a member in the community, the case manager must ensure that the member's privacy is being protected. Ensuring that the individual is the actual member is one part of safeguarding privacy. The CMO must identify practices that will ensure member privacy when the case manager is meeting with the member in a public place and discussing PHI.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As noted in the HSAG "Findings" above, WellCare does meet all member privacy protections through telephonic settings. However, HSAG identified that there were no documented protections in place when meeting with a member in a public setting. <u>Intervention A: Mandatory General Training on HIPAA Privacy Requirements</u> 1. All existing staff and new hire staff must complete two mandatory eLearning modules in the Learning Management System (LMS) called WellCare University with a passing score of 85%, within 30 days of module assignment for existing staff and within 30 days of new hire date. They are HIPAA Introduction Safeguarding PHI and HIPAA Compliance 2014. 2. eLearning completion compliance tracked by WellCare University LMS and Compliance Director. If modules not completed, email	<u>Intervention A: HIPAA Public Privacy Corporate Compliance Monitoring and Oversight</u> 1. eLearning completion compliance tracked by WellCare University LMS and Compliance Director. 2. If modules not completed, email notification reminders are forwarded to employee, their supervisor, and to the Director, VP, Sr. Medical Director and State President at intervals of 21, 14 and 7 days prior to completion due date. 3. Failure to attain 85% or complete HIPAA training modules on time results in a 7 day suspension of duty, written reprimand and can progress to termination. <u>Intervention B: HIPAA Public Privacy Compliance Monitoring and Oversight</u> Training rosters will validate training has been completed for existing and new hire staff.	<u>Intervention A</u> ◆ LaDonna Battle (Content Approver) ◆ Brenda Richardson (Content Trainer) ◆ Kenny Ensley (Compliance Monitoring) <u>Intervention B</u> ◆ LaDonna Battle (Content Approver) ◆ Brenda Richardson (Content Trainer) ◆ Case Management Supervisors: Mary Burt, Natalie Davis, Akan Iyamu, Tiffany Weaver,	<u>Intervention A</u> ◆ 9/25/14: Existing and New Hires classes completed HIPAA eLearning Modules ◆ 10/20/14: First New Hire class completed HIPAA eLearning modules. ◆ 11/24/14: Second New Hire class completed HIPAA eLearning modules.

Standard IV—Coordination and Continuity of Care

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

notification reminders are forwarded to employee, their supervisor, and to the Director, VP, Sr. Medical Director and State President at intervals of 21, 14 and 7 days prior to completion due date. 3. Failure to attain 85% or complete HIPAA training modules on time results in a 7 day suspension of duty, written reprimand and can lead to termination. <u>Intervention B: Implementation of HIPAA Public Privacy Requirements</u> 1. Updated HIPAA compliance templates to include a new "Meeting Member in a Public Place" template to prompt CM of environmental factors to monitor/document during a public visit and created training outline. 2. Training for all existing and new hire staff given on How to Protect Member Privacy while in a Public Place and on new documentation template and inclusive of the following elements: ◆ Administrative, technical and security safeguards; ◆ Validation of HIPAA identifiers to confirm the member before starting the interview/visit; ◆ Selection of a meeting location which provides for privacy outside of general traffic in the environment; ◆ Securing agreement from the member to maintain dialog in low tones to minimize audible transfer of the conversation; ◆ Use of privacy screen when laptop is in use;	<u>Intervention C: Supervisor Audits</u> 1. Monitoring and oversight of the Case Manager's (CM) compliance occurs through: a) Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager is evaluated on the elements above (Intervention B-2 a-h) for the protection of member privacy. b) Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart Review Tool. Passing is 90%. The documentation is evaluated to ensure member privacy has been recorded. 2. If observations uncover a CM not properly protecting member privacy, immediate corrective intervention occurs followed by post visit remediation. 3. Continued non-compliance and failed audits will be addressed via: a) Formal verbal warning in 1:1 coaching with Supervisors during the post observational or audit review; b) 1:1 coaching sessions, as needed, with the Senior Health Services Trainer to address areas of improvement , with reports to Supervisors as to progress; and	Sharon Libby (Content Facilitators) <u>Intervention C</u> ◆ Case Management Supervisors: Mary Burt, Natalie Davis, Akan Iyamu, Tiffany Weaver, Sharon Libby (Process Auditors & Compliance Coaching) ◆ Brenda Richardson (Performance Training) <u>Intervention D</u> ◆ Ericka Searcy, (Reports Monitoring) ◆ Brenda Richardson, (Performance Training) ◆ Rosa Rivera-Lozada- (Outcomes Monitoring) ◆ LaDonna Battle, (Outcomes Monitoring)	◆ 1/9/15: Third New Hire class completed HIPAA eLearning modules. ◆ Ongoing Process: All future new hires will complete eLearning modules within 30 days of hire date. ◆ August 2015: eLearning content will be reviewed for annual updates as indicated and approved by clinical leadership. ◆ Annually in Q4: all staff will be auto assigned Mandatory renewal of updated HIPAA eLearning modules. Begins 10/20/15.

Standard IV—Coordination and Continuity of Care

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

◆ Maintaining control of the laptop at all times and ensuring the laptop is positioned away from public viewing to others passing by; Shielding paper documents that may be used during the discussion; and ◆ Ability to stop the visit or reschedule if the environment is not conducive to member privacy or safety. <u>Intervention C: HIPAA Public Privacy Compliance Monitoring and Oversight</u> 1. Monitoring and oversight of the Case Manager's (CM) compliance occurs through: a) Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager is evaluated on the elements above (Intervention B-2 a-h) for the protection of member privacy. b) Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart Review Tool. Passing is 90%. The documentation is evaluated to ensure member privacy has been recorded. 2. If observations uncover a CM not properly protecting member privacy, immediate corrective intervention occurs followed by post visit remediation. 3. Continued non-compliance and failed audits will be addressed via:	c) Progressive Standard HR performance action plans including written, final written and termination. <u>Intervention D: Tracking and Monitoring</u> 1. The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. 2. The trainer will address any group noncompliance trends with HIPAA Privacy Refresher training in Regions tracking <90% compliance. 3. Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring: ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance	◆ Dr. John Johnson, (Outcomes Monitoring) ◆ Ted Webster and Kenny Ensley, (Compliance Monitoring)	<u>Intervention B</u> ◆ 11/26/14: Template written and approved for implementation. ◆ Completed Regional Training for 64 Existing staff & New Hires: ▪ 12/2/14: Atlanta North and Non Metro ▪ 12/3/14: GA North Central and East GA ▪ 12/4/14: Atlanta South ▪ 12/9/14: Southwest and South East GA ▪ 12/22/14: Multiple regional new hire staff completed ◆ August 2015: template will be reviewed for

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a) Formal verbal warning in 1:1 coaching with Supervisors during the post observational or audit review; b) 1:1 coaching sessions, as needed, with the Senior Health Services Trainer to address areas of improvement , with reports to Supervisors as to progress; and c) Progressive Standard HR performance action plans including written, final written and termination. <u>Intervention D: Tracking and Monitoring</u> 1. The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. 2. The trainer will address any group noncompliance trends with HIPAA Privacy Refresher training in Regions tracking <90% compliance. 3. Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring: ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance			annual updates and approved by clinical leadership ◆ Ongoing Process: all new hire training classes will include Privacy template and Public Privacy training curriculum. <u>Intervention C</u> ◆ 12/22/14: Began CM observational and documentation audits for compliance with : ▪ Documenting using the new "Meeting Members in Public Setting" Template. ▪ Adherence to the guidelines on how to maintain privacy in

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			pubic place guidelines. <u>Intervention D</u> ◆ 3/15/15: Begin HIPAA Compliance Trend Report ◆ Ongoing Process: content and updated performance training repeated as needed ◆ Ongoing Process: as indicated by monthly HIPAA Compliance Trend reports ◆ YEAR END REVIEW: effectiveness of Privacy Program to be included in Program Evaluation.
Other Evidence/Documentation: Intervention A - GA HIPAA Compliance Training Roster 7.2014-5.2015 Intervention B - Doc Template - Meeting Member in Public Setting Intervention B - Sign-In Sheet - ATL-N-ATL-S-Non-Metro 12.2.14-12.4.14 Intervention B - Sign-In Sheet - Central 12.3.14			

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Intervention B - Sign-In Sheet - SE 12.9.14 Interventions B-C-D -CCM & OB High Risk Audit Tools Interventions B-C-D -CCM Audit Tool Description 4-12-15 Final
July 2015 Re-review Findings: WellCare provided an updated HIPAA policy that reflected procedures to be used by case managers when meeting with members in a public setting. The CMO's new HIPAA compliance template included a procedure titled Meeting Member in a Public Place." These procedures were used by the case manager to identify environmental factors that could impact the case manager's ability to maintain the member's privacy. The CMO provided HIPAA training online for all current and new hire case managers and monitored use of these skills with direct supervision and review of documentation.
July 2015 Required Actions: None.

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9. Case Management—Components: *Contract 4.11.9.1-2*

The CMO's case management system emphasizes prevention, continuity of care, and coordination of care, and includes the following:

c. Development of a care plan.

Findings: During the case file review, HSAG identified that care plans were being completed during the identified timelines. However, the care plans did not address member-identified needs and concerns. HSAG determined that the identification of goals and interventions was based on the case manager's assessment and not on member-reported issues. During the case file reviews WellCare staff indicated that a member's agreement to the care plan represented the care plan being member centered as opposed to actual member contribution and prioritization.

Required Actions: Ensure the care plan is member-centered and addresses the problem area or concerns. Goals need to be individualized (based on reported member needs), measurable, realistic, and attainable by target dates.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
WellCare's enhanced "Model of Care", transitioned in October 2014, is founded on the principle that the goal of case management is to identify the member's individual care needs based on an appraisal of medical, social, behavioral and community resources available to empower self-care management. This support system is designed to ensure the member's care plan is specific to that individual based on their readiness for change, receptiveness for support, and capacity to invest in their individualized plan of care. <u>Intervention A: Training on Member Engagement and Assessment Skills</u> 1. To ensure the enhanced Model of Care founding principles are achieved, all WellCare Field Case Managers, Care Coordinators, and Community Health Workers completed two prerequisite eLearning Modules for Motivational Interviewing in WellCare University:	<u>Intervention A & B: Compliance & Monitoring</u> Training rosters will validate training has been completed for existing and new hire staff. <u>Intervention C: Member Centric Care Plan Compliance Monitoring and Oversight</u> 1. Monitoring and oversight of the Case Manager's (CM) compliance occurs through two methods: a) Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager skills are evaluated in assessment and needs identification, engaging member in setting goal priorities and agreement on member focused customized care plan. b) Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart	<u>Intervention A</u> ◆ LaDonna Battle (Content Approver) ◆ Brenda Richardson (Content Facilitator) ◆ Ramona Mouhourtis (Content Facilitator) ◆ Marlo Mellis, (Certified MI Trainer) ◆ Brenda Richardson	<u>All Interventions</u> ◆ March 13, 2015

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Fostering Behavioral Change and Motivational Interviewing (MI); and Motivational Interviewing (MI). 2. All staff received 8 hours of instructor led Motivational Interviewing (MI) training and role plays which included a series of skills practice designed to: ◆ Develop and maintain rapport with the member; ◆ Identify the member's core motivational issues; ◆ Reflect and empathize with these issues; ◆ Explore the line of reasoning for each issue and; ◆ Invite the member to draw a new conclusion. 3. All CM's are trained in conducting medical interviews using an assessment and to enter Member responses WellCare's medical management system (EMMA). Using branching logic, this system produces actionable intervention recommendations within an NCQA compliant care plan. (NCQA Standard QI 7, Element D-Individualized Care Plan) Guidelines are as follows: a) CM uses information from assessment and other sources, to develop a member focused customized comprehensive care plan b) Care plan includes information on actions or interventions and their duration that a CM Interdisciplinary Care team (ICT) takes to address member's medical, BH, functional and support needs. CM communicates information from providers and other ICT team with the member. c) The CM documentation shows that the ICT develops a care plan for each member that includes: i. Prioritized goals that reflect member/caregiver preferences and involvement; ii. Self-Management plan/ identification of barriers;	Review Tool. Passing is 90%. The documentation is evaluated to ensure member participation in customized care plan development has been recorded using the "Validating Member Participation in Care Plan" template. <u>Intervention D: Tracking and Monitoring</u> 1. The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. 2. The trainer will address any group noncompliance trends with HIPAA Privacy Refresher training in Regions tracking <90% compliance. 3. Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring. ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance	(Content Trainer) ◆ Jennifer Hopkins (Content Trainer) ◆ Case Management Supervisors: Mary Burt, Natalie Davis, Akan Iyamu, Tiffany Weaver, Sharon Libby (Content Facilitators) <u>Intervention B</u> ◆ LaDonna Battle (Content Approver) ◆ Brenda Richardson (Content Trainer) ◆ Case Management Supervisors: Mary Burt, Natalie Davis, Akan Iyamu, Tiffany Weaver, Sharon Libby (Content Facilitators)	

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iii. Schedule for follow-up; and iv. Process to assess member progress. d) Based on the members specific needs the care plan also identifies; i. Resources to be utilized and appropriate level of care; ii. CM facilitate referral to other ICT providers on behalf of member; iii. Planning for coordination of care including transitions and transfers and identifying how and when ICTs follow-up with a member after referral to a health resource; and iv. Collaborative approaches used to build member safety net. e) The member is afforded the right to accept, decline or customize their goals based on preference. f) The CM supports the member in the finalization of goals that are realistic, measurable and can be reasonably attained within the specified time frames. g) The member centered goals are shared with the provider and integrated ICT for review and alignment with member directed supportive interventions. h) As the member progresses in goal attainment, additional goals may be added at the discretion of the member with assistance from the CM. <u>Intervention B: Implementation of Member Centric Care Plan Template</u> 1. Update the Clinical care plan process and created Documentation Template "Validating Member Participation in Care Plan" to reflect the member's		<u>Intervention C</u> ◆ Brenda Richardson (Performance Training) ◆ Case Management Supervisors: Mary Burt, Natalie Davis, Akan Iyamu, Tiffany Weaver, Sharon Libby (Content Facilitators & (Compliance Coaching) <u>Intervention D</u> ◆ Ericka Searcy (Reports Monitoring) ◆ Brenda Richardson (Performance Training) ◆ Rosa Rivera-Lozada- (Outcomes Monitoring)	

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engagement in care plan process and allow for Member-Reported issues to be identified by documenting: ◆ CM reviewed care plan with member ◆ Member directed and selected goals related to their specific needs and concerns and determined which are to be addressed first ◆ Member selected other goals to be addressed at a later date ◆ Final member focused care plan to be mailed to member and faxed copy to Providers for review and input 2. Training for all existing and new hire staff on use of the new member centric care plan documentation template <u>Intervention C: Member Centric Care Plan Compliance Monitoring and Oversight</u> 1. Monitoring and oversight of the Case Manager's (CM) compliance occurs through two methods: a) Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager skills are evaluated in assessment and needs identification, engaging member in setting goal priorities and agreement on member focused customized care plan. b) Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart Review Tool. Passing is 90%. The documentation is evaluated to ensure member participation in customized care plan development has been recorded using the		◆ LaDonna Battle, (Outcomes Monitoring) ◆ Dr. John Johnson, (Outcomes Monitoring) ◆ Ted Webster and Kenny Ensley, (Compliance Monitoring)	

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"Validating Member Participation in Care Plan" template. Intervention D: Tracking and Monitoring 1. The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. 2. The trainer will address any group noncompliance trends with HIPAA Privacy Refresher training in Regions tracking <90% compliance. 3. Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring. ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance			
Other Evidence/Documentation: CM Comprehensive Resource Guide 2.0 Edition, p. 158-176 Developing a Care Plan Intervention A1 - Fostering Behavioral Change Transcript Rpt 0914-0515 Intervention A1 - MI Online Transcript Report 0914-0515 Intervention A2 - MI Participant Guide 9-17 Intervention A2 - MOC 2.0 Refresher & MI Classes 12.22.15-2.13.15 Intervention A3 - NEW HIRE TRAINING CALENDAR 12.8.14 Intervention B1 -DocTemplatesMOC2.0(Rev12.31.14) p.12-13,17,22 Intervention B2 - Sign in Sheet- Central & East 12.3.14 Intervention B2 - Sign-In Sheet - SE 12.9.14 Intervention B2- sign in sheet-Atlanta North, South and Non Metro Interventions C-D - CCM Audit Tool Description 4-12-2015 Final Interventions C-D -Audit Reviewer Eval_CCM & OB High Risk Audit Tools			

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July 2015 Re-review Findings: WellCare updated its "Model of Care" in October 2014 with a focus on "identify [identifying] the member's individual care needs based on an appraisal of medical, social, behavioral and community resources available to empower self-care management." During the on-site interview CMO staff reported that training had been completed with all care managers and that all incoming care managers were being trained on the development of member-centered care plans. WellCare also provided the training guides and training sign-in sheets which supported the report that training had been completed.
July 2015 Required Actions: None.

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9. Case Management—Components: *Contract 4.11.9.1-2*

The CMO's case management system emphasizes prevention, continuity of care, and coordination of care, and includes the following:

h. Follow-up.

Findings: During the case management file reviews, HSAG identified that the care plan and a letter explaining that the member was enrolled in case management were faxed to the member's PCP, although during file reviews HSAG noted that the care plan was not always provided in a timely manner. During file reviews HSAG noted lack of follow-up with members to ensure access to and receipt of needed services, such as assistance with hypertension management, follow-up for a failed glucose tolerance test, and lack of acknowledgement or response to a parent's inquiry. For all case files reviewed, no documented outreach to members' PCPs or specialists other than faxing of the care plan was noted.

Required Actions: Continue to fax the member's care plan to the PCP and specialists, and ensure that the care plan is faxed in a timely manner for all members. Reach out to the members' providers to gain input for the assessment and care plans, and to ensure members are following through with provider recommendations for care. Follow up with members in a timely manner when they or their family/guardian/caregiver leave a message for the case manager. If the case manager is out of the office or unavailable, the case manager's team members should reach out to address the member's needs.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As noted in the HSAG "Findings" above, WellCare does fax the member care plans to the PCP and Specialists. However, HSAG identified this was not always accomplished in a timely manner. <u>Intervention A: Communication of Care Plans</u> 1. On 12/19/14, the WellCare Provider Advisory Council was asked to provide feedback on the preferred method of communication for care plan engagement, distribution, and receipt of feedback. a. The council providers overwhelmingly advised that fax or email transmissions, as well as, accessibility of the member record on the provider portal were all preferred communication methods. They did not support being required to sign-off on the care plan or	<u>Intervention A: Provider Advisory Feedback</u> 1. Presentation of the topic to Provider Advisory Council 2. Integration of the outcome into the operational process – process and training 3. Care Plan integration inquiry through new medical management platform (MMP). 4. Documentation Template updated <u>Intervention B: Discharge Planning</u> 1. Integration of the operational process – process and training <u>Intervention C: Case Manager Contact</u> 1. Integration of the operational process into new hire training.	<u>Intervention A & D:</u> LaDonna Battle <u>Intervention B & C:</u> Margaret Pryce	<u>Intervention A:</u> ◆ 12/19/14 – Obtain provider feedback on best alternatives to communicate member care plan. ◆ 12/2/14-12/4/14 – Trained Care Management Staff on ways to solicit input from the Member & Provider

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receiving daily telephone calls to the office to advise of routine coordination issues that do not require provider authorization. The Council providers indicated that complex care coordination requests could be achieved by accompanying the member to their next office visit. b. Based on this input from the Provider Advisory Council, the Care Managers were educated on: Ensuring care plans were comprehensive and submitted within 30 days of completion to the provider via fax, email, or mail; securing permission from the member to attend appointments to discuss the treatment plan with the provider and member/caregiver in an effort to support the medical management plan through care plan interventions; when to convene and ICT with provider participation and escalated Sr. Medical Director support, if applicable. c. Begin exploration of information system capability to apply the member care plan to the member, provider, and/or mobile application portals for accessibility and transparency to the stakeholders. <u>Intervention B: Discharge Planning</u> 2. HSAG instructed WellCare to contact the provider to obtain their input and ensure the member is following through with care recommendations. a. In December 2014, WellCare enhanced the Discharge Follow-up Program by re-directing			◆ 6/9/15- Use Case initiated with MMP Technology team for care plan exposure on member/provider portals. ◆ 11/26/14 - Documentation Template updated <u>Intervention B:</u> 12/1/14 – Created workflows for the Member Engagement Welcome Home Team to use for their Discharge Follow-up Program. <u>Intervention C:</u> This is an ongoing intervention that has been in place since May 2012. All new hires have been educated on this process.

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onsite nurses to high volume hospitals and built out a new behavioral health welcome home program to ensure Members receive needed services following their hospital discharge. b. This Program is administered through our "Member Engagement Welcome Home Team". HSAG also instructed WellCare to follow-up with members in a timely manner after the member attempts to contact the Case Manager. <u>Intervention C: Case Manager Contact</u> 3. The member is given the contact numbers for their Case Manager upon enrollment to case management, which includes the Case Manager's business card with telephone contact information, and the toll-free Case Management contact number. a. If the Case Manager is not available, then the member is instructed to call the toll-free line for a live representative for our health services member engagement team. b. The representative will attempt to resolve the member's question/issue or will take a detailed message and forward to the Case Manager and the supervisor for follow-up within the same business day. c. A separate member of the Care Team may outreach to the member to ensure a timely response.			

Other Evidence/Documentation:
Developing Care Plan
Welcome Home Behavioral Criteria
Intervention A - Doc Templates MOC 2.0(Rev12.31.14), p. 13

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Intervention A - NEW HIRE TRAINING CALENDAR 12082014 Intervention A - Provider Advisory Board Minutes 12.19.14 Intervention B - WH Discharge Follow Up Screening Process Intervention C - IB-Member or Provider Calling for Assigned CM-SW
July 2015 Re-review Findings: WellCare provided detailed documentation of updated processes for delivering member care plans to providers, care plan monitoring, and ensuring timely responses to member inquires. In review of these process improvements and policy changes, HSAG noted that these implemented changes should provide care managers with greater monitoring of member healthcare services to ensure opportunities for coordination and continuity of care.
July 2015 Required Actions: None.

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12. Discharge Planning: *Contract 4.11.11*
The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: WellCare provided documentation that outlined the CMO's current discharge program. During the interview, staff identified that the CMO was moving toward utilizing the Coleman Model for Discharge as the foundation for its discharge process. Staff reported that the CMO had conceptualized a hybrid of the Coleman Model for Discharge that better aligns with current resources. During the review of case management files, staff described how the UM team developed and implemented the discharge planning process. However, during the file review, for cases where the member was hospitalized, no discharge planning was noted.

Required Actions: WellCare should ensure discharge planning is communicated between UM and CM staff and is documented for all members in case management to ensure coordination of care.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Meeting with (UM/TUM) Utilization Management/Transition Management for Discharge Planning to review and update discharge planning process between inpatient care setting and the field. 2. Implemented the interdepartmental discharge planning process as follows: ◆ Using WellCare's Medical Management system (EMMA) UM teams monitor daily hospital census for hospitalized active enrolled members in the Field Case Management Program Member is open in Case Management and is hospitalized. ◆ When Active member in Case Management is identified, UM Nurse will document inpatient notification in a TUM note in EMMA (Transitional UM)UM Nurse will notify the Case Manager via EMMA email system (Qmail) that the member, who is already enrolled in Case Management, is in the hospital.	Tracking and Monitoring: UM Rounds are tracked on the Action Registry for weekly progress actions and referral assignments. ◆ The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. ◆ PCP/Specialist follow-up and follows process to notify CM s and discuses in weekly ICT meetings ◆ The trainer will address any group noncompliance trends with Discharge Planning Process training in Regions tracking <90% compliance ◆ Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field	Intervention 1 ◆ LaDonna Battle (Content Approver) ◆ Mary L. Welch (Content Approver) Intervention 2 ◆ Angel Pellot (Intergroup Facilitator) ◆ Akan Iyamu & Natalie Davis (Intergroup Facilitator) ◆ CM Supervisors: Mary Burt, Natalie Davis,	Intervention 1 ◆ 12/1/14: Final Discharge Planning process and approval meeting Intervention 2 ◆ 12/1/14: Email notification with Step Action process for discharge planning sent to all CM supervisors. ◆ 12/3/14 and 12/4/14:

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◆ Utilization Nurse will review the d/c plans and enter a Transition Care Management (TCM) Note providing review findings and/or collaboration needs "reviewed the d/c plan, no further recommendations at this time", 'recommend additional resources'. ◆ Case Manager and UM nurse will conduct transitional handoff via phone or use (EMMA as needed for review and clarification of discharge planning , anticipated discharge dates and referrals for post discharge Care Management or community resources needed. 3. Initiate Collaborative Interdisciplinary Care Team (ICT) Meetings: ◆ The goal of the UM Nurses being part of the GA ICT configuration is to leverage synergy and collaboration to proactively assure member's needs are met as they transition from inpatient treatment back to their home, community and/or alternate setting. Collaborative discussions and interventions will promote optimal heath, effective and efficient uses of available resources, and reduce the potential for complications and/or re-admissions. ◆ Transition of Care Rounds is conducted weekly by the Medical Director. UM team monitors Complex cases for readmissions, subsequent ER visits. CM and UM review members in NICU, LOS>30days, Skilled Nursing, P4HB and members with complex discharge are reviewed to discharge referrals to Case Management.	Health Services and Senior Medical Director for outcomes monitoring ▪ Outliers <90% on audits ▪ Quarterly trends based on State, Regional compliance	Akan Iyamu, Sharon Libby, Tiffany Weaver (Content Facilitators) ◆ Kerry Sullivan (process facilitator) <u>Intervention 3</u> ◆ Kerry Sullivan ◆ UM CM Supervisors; Mary Burt, Natalie Davis, Akan Iyamu, Sharon Libby, Tiffany Weaver (Content & Process Facilitators) ◆ Dr. John Johnson (Lead) <u>Intervention 4</u> ◆ Ericka Searcy (Reports Monitoring) ◆ Brenda Richardson (performance training)	Discharge Planning for Integrated UM/CM Staff ICT meetings in all <u>Intervention 3</u> ◆ 11/19/14: Supervisors notified that UM teams in some regions would begin attending ICT meetings. ◆ 12/3/14 and 12/4/14: UM team members began attending Field Interdisciplinary Care Team Meetings via teleconference call. ◆ 1/8/15: UM rounds initiated; Action Rounds started <u>Intervention 4</u>

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◆ UM team members attend weekly Interdisciplinary Care Team Meetings to discuss High risk members, enrolled or to be referred to Complex case management for discussion of specific discharge planning needs with assigned Case manager in the region where member resides. 4. Tracking and Monitoring: UM Rounds are tracked on the Action Registry for weekly progress actions and referral assignments. ◆ The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. ◆ PCP/Specialist follow-up and follows process to notify CM s and discuses in weekly ICT meetings ◆ The trainer will address any group noncompliance trends with Discharge Planning Process training in Regions tracking <90% compliance ◆ Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring ▪ Outliers <90% on audits ▪ Quarterly trends based on State, Regional compliance		◆ Rosa Rivera-Lozada (Outcomes Monitoring) ◆ LaDonna Battle (Outcomes Monitoring) ◆ Dr. John Johnson (Outcomes Monitoring) ◆ Ted Webster and Kenny Ensley, (Compliance Monitoring)	◆ 3/15/15: Begin Discharge Planning Trend Report ◆ Ongoing Process: content and updated performance training repeated as needed ◆ Ongoing Process: as indicated by monthly Discharge Planning Trend reports ◆ YEAR END REVIEW: effectiveness of Monitoring and addressing needs of members discharged from inpatient care to be included in Program Evaluation.
Other Evidence/Documentation: TUM-TCM STEP ACTION PROCESS			

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
Intervention 2 - Discussion Topics_Central Pod Meeting 12-3-14 Intervention 2 - TUM-DCP Communication Examples Intervention 3 - UM Rounds Meeting Minutes 4.30.15 Intervention 4 - CCM Audit Tool Description 4-12-2015 Final Intervention 4 - GA UM Rounds Tracker 4.30.15 Intervention 4 - Summary Audit Reviewer Eval-CCM&OB High Risk Audit Tools
July 2015 Re-review Findings: WellCare developed and implemented comprehensive changes to its discharge planning process. During the on-site interview CMO staff shared an "interdepartmental discharge planning process" that allowed for greater communication between utilization management and case management staff. The CMO conducted an internal audit after implementation of this process improvement. In review of this documentation, HSAG noted an increase in early outreach to members after discharge.
July 2015 Required Actions: None.

Standard V—Coverage and Authorization of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

14. Timelines—Expedited Authorizations Decisions and Notifications: *42 CFR 438.210(d)(2)(i); Contract 4.11.2.5.2*

If the provider indicates, or the CMO determines, that following the standard timeframes could seriously jeopardize the member's life or health, the CMO makes an expedited authorization determination and provides notice within 24 hours.

Findings: During staff interviews, it was noted that all pre-service requests that were marked urgent were processed within the 24-hour time frame. Several meeting minutes noted expedited requests that were not meeting the turnaround times.

Required Actions: The CMO needs to review the current process for an expedited review request. It was noted that the CMO allowed and approved Therapy Network of Georgia's (TNGA's) authority to re-classify urgent requests as routine if not medically indicated. The CMO needs to adhere to the definition of an expedited review and ensure it is consistently applied both internally and by its delegates. The CMO needs to ensure timeliness of expedited service requests.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. WellCare to notify Therapy Network of Georgia (TNGA) to process all expedited prior authorization requests within 24 hours without the option of "downgrading" to a non-expedited request. 2. TNGA to update policies and performance standards documents. 3. WellCare Intake Agents will be formally coached on accurate data entry for Expedited authorization requests. 4. Enhance Step Actions for the WellCare Intake Agents to insure proper data entry elements are captured.	1. To ensure policy changes are being adhered to, WellCare will monitor TNGA's expedited authorization timeliness totals for the months of January through June 2015, through the GMCF PA Portal Adhoc Report. Reports are reviewed by and feedback is provided to TNGA by Yesenia Stokes. ◆ 2/16/15 – Review the first TNGA Adhoc Report & notify TNGA of findings. ◆ 3/16/15 – Review the second TNGA Adhoc Report & notify TNGA of findings. ◆ 4/15/15 – Review the third TNGA Adhoc Report & notify TNGA of findings. ◆ 5/15/15 – Review the fourth TNGA Adhoc Report & notify TNGA of findings. ◆ 6/15/15 – Review the fifth TNGA Adhoc Report & notify TNGA of findings. ◆ 7/15/15 – Review the sixth TNGA Adhoc	Intervention 1: James Johnson Intervention 2: Marty Bilowich Intervention 3: Hillary Puleo Intervention 4: Bill Gaither	Intervention 1: 12/11/14 – Notified TNGA to revise process. Intervention 2: 1/8/15 – TNGA updated policy UM-70037 & Timeliness Standards. Intervention 3: 12/15/14 – Develop Coaching Form to communicate data entry errors to the WellCare Intake Team. Intervention 3: 12/30/14 – Intake Agents received coaching on accurate data entry, based on errors identified the prior week

Standard V—Coverage and Authorization of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
	Report & notify TNGA of findings. ◆ 7/17/15 – Determine need for continued monthly monitoring of TNGA performance and the need for additional corrective actions. 2. Perform ongoing Quality Assurance Testing on WellCare Intake Agent authorization classifications. This is conducted by Hillary Puleo.		(12/22/14). Intervention 4: 1/12/15 – Step Actions were enhanced to guide Intake Agents to properly enter the classification of authorization cases as either Standard or Expedited as requested by the provider.

Other Evidence/Documentation:
Element 14, Interventions 1 & 2 - (92) Administrative Denials
Element 14, Interventions 1 & 2 - UM-70037 Utilization Timeliness Standards
Element 14, Intervention 3 - Examples of Misc
Element 14, Intervention 3 - Intake Coaching Form
Element 14, Intervention 4 - BH-Triaging a Fax Request
Element 14, Evaluation 1 - TNGA April Expedited Evidence_Random Sampling
Element 14, Evaluation 1 - TNGA February Expedited Evidence_Random Sampling
Element 14, Evaluation 1 - TNGA January Expedited Evidence_Random Sampling
Element 14, Evaluation 1 - TNGA March Expedited Evidence_Random Sampling
Element 14, Evaluation 1 - TNGA May Expedited Evidence_Random Sampling
Element 14, Evaluation 2 - Fax Audit Form
Element 14, Evaluation 2 - Performance Standards Updated Quality
Element 14, Evaluation 2 - Phone Audit Form
Element 14, Evaluation 2 - Tampa Phone and Fax Audit Reports 2015

July 2015 Re-review Findings: HSAG reviewed all documentation provided by the CMO. The training outlined the data entry process for expedited requests, and the CMO's policy reflected current procedures for handling an expedited review request. During the on-site interview WellCare staff reported that the Therapy Network of Georgia (TNGA) updated policies and performance standards documents to reflect the "processing of all expedited prior authorization requests within 24 hours without the option of 'downgrading' to a non-expedited request." Additionally, CMO intake staff members were trained on data entry of expedited authorization requests to ensure information was entered into the system correctly.

July 2015 Required Actions: None.

Standard V—Coverage and Authorization of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

17. Notice of Adverse Action: *42 CFR 438.210(c); Contract 4.14.3.2*

The CMO notifies the requesting provider in writing and gives the member written notice of any CMO proposed decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Findings: During review of denial files, it was noted that a member denial letter was not issued for a pharmacy request. There was evidence of a member pharmacy denial letter in the oversample, which was for a specialty drug.

Required Actions: The CMO must ensure that members are notified of any denial of service, including pharmacy.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
During HSAG's onsite review, WellCare Pharmacy staff discovered they had mistakenly deemed "preferred drug alternative" decisions as non-denials and therefore, had not been issuing Notice of Action letters to members. WellCare's Pharmacy Team updated the system that generates pharmacy letters for action code RXMDLD (deny for covered alternatives), so that all members receive denial letters even when preferred alternatives are offered.	Pharmacy Notice of Action Letter Testing was completed on 12/10/2014 to ensure process worked correctly before full deployment.	◆ Ginny Yates ◆ Roberta Phillips	◆ 11/18/14 – Pharmacy Ops notified of process update ◆ 12/16/14 – New process deployed

Other Evidence/Documentation:
Element 17 - 20RX-020-PR-001 Medicaid Denial Letters Procedure
Element 17 - NOA Denied for Preferred Letter

July 2015 Re-review Findings: WellCare provided documented changes to its notification process and the sample denial notification from the pharmacy system, which indicated that all members were provided denial letters even when preferred alternatives were available.

July 2015 Required Actions: None.

Standard V—Coverage and Authorization of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

24. Notice of Action—Decisions Not Reached Within the Required Timeframes: *42 CFR 438.404(c)(5) and (6); Contract 4.14.3.4.8*

For both standard and expedited authorization decisions not reached within the required timeframes according to 4.11.2.5, the CMO mails the notice of action on the date the timeframe expires, as this constitutes a denial and is thus an adverse action.

Findings: The written documentation indicated that an adverse decision was rendered when the review time frame ends. During interviews, staff indicated that a service request would be approved if the time frame had expired.

Required Actions: The CMO must mail an NOA on the date of an expired time frame, indicating an adverse action.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
During HSAG's onsite review it was noted that authorization decisions were not issued Notice of Action (NOA) letters on or before the end of the allowed review time frames. 1. Should we reach the final day, within the timeliness standard, the member will be sent a letter detailing that we failed to meet our turnaround times, appeals and grievance information, and an explanation that the authorization was approved. This will be monitored daily via the held and productivity reports. 2. Update UM Prior Authorization Step Actions to require a Notice of Action letter to be sent no later than on the date the timeframe expires.	The Georgia Held Report is generated and reviewed three times a day to ensure compliance with the turn-around-times (TAT).	◆ Cindy Hankin ◆ Angel Pellot	◆ 12/30/14 – Updated UM Prior Authorization Step Actions – A Notice of Action letter is sent on the date timeliness is set to expire, but prior to the actual expiration, if no previous action had been taken.

Other Evidence/Documentation:
Element 24, Interventions 1&2 - GA MEMBER LETTER 3-2015
Element 24, Interventions 1&2 - OUTPATIENT SAT GA MEDICAID NOA
Element 24, Evaluation Method - Georgia Held Report_TAT_061015_4PM

July 2015 Re-review Findings: On 12/30/2014, WellCare implemented changes to its process of sending a notice of action. The new process ensured that members were sent an NOA on or before the end of the allowed review time frames. The CMO provided the Georgia Held Report, which was generated by CMO staff three times per day; this report detailed the CMO's compliance with NOA turnaround times.

July 2015 Required Actions: None.

Standard I—Practice Guidelines

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

6. In order to ensure consistent application of the guidelines, the CMO encourages providers to utilize the guidelines and measures compliance with the guidelines until 90 percent or more of the providers are consistently in compliance.

Findings: WellCare provided its 2014 preliminary clinical practice guideline (CPG) compliance results, which indicated that providers were still not compliant with the CPG goal.

Required Actions: WellCare still needs to improve CPG compliance until 90 percent of the CMO's providers comply with its CPGs.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Last year, WellCare adopted a biannual rapid cycle monitoring program for those CPGs that did not meet the 90% compliance threshold. This program did not result in an increase of CPG compliance. Further drill-down revealed that the CPGs for the management of diabetes attributed to the decline in our overall score. These findings have prompted WellCare to adjust the existing biannual rapid cycle monitoring program as follows: ◆ Intervention #1 - Providers that fail the initial audit will be required to develop and implement a Corrective Action Plan over the next 90 day period. ◆ Intervention #2 – WellCare will provide coaching to failed providers during the period they are developing their Corrective Action Plan. During this 90-day period, WellCare will help Providers develop and comply with the CAP. The coaching can be done via monthly letter, phone call, or face-to-face visit with the provider. When appropriate, we will also provide tools to help providers document	◆ Intervention #1 – WellCare requires the provider to submit a CAP to the health plan within 30 days. ◆ Intervention #2 – A re-audit will take place to ensure compliance. The re-audit will be scheduled once claims data is identified in the system to ensure an adequate sample is available, or within 90 of CAP implementation. ◆ Intervention #3 – Monitor provider office quality scores via Gaps in Care Report. Completed Care Gaps and pharmacy data will show CPG adherence, in addition to documentation. ◆ Intervention #4 – Monitor provider office quality scores via Gaps in Care Report. Completed Care Gaps and pharmacy data, will show CPG adherence, in addition to documentation.	◆ Dr. John Johnson ◆ Tabitha Echols ◆ Marianne Thomas	◆ Intervention 4: 4/1/15 – Widespread diabetes management education published. ◆ 6/30/15 – Initial CPG Compliance Audits will be completed. ◆ Intervention 2: 7/1/15 – 9/30/15 – Coaching on CPG Adherence will be provided to all "failed providers". ◆ Intervention 1: 9/30/15 – Corrective Action Plans are due from those providers that failed the initial audit. ◆ Existing Intervention:

Standard I—Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
compliance with the CPGs. Progress will be tracked monthly until the CAP is no longer applied or other actions are taken. ◆ Existing Intervention that will continue – WellCare will re-audit those providers that failed the initial audit. ◆ Intervention #3 - Providers that continue to achieve scores below 80% will receive one-on-one education from the WellCare Sr. Medical Director. ◆ Intervention #4 - Widespread diabetes management education will be provided to all PCPs and Pediatricians, as these are the primary provider types responsible for CPG adherence failure.			11/30/15 – Re-audit of those failed providers will be conducted. ◆ Intervention 3: 12/31/15 – Sr. Medical Director will conduct educational interventions if re-audit reveals the providers Corrective Action Plan has not proven to be effective at improving the provider's CPG Compliance.
Other Evidence/Documentation: Element 6 - SAT Provider CPG Compliance – FINAL Element 6 - SAT Provider CPG Education – FINAL Element 6, Intervention 3 - CPG Audit Follow-up 06-25-2015 Element 6, Intervention 4 - Provider Newsletter February 2015, p.2			
July 2015 Re-review Findings: WellCare provided its 2014 CPG compliance results, which indicated that providers were not compliant with the CPG goal. Specifically, providers received excellent scores (97 percent and 100 percent, respectively) on the use of Asthma and Attention Deficit Hyperactivity Disorder (ADHD) CPGs. However, the providers' score on Diabetes CPG use (67 percent) lowered the combined score to 88 percent.			
July 2015 Required Actions: WellCare must continue its current interventions and apply new interventions with providers until 90 percent of the CMO's providers comply with its CPGs.			

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

6. The CMO achieved DCH-established performance targets.
State-specified element

Findings: WellCare did not meet all DCH-established performance targets for CY 2013. The following deficiencies were noted.

Measure	Targets CY2013	WellCare CY 2013 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE—6 OR MORE VISITS (HYBRID)	70.70	68.46
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE (HYBRID)	72.26	68.25
ADOLESCENT WELL-CARE VISITS (HYBRID)	49.65	43.75
CHILDREN AND ADOLESCENT ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.59	90.61
ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.52	85.05
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	77.51
CERVICAL CANCER SCREENING **(HYBRID)**	78.51	73.93
PRENATAL AND POSTPARTUM CARE **(HYBRID)**		
TIMELINESS OF PRENATAL CARE	90.39	84.07
POSTPARTUM CARE	71.05	63.24
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits **(HYBRID)**	72.99	65.93
CHLAMYDIA SCREENING IN WOMEN	58.40	49.83
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 **(HYBRID)**	80.91	74.59
APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	76.37	75.94
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	90.56	90.45
COMPREHENSIVE DIABETES CARE—All Components **(HYBRID)**		
HBA1C TEST	87.01	78.45
HBA1C CONTROL <8%	48.72	39.64
HBA1C CONTROL <7%	36.72	30.08
EYE EXAM	52.88	34.87
LDL SCREEN	76.16	69.24
LDL CONTROL	35.86	28.95
ATTENTION TO NEPHROPATHY	78.71	74.51
BP CONTROL <140/80	39.10	33.55
BP CONTROL <140/90	63.50	56.91
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	52.48	41.12
Continuation	63.11	54.18
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	69.57	52.39

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

30 DAY	84.28	72.63
AMBULATORY CARE per 1000 Member Months OP VISITS	 388.71	 361.52
PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	52.65
ANTIDEPRESSANT MEDICATION MANAGEMENT Effective Acute Phase Treatment Effective Continuation Phase Treatment	 52.74 37.31	 44.15 29.43
CONTROLLING HIGH BLOOD PRESSURE **(HYBRID)**	57.52	47.67
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT Initiation of Treatment Engagement of Treatment	 43.62 18.56	 31.37 9.38
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS Total	88.55	87.01
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	81.28
ELECTIVE DELIVERY (HYBRID)	2.00	1.00
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.30
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years Medication Compliance 50% Total Medication Compliance 75% Total	 52.31 29.14	 48.15 22.28

Required Actions: WellCare must meet all DCH-established performance targets before this element will be given a *Met* status.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
HEDIS Measure Performance Improvement is owned collaboratively by multiple areas across the WellCare organization. ◆ Provider Relations - The Clinical HEDIS Practice Advisors (CHPAs) conduct face-to-face provider education visits with Provider Relations Representatives to ensure consistent messaging and education on HEDIS measures. The CHPA Team will provide CPG education. Recently, WellCare began participating in rapid cycle performance	◆ Provider Relations – Monitor HEDIS improvement by monitoring provider office quality scores via Gaps in Care Report. Completed Care Gaps and pharmacy data on measures requiring medication adherence will show CPG compliance, in addition to appropriate documentation. ◆ Pharmacy – Utilize monthly pharmacy data reports to identify continued member non-compliance with ADHD medications. Encourage providers to sign	◆ Dr. John Johnson ◆ Marianne Thomas ◆ Myra Copeland ◆ Ginny Yates	8/1/2015 – Completion of this year's targeted education efforts to increase Performance Measure scores.

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
improvement projects (PIPS) that align with improving multiple measures where CPG guidance is required. With each PIP, a rapid cycle process will be used to expedite the improvement in outcomes. The goal is to identify successful interventions that are working for the pilot participants and roll those interventions out on a larger scale. ◆ Pharmacy - The QI Behavioral Health Project Manager works with the Pharmacy Department by conducting face to face visits to educate Providers on ADHD measures. The CPG is based on AAP guidelines, as is WellCare's audit tool for the CPG. During the QI Behavioral Health face-to-face provider visits, WellCare educates on the HEDIS requirements for initiation and continuation follow-up visits after the medication is prescribed. WellCare has identified that the CPG tool is not in alignment with the HEDIS guidelines. Therefore, this CPG will be updated in Q2 2015 to bring it into alignment with HEDIS guidelines. By revising the CPG to reflect HEDIS guidelines, we expect to see an improvement on the ADHD audit scores as well. ◆ Health Services and Member & Provider Outreach Teams - The QI Project Manager provides specific data on members with care gaps to the Disease Management team for outreach. The Disease Management team will be making outbound calls to diabetic members in an effort to improve A1c and LDL-C testing and control. ◆ Member and Community Outreach Teams - Assisting with telephonic and face-to-face	up for Rx Ante as a tool to monitor member medication adherence. ◆ Health Services, Member and Provider Outreach Teams – Performance Measure Improvement will be measured by monitoring Care Gaps report and CPG quarterly audits. ◆ Member and Community Outreach – Performance Measure Improvement will be measured by monitoring Care Gaps report and CPG quarterly audits.		

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
education, as well as, conducting health fairs throughout the community. In 2014, our Outreach Teams conducted 83 HEDIS events. A total of 776 members received education and screenings for Dental, Child/Adolescent Immunizations, Health Check, and Well Child checks. An additional 490 pregnant members received education and support through Prenatal Education Events held throughout the state.			
Other Evidence/Documentation:			
July 2015 Re-review Findings: At the time of the on-site visit, WellCare's performance measures were being validated and final rates were not available for review. Post-audit review of the finalized rates indicated that WellCare did not achieve all of the DCH targets.			
July 2015 Required Actions: WellCare must meet all DCH-established performance targets to obtain a *Met* status for this element. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.			

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

16. The CMO has a process for evaluating the impact and effectiveness of the QAPI Program.
42CFR438.240(b)(3)
Contract: 4.12.5.2

Findings: WellCare continues to adjust its QAPI Program to ensure it evaluates the impact and effectiveness of its quality programs.

Required Actions: WellCare must incorporate DCH's suggested revisions into its QAPI report to ensure all quality elements are addressed and integrated into the overall quality program.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
WellCare will revise the annual assessment of our quality program to ensure all quality elements are addressed and integrated into the overall quality program. Oversight of the QAPI will be shared by the entire Georgia Senior Leadership Team.	The QAPI will be monitored by reviewing Performance Measure Improvement via the Care Gaps report and CPG quarterly audits. CAHPS results will be used as a guide to determine member satisfaction combined with monitoring Member Complaints.	Dr. John Johnson	6/30/2015 – File the annual QAPI with DCH

Other Evidence/Documentation:
Element 16 - 2015 QAPI Program Description

July 2015 Re-review Findings: WellCare provided its QAPI plan. Documentation which would demonstrate that the improvement of quality elements such as the performance improvement measures, care gaps reports, and Consumer Assessment of Healthcare Providers and Systems (CAHPS)[A-1] results were not submitted to demonstrate the QAPI's effectiveness.

July 2015 Required Actions: WellCare must incorporate DCH's suggested revisions and continue to evaluate the overall effectiveness of the QAPI plan on the quality of healthcare provided to its members. The CMO should assess its evaluation methods and implement modifications as needed.

[A-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality(AHRQ).

Standard VII—Coordination and Continuity of Care—Focused Review

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)

1. In addition to the above requirements, the CMO's care coordination system includes the following related and additional functions:

- Case Management
- Disease Management
- Transition of Care
- Discharge Planning

Findings: WellCare did not demonstrate evidence of ongoing monitoring of its staff related to discharge planning. The case file review showed that discharge plans were not noted in cases for members being discharged from an inpatient facility. Based on the file review, the findings showed that the CMO did not fully demonstrate that case managers adequately addressed members' discharge planning needs.

Required Actions: The CMO must ensure that case managers are adequately monitoring and addressing needs of members discharged from an inpatient care setting.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Meeting with Utilization Management/Transition Management (UM/TUM) for Discharge Planning to review and update discharge planning process between inpatient care setting and the field. 2. Implemented the interdepartmental discharge planning process as follows: a) Using WellCare's Medical Management system (EMMA) UM teams monitor daily hospital census for hospitalized active enrolled members in the Field Case Management Program Member is open in Case Management and is hospitalized. b) When Active member in Case Management is identified, UM Nurse will document inpatient notification in a TUM note in EMMA (Transitional UM)UM Nurse will notify the Case Manager via EMMA email system (Qmail) that the member, who is already enrolled in Case Management, is in the hospital.	1. Discharge Planning follow-up Compliance Monitoring and Oversight a) Monitoring and oversight of the Case Manager's (CM) compliance occurs through: i. Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager's skills are evaluated in assessment and identification of needs associated with inpatient stay, engaging member in setting goal priorities and agreement on member focused customized care plan. ii. Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart Review Tool. Passing is 90%. The documentation is evaluated to	Interventions 1 & 2 (Content Approvers) ◆ LaDonna Battle ◆ Mary L. Welch ◆ Cindy Hankin Interventions 1 & 2 (Intergroup Facilitators) ◆ Angel Pellot ◆ Akan Iyamu ◆ Natalie Davis Interventions 1 & 2 (Content Facilitators) ◆ Mary Burt (CM)	Interventions 1 & 2 ◆ 12/1/14: Discharge Planning process approved ◆ 12/1/14: Step Action Process for discharge planning sent to all CM supervisors. ◆ 12/3/14 and 12/4/14: Discharge Planning training for Integrated

Standard VII—Coordination and Continuity of Care—Focused Review

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)

c) Update Audit Tools to include a Quality Assurance process to validate that the Member's discharge plan has been documented. d) Update the Documentation Template that allows for Member-reported issues to be identified. Also include confirmation that Member works with Care Manager to prioritize objectives. e) Train Care Management Staff on how to encourage Members to identify and prioritize objectives. f) Implement a monitoring step that reviews a summary on the status of Care Managers documenting involvement in the Member's discharge plan prior to discharge. g) Utilization Nurse will review the d/c plans and enter a Transition Care Management (TCM) Note providing review findings and/or collaboration needs "reviewed the d/c plan, no further recommendations at this time", 'recommend additional resources' h) Case Manager and UM nurse will conduct transitional handoff via phone or use (EMMA as needed for review and clarification of discharge planning , anticipated discharge dates and referrals for post discharge Care Management or community resources needed. 3. Initiate Collaborative Interdisciplinary Care Team (ICT)Meetings ◆ The goal of the UM Nurses being part of the GA ICT configuration is to leverage synergy and collaboration to proactively assure member's needs are met as they transition from inpatient treatment back to their home, community and/or alternate	ensure post discharge needs are assessed and identified, coordinated, arranged and scheduled and documented b) If observations uncover a CM not properly engaging member in plan development through Motivational Interviewing techniques, immediate redirection will be provided at that time followed by post visit remediation. c) Continued non-compliance will be addressed via: iii. Formal verbal warning in 1:1 coaching with Supervisors during the post observational or documentation audit review; iv. 1:1 coaching sessions, as needed, with the Senior Health Services Trainer to address areas of improvement , with reports to Supervisors as to progress; and v. Progressive Standard HR performance action plans including written, final written and termination. 2. Tracking and Monitoring a) UM Rounds are tracked on the Action Registry for weekly progress actions and referral assignments b) The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification.	◆ Natalie Davis (CM), ◆ Akan Iyamu (CM) ◆ Sharon Libby (CM) ◆ Tiffany Weaver (CM) ◆ Angel Pellot (UM) ◆ Kerry Sullivan (UM) <u>Intervention 3</u> • Dr. John Johnson <u>Intervention 4 (Process Facilitators)</u> ◆ Mary Burt (CM) ◆ Natalie Davis (CM), ◆ Akan Iyamu (CM) ◆ Sharon Libby (CM) ◆ Tiffany Weaver (CM) <u>Intervention 5</u>	CM/UM Staff during ICT meetings in all regions. <u>Intervention 3</u> ◆ 11/19/14: Supervisors notified that UM teams in some regions would begin attending ICT meetings. ◆ 12/3/14 and 12/4/14: UM teams member began attending Field Interdisciplinary Care Team Meetings via teleconference call <u>Intervention 4</u> ◆ 12/3/14 and 12/4/2014: Staff Training during ICT meetings in all regions staffed with

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)			
setting. Collaborative discussions and interventions will promote optimal heath, effective and efficient uses of available resources, and reduce the potential for complications and/or re-admissions. ◆ Transition of Care Rounds is conducted weekly by the Medical Director. UM team monitors Complex cases for readmissions, subsequent ER visits. CM and UM review members in NICU, LOS>30days, Skilled Nursing, P4HB and members with complex discharge are reviewed to discharge referrals to Case Management. ◆ UM team members attend weekly Interdisciplinary Care Team Meetings to discuss High risk members, enrolled or to be referred to Complex case management for discussion of specific discharge planning needs with assigned Case manager in the region where member resides. PCP/Specialist follow-up and follows process to notify CMs and discusses in weekly ICT meetings. 4. Following discharge from an inpatient facility: a) CM receives from UM via the medical management system a Discharge Charge Planning Note (DCP) which notifies CM of specific needs that require post discharge coordination ex. medications, DME, appointments, and transportation are in place. b) CM will call member to schedule home visit within 7 days of discharge date. Members are encouraged to attend their post hospitalization follow-up visit with MD. c) CM uses information from assessment and/or concerns triggered by member's inpatient stay to develop a member-focused customized	c) The trainer will address any group noncompliance trends with Discharge Planning Process training in Regions tracking <90% compliance d) Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance.	<u>(Process Auditors & Coaching)</u> ◆ Mary Burt (CM) ◆ Natalie Davis (CM), ◆ Akan Iyamu (CM) ◆ Sharon Libby (CM) ◆ Tiffany Weaver (CM) ◆ Brenda Richardson (Performance Training) <u>Intervention 6</u> ◆ Ericka Searcy (Reports Monitoring) ◆ Brenda Richardson (Performance Training) ◆ Rosa Rivera-Lozada (Outcomes Monitoring) ◆ LaDonna Battle (Outcomes Monitoring)	inpatient UM team members completed. Reviewed discharge planning process <u>Intervention 5</u> ◆ 1/15/15: Following completion of above training both Monthly Observational & Documentation Audits were initiated <u>Intervention 6</u> ◆ 1/8/15: Started Action Registry tracking ◆ 3/15/15: Begin Discharge Planning Trend Report ◆ Ongoing Process: content and updated performance

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)			
comprehensive care plan that includes information on actions or interventions and their duration that a CM Interdisciplinary Care team (ICT) takes to address member's medical, BH, functional and support needs d) CM communicates information from providers and other ICT team with the member e) The CM documentation shows that the ICT develops a care plan for each member that includes: i. Prioritized goals that reflect member/caregiver preferences and involvement; ii. Self-Management plan/ identification of barriers; iii. Schedule for follow-up; and iv. Process to assess member progress. f) Based on the members specific needs the care plan also identifies: i. Resources to be utilized and appropriate level of care; ii. Referrals to other ICT providers on behalf of member planning for coordination of care, including transitions and transfers, and identifying how and when ICTs follow-up with a member after referral to a health resource; and iii. Collaborative approaches used to build member safety net. g) The member is afforded the right to accept, decline or customize their goals based on preference. h) The CM supports the member in the finalization of goals that are realistic, measurable and can be		◆ Dr. John Johnson (Outcomes Monitoring) ◆ Ted Webster and Kenny Ensley (Compliance Monitoring)	training repeated, as needed ◆ Ongoing Process: as indicated by monthly Discharge Planning Trend reports ◆ YEAR END REVIEW: effectiveness of monitoring and addressing needs of members discharged from inpatient care to be included in Program Evaluation.

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)			
reasonably attained within the specified time frames. i) The member centered goals are shared with the provider and integrated ICT for review and alignment with member directed supportive interventions. j) As the member progresses in goal attainment, additional goals may be added at the discretion of the member with assistance from the CM. 5. Discharge Planning follow-up Compliance Monitoring and Oversight a) Monitoring and oversight of the Case Manager's (CM) compliance occurs through: i. Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager's skills are evaluated in assessment and identification of needs associated with inpatient stay, engaging member in setting goal priorities and agreement on member focused customized care plan. ii. Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart Review Tool. Passing is 90%. The documentation is evaluated to ensure post discharge needs are assessed and identified, coordinated, arranged and scheduled and documented b) If observations uncover a CM not properly engaging member in plan development through Motivational Interviewing techniques, immediate			

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)			
redirection will be provided at that time followed by post visit remediation. c) Continued non-compliance will be addressed via: i. Formal verbal warning in 1:1 coaching with Supervisors during the post observational or documentation audit review; ii. 1:1 coaching sessions, as needed, with the Senior Health Services Trainer to address areas of improvement , with reports to Supervisors as to progress; and iii. Progressive Standard HR performance action plans including written, final written and termination. 6. Tracking and Monitoring a) UM Rounds are tracked on the Action Registry for weekly progress actions and referral assignments b) The Senior Project Analyst will track and review monthly performance statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. c) The trainer will address any group noncompliance trends with Discharge Planning Process training in Regions tracking <90% compliance d) Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance			

Standard VII—Coordination and Continuity of Care—Focused Review

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)

Other Evidence/Documentation:
TUM-TCM STEP ACTION PROCESS
Intervention 2 - TUM-DCP Communication Examples
Intervention 3 - UM Rounds Meeting Minutes 4.30.15
Intervention 2 - Discussion Topics_Central Pod Meeting 12-3-14
Interventions 5-6 - CCM Audit Tool Description 4-12-2015 Final
Interventions 5-6 - GA UM Rounds Tracker 4.30.15
Interventions 5-6 - Summary Audit Rev Eval-CCM&OB High Risk Audit Tools

July 2015 Re-review Findings: WellCare provided documentation that detailed the process improvements for the CMO's discharge process. The CMO also provided observational and documentation audits that illustrated upward trends in completion of discharge outreach, assignment to case management post discharge for members not already in case management, and an increase in coordination of care activities for members transitioning from an inpatient facility to the community. During the on-site interview, WellCare staff reported that the implemented changes to the discharge planning process provide comprehensive monitoring of members discharged from impatient facilities. The identified changes should allow for greater communication internally and timely, ongoing feedback from providers to ensure coordination of care, medication reconciliation, and timeliness of services (i.e., post discharge follow-up appointments or any home care service needs). Staff members also shared a formal monitoring process to conduct follow-up review and training with staff.

July 2015 Required Actions: None.

Standard VII—Coordination and Continuity of Care—Focused Review

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

2. Case Management Components: Contract §4.11.9.1-2

The CMO's case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:

- Early identification of members who have or may have special needs
- Assessment of member's risk factors
- Development of a care plan
- Referrals and assistance to ensure timely access to providers
- Coordination of care actively linking the member to providers, medical services, residential, social and other support services where needed
- Monitoring
- Continuity of care
- Follow-up documentation

Findings: During the interview, staff described the UM team's role and responsibility in developing and implementing the discharge planning process. However, during the file review, for cases involving member hospitalization, HSAG did not identify that any discharge planning was noted.

Required Actions: Ensure that discharge planning is documented for all members discharged from an inpatient care setting.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. All Members that have been discharged from an inpatient hospital stay will receive a discharge plan from the hospital. Those members that have agreed to be part of the WellCare Case Management Program will receive a patient centered discharge plan created by WellCare, in partnership with the member. 2. Implement a weekly Supervisor monitoring step that reviews a summary on the status of Care Managers documenting the member's involvement in the patient centered discharge plan, prior to actual discharge. Problems identified through Supervisor monitoring result in coaching, verbal warnings, and written counseling. 3. Implement monthly Quality Assurance audits, performed by our Compliance Team, to validate that the Member's	Implement monthly Quality Assurance audits, performed by our Compliance Team, to validate that the Member's discharge plan has been documented. Negative audit findings result in retraining of the UM team members identified through these audits.	Intervention 1: Cindy Hankin Intervention 2: Angel Pellot Intervention 3: Kenny Ensley	Intervention 1: 10/30/14 – WellCare discharge planning program was fully implemented Intervention 2: 10/24/14 – Weekly Supervisor Monitoring Reviews Intervention 3: 2/1/15 – Monthly Compliance Team

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
discharge plan has been documented. Negative audit findings result in retraining of the UM team members identified through these audits.			Quality Assurance Audits began.
Other Evidence/Documentation: CCM Audit Tool Description 4-12-2015 Final CM 2.0_Care Plan Development Developing Care Plan Discussion Topics_Central Pod Meeting 12-3-14 GA UM Rounds Tracker 4.30.15 Summary Audit Reviewer Eval-CCM&OB High Risk Audit Tools TUM-DCP Communication Examples TUM-TCM STEP ACTION PROCESS UM Rounds Meeting Minutes 4.30.15			
July 2015 Re-review Findings: WellCare redesigned its discharge planning process. WellCare provided documentation that detailed the process improvements for the CMO's discharge process. The CMO also provided observational and documentation audits that illustrated upward trends in completion of discharge outreach, assignment to case management post discharge for members not already in case management, and an increase in coordination of care activities for members transitioning from an inpatient facility to the community. These implemented changes allowed for the provision of timely coordination of care, timely feedback from providers, and interdepartmental coordination.			
July 2015 Required Actions: None.			

Standard VII—Coordination and Continuity of Care—Focused Review

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

5. Discharge Planning: Contract 4.11.11

The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: Case file reviewed showed that WellCare was unable to demonstrate discharge planning for all members.

Required Actions: WellCare must ensure discharge planning is in place for members and communicated to the case manager for members enrolled in case management.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Discharge planning is initiated when the member enters the hospital. UM and Concurrent Review Teams monitor members for discharge needs and communicate referrals for post-discharge Care Management through transitional referral note types in the medical management system. Activation of note types to drive and monitor referrals between UM and CM for: ◆ GPP – GA Pregnancy Program ◆ TUM – Transitional UM discharge WITH existing Case Manager (routes to primary CM directly) ◆ DCP – transitional UM discharge WITHOUT existing Case Manager (routes to regional CM directly and assigned through distribution algorithm by county/zip code) 2. High risk members are discussed in weekly interdisciplinary pod rounds (UM inclusive) and in weekly ICT Utilization rounds (CM/UM inclusive). Complex cases are monitored for readmissions, subsequent ER visits, and PCP/Specialist follow-up.	1. Discharge Planning follow-up Compliance Monitoring and Oversight a) Monitoring and oversight of the Case Manager's (CM) compliance occurs through: i. Observational Visits – The CM Supervisors conduct monthly "ride-along" with each Case Manager. During this visit, the Case Manager's skills are evaluated in assessment and identification of needs associated with inpatient stay, engaging member in setting goal priorities and agreement on member focused customized care plan. ii. Documentation Audits – The CM Supervisors conduct monthly audits of no fewer than 5 records utilizing the CCM Chart Review Tool. Passing is 90%. The documentation is evaluated to	<u>Intervention 1</u> ◆ LaDonna Battle ◆ Kellie Lee ◆ Cindy Hankin ◆ Rosa RiveraLozada ◆ Debbie Moorhead <u>Intervention 2</u> ◆ Dr. Johnson ◆ LaDonna Battle ◆ Ericka Searcy <u>Intervention 3</u> ◆ Margaret Pryce ◆ Rosa RiveraLozada ◆ Debbie Moorhead	<u>Intervention 1</u> ◆ 11/3/14: Technical specification completed, user acceptance testing, and placed in production for direct care management referrals for assignment distribution. ◆ Ongoing: Referrals are validated by Daily Census Report, Daily Assignment Report, and the Case Management Case Load Tracker (SHS). <u>Intervention 2</u> ◆ 1/8/15: Initiated UM/CM collaborative transitional rounds.

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
3. In addition, the Welcome Home Team, managed through Health Services Member Engagement, places calls to low/moderate risk members within 7 days post discharge to ensure medications, DME, appointments, and transportation are in place. Members requiring referral to CM are communicated via the note types defined above. Urgent cases are warm-transferred to the regional care management team for immediate intervention.	ensure post discharge needs are assessed and identified, coordinated, arranged and scheduled and documented b) If observations uncover a CM not properly engaging member in plan development through Motivational Interviewing techniques, immediate redirection will be provided at that time followed by post visit remediation. c) Continued non-compliance will be addressed via: iii. Formal verbal warning in 1:1 coaching with Supervisors during the post observational or documentation audit review; iv. 1:1 coaching sessions, as needed, with the Senior Health Services Trainer to address areas of improvement , with reports to Supervisors as to progress; and v. Progressive Standard HR performance action plans including written, final written and termination. 2. Tracking and Monitoring a) UM Rounds are tracked on the Action Registry for weekly progress actions and referral assignments b) The Senior Project Analyst will track and review monthly performance		Transitional Care Management registry is maintained weekly for reconciliation of pending discharges, follow-ups, updates on CM/DM/UM/BH/ P4HB/FIN referrals. ◆ Ongoing: Minimum bi-weekly rounds are conducted, with weekly rounds coordinated based on census. <u>Intervention 3</u> ◆ 11/13/14: Initiated use of the Discharge planning note types. ◆ Ongoing: Referrals are validated by Daily Census Report, Daily Assignment Report and the Case Management Case Load Tracker (SHS).

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
	statistics gathered by monitoring observational and documentation audits for State, Regional, CM level reporting and trend identification. c) The trainer will address any group noncompliance trends with Discharge Planning Process training in Regions tracking <90% compliance d) Performance analytics and other tracking information are reported upward to the Director, Field Health Services, VP of Field Health Services and Senior Medical Director for outcomes monitoring ◆ Outliers <90% on audits ◆ Quarterly trends based on State, Regional compliance		
Other Evidence/Documentation: CCM Audit Tool Description 4-12-2015 Final Discussion Topics_Central Pod Meeting 12-3-14 GA UM Rounds Tracker 4.30.15 Summary Audit Reviewer Eval-CCM&OB High Risk Audit Tools TUM-DCP Communication Examples TUM-TCM STEP ACTION PROCESS UM Rounds Meeting Minutes 4.30.15 WH Discharge Follow Up Screening Process			
July 2015 Re-review Findings: WellCare redesigned its discharge planning process. WellCare provided documentation that detailed the process improvements for the CMO's discharge process. The CMO also provided observational and documentation audits that illustrated upward trends in completion of discharge outreach, assignment to case management post discharge for members not already in case management, and an increase in coordination of care activities for members transitioning from an inpatient facility to the community. These implemented changes allowed for the provision of timely coordination of care, timely feedback from providers, and interdepartmental coordination.			
July 2015 Required Actions: None.			

Appendix C. **On-Site Review Participants**

The document following this page includes the dates of HSAG's on-site review, the names/titles of the HSAG reviewers, and the names/titles of other individuals who participated in or observed some or all of the on-site review activities, including WellCare's key staff members who participated in the interviews that HSAG conducted.

Review Dates

The following table shows the dates of HSAG's on-site visit to WellCare.

Table C-1—Review Dates	
Date of On-Site Review	July 23–24, 2015

Participants

The following table lists the participants in HSAG's on-site review for WellCare.

Table C-2—HSAG Reviewers and WellCare of Georgia, Inc./Other Participants		
HSAG Review Team		Title
Team Leader	Elizabeth Stackfleth, MPA	Director, State & Corporate Services
Reviewer	Rachel Costello, PhD, MS, PCC-S	Senior Project Manager, State & Corporate Services
Reviewer	Steve Kuszmaul, MBA	Project Manager, State & Corporate Services
WellCare of Georgia, Inc. Participants		Title
Jamie Calabrese, MD		Medical Director
John Johnson, MD, MBA		Senior Medical Director
Dauda Griffin, MD		Behavioral Health Medical Director
Ginny Yates, PharmD		Senior Director, State Pharmacy Performance
Roman Kulich		President, Georgia Region
Debra Cerrato		Manager, Quality Improvement
Tamika Graham		Manager, Quality Improvement
Marianne Thomas		Senior Director of Quality Improvement
Faith DeCoster		Credentialing Manager
Myra Copeland		Manager, Quality Improvement
Melinda Mosser		Manager, Corporate Oversight—Delegation
Valda John		Project Manager, Appeals
Katrina Davis		Senior Grievance Project Manager
Amy House		Director of Network Management
Annette Zerbe		Senior Director, Regulatory Affairs
Kenny Ensley		Compliance Director
Jamie Sheirer		Member Communications Specialist
Carletta Youngs		Community Relations
Joshua Luft		Director, Reporting and Analytics
Heather DiNapoli		Senior Project Manager, Reporting and Analytics
Nichole Dorcean		Project Analyst
James Johnson		Senior Director, Operations and Outreach
Steve Meeker		Chief Operating Officer

Table C-2—HSAG Reviewers and WellCare of Georgia, Inc./Other Participants	
Alicia Johnson	Director, Medicaid Marketing
Mark Ruise	Senior Project Manager
Felicia Thomas	Senior Director, Products
Abby Abramson	Senior Operations Support Specialist
Natalie Lugo	Enrollment Supervisor
Morgan Ranie	Enrollment Manager
Nikkole Fernandez	Operations Support Specialist
Cindy Hankin, RN	Senior Director, Utilization Management
LaDonna Battle	VP, Field Health Services
Brenda Richardson	Senior Health Services Training Specialist
Janise Smith	Senior Manager, Product Medicaid
Neana Canon	Quality Improvement Analyst
Rozona Kassan	Quality Improvement Project Manager
Yesenia Stokes	Project Manager, Information Technology and Operations
Audrey Eleby	Senior Manager, Field Health Services
Rosa Rivera-Lozado	Director, Field Health Services
Department of Community Health Participants	**Title**
Janice Carson, MD, MSA	Assistant Chief
Tiffany Griffin, BSN	Quality Program Specialist II

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D. **Review Methodology**

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the DCH Georgia Families CMOs addresses HSAG's:

- Objective for conducting the reviews.
- Activities in conducting the reviews.
- Technical methods of collecting the data, including a description of the data obtained.
- Data aggregation and analysis processes.
- Processes for preparing the draft and final reports of findings.

HSAG followed standardized processes in conducting the review of each CMO's performance.

Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs. HSAG assembled a team to:

- Collaborate with DCH to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, on-site review activities schedules, and on-site review agenda.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective, and based on the results of collaborative planning with DCH, HSAG developed and used a data collection tool to assess and document the CMOs' compliance with certain federal Medicaid managed care regulations, State rules, and the associated DCH contractual requirements. The review tool included requirements that addressed the following performance areas:

- Standard I—Provider Selection, Credentialing and Recredentialing
- Standard II—Subcontractual Relationships and Delegation
- Standard III—Member Rights and Protections
- Standard IV—Member Information
- Standard V—Grievance System
- Standard VI—Disenrollment Requirements and Limitations
- Follow-up on areas of noncompliance from the prior year's review

The DCH and the CMOs will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

The review was the second year of the current three-year cycle of CMO compliance reviews.

HSAG's Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DCH and the CMOs, as they related to the scope of the review. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[D-1] for the following activities:

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the two-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate their preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of sample cases plus an oversample for grievances, appeals, credentialing, and recredentialing cases for the on-site CMO audit from the list submitted to HSAG from the CMO.

On-site review activities: HSAG reviewers conducted an on-site review for each CMO, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents and files HSAG requested that the CMOs have available on-site.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

[D-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the CMOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Description of Data Obtained

To assess the CMOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CMOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written informational materials
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMOs' key staff members.

Table D-1 lists the major data sources HSAG used in determining the CMOs' performance in complying with requirements and the time period to which the data applied.

Table D-1—Description of the CMOs' Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 1, 2014–June 30, 2015
Information obtained through interviews	July 30, 2015—the last day of each CMO's on-site review
Information obtained from a review of a sample of the CMOs' records for file reviews	July 1, 2014–June 30, 2015

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

Met indicates full compliance defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.

- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to, care and services the CMOs provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the CMOs' performance in complying with each of the requirements.
- Scores assigned to the CMOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to DCH and to the CMOs for their review and comment prior to issuing final reports.

Appendix E. **Corrective Action Plan**

Following this page is a document HSAG prepared for WellCare to use in preparing its corrective action plan (CAP). The template includes each of the requirements for which HSAG assigned a performance score of *Not Met*, and for each of the requirements, HSAG's findings and the actions required to bring the organization's performance into full compliance with the requirement.

Instructions for completing and submitting the CAP are included on the first page of the CAP document that follows.

Criteria that will be used in evaluating the sufficiency of the CAP are:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Corrective action plans that do not meet the above criteria will require resubmission of the CAP by the organization until it is approved by DCH. Implementation of the CAP may begin once approval is received.

Appendix E. State of Georgia
Department of Community Health (DCH)
Corrective Action Plan
for WellCare of Georgia, Inc.

Instructions: For each of the requirements listed below that HSAG scored as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the CMO will measure the effectiveness of the intervention
- Individual(s) responsible for ensuring that the planned interventions are completed
- Proposed timeline for completing each planned intervention

This plan is due to DCH no later than 30 calendar days following receipt of this draft External Quality Review of Compliance With Standards report. The DCH, in consultation with HSAG, will review and approve the CAPs to ensure that they sufficiently address the interventions needed to bring performance into compliance with the requirements. Approval of the CAPs will be communicated in writing. Once approved, CAP activities and interventions may begin. Follow-up monitoring will occur to ensure that all planned activities and interventions were completed.

Standard I—Provider Selection, Credentialing, and Recredentialing			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
6. The Contractor makes credentialing decisions on all completed application packets within 120 calendar days of receipt. *Contract: 4.8.15.1*			
Findings: The Credentialing & Recredentialing Procedure identified the time frame for credentialing decisions as 120 days. During the on-site interviews, credentialing staff reported that the time frame for credentialing decisions was 180 days, as this was the NCQA standard. During the credentialing file review, two cases reviewed had credentialing decisions that were made beyond 120 calendar days from receipt of the application. The application for Case 5 was received on 02/03/2015, and the credentialing decision was made on 06/08/2015, which was 126 days after receipt of the application. The application for Case 6 was received on 06/08/2014, and the credentialing decision was made on 10/27/2014, which was 142 days after receipt of the application. Staff provided documented outreach and facilitated communication between the credentialing staff and the provider requesting the necessary documentation.			
Required Actions: As of August 1, 2015, via its centralized credentialing verification organization, DCH assumed most credentialing and recredentialing activities, which were previously performed by the CMOs. Therefore, WellCare will no longer be responsible for credentialing and recredentialing the majority of providers in its network. The CMO should work with DCH to identify any needed actions based on HSAG's findings.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
11. For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following: ◆ Within ten (10) days of the Contractor mailing the notice of action, or ◆ The intended effective date of the proposed action. For all other actions, 30 calendar days from the date of the notice of proposed action. *42CFR438.402(b)(2) and 438.420(a)* *Contract: 4.14.4.2 and 4.14.7.1*			
Findings: The Georgia Administrative Review Procedure indicated that WellCare "allows at least 10 calendar days following an action to terminate, suspend, or reduce services" for the member to file a request for administrative review; however, it did not address the fact that timely filing includes the later of either 10 days or the intended effective date of the proposed action.			
Required Actions: WellCare must include in its policy and procedure the fact that the member may file a request for administrative review by the later of either 10 days after the NOA is mailed or the intended effective date of the proposed action.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard V—Grievance System

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

16. Notices of proposed action must contain:

- The action the Contractor has taken or intends to take, including the service or procedure that is subject to the action.
- Additional information, if, any that could alter the decision.
- The specific reason used as basis for the action (the reasons must have a factual basis and a legal/policy basis).
- The member's right to file an appeal (administrative review) through the Contractor's internal Grievance System and how to do so.
- The provider's right to file a provider complaint under the Contractor's provider complaint system.
- The requirement that a member exhaust the Contractor's internal administrative review process.
- The circumstances under which expedited review is available and how to request it.
- The member's right to have benefits continue pending resolution of the appeal (administrative review) and how to request that benefits be continued.
- The circumstances under which the member may have to pay for the costs of services if benefits are continued during the administrative review process.

42CFR438.404(b)
Contract: 4.14.3.3

Findings: The Adverse Determinations Proposed Actions policy indicated that all adverse determination notices included the requirements listed in this element. WellCare supplied the Notice of Proposed Action form letter, and it did not contain the notice that the member must exhaust WellCare's internal administrative review process.

Required Actions: WellCare must change its Notice of Proposed Action form letter to include a notice that the member must exhaust WellCare's internal administrative review process.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
20. The Contractor acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language. *42CFR438.406(a)(2)* *Contract: 4.14.1.5*			
Findings: The Georgia Administrative Review policy indicated that WellCare acknowledged receipt of each filed administrative review in writing within 10 calendar days of receipt and that the acknowledgment letter was available in the member's primary language. The Georgia Medicaid Grievance Procedure indicated that WellCare mailed the acknowledgment letter within 10 business days; however, the procedure did not address that the letter would be available in the member's primary language. Three of the 10 grievance acknowledgement letters reviewed during the on-site review were not sent to the member within 10 working days. All 10 administrative review (appeal) files met the acknowledgement timeliness requirement.			
Required Actions: WellCare must revise its Georgia Medicaid Grievance procedure to include the provision that the acknowledgment letter would be available in the member's primary language. WellCare must acknowledge all grievances within 10 working days.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard V—Grievance System

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes:
    - The results and date of the adverse action including the service or procedure that is subject to the action.
    - Additional information, if any, that could alter the decision.
    - The specific reason used as the basis of the action.
    - The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing is date stamped.
    - The right to continue to receive benefits pending a State Administrative Law hearing.
    - How to request continuation of benefits.
    - Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State Administrative Law hearing.
    - Circumstances under which expedited resolution is available and how to request it.

42CFR438.408(e)
Contract: 4.14.5.2

Findings: The Georgia Administrative Review procedure indicated that the notice of adverse action met the language and format requirements specified in the contract and included the requirements listed in this element. The Administrative Review Determination Final Denial Notice contained the required information. Five of the 10 administrative review (appeal) resolution letters reviewed during the on-site audit did not meet the fifth-grade reading/understandability level. In these cases procedure codes and medical terminology were used, which raised the reading level.

Required Actions: WellCare must ensure that all administrative review resolution letters are written in easily understood language.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(f) **Timelines—Returning Calls After-Hours:** *Contract 4.8.14.4*

The CMO ensures that provider response times for returning calls after-hours do not exceed the following:

- Urgent Calls—Twenty minutes
- Other Calls—One hour

Findings: WellCare monitored providers returning calls after hours. The CMO staff indicated that when providers were not compliant with either of these standards, they would receive a letter indicating the deficiency. The CMO staff also explained the provider corrective action process.

Required Actions: The CMO must ensure that 90 percent of its providers address urgent calls within 20 minutes and other calls within one hour.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As a result of reviewing the finding of the HSAG EQRO audit, WellCare acknowledges that Returning Calls After-Hours is a standard some providers struggle to meet. There is a current audit and education effort in place for this standard, which currently includes: The Myers Group, on WellCare's behalf, conducts quarterly monitoring of after-hours return call times. TMG calls a statistically valid random sample of providers each quarter to specifically find out if urgent after-hours calls are being returned within 20 minutes and if other after-hours calls are being returned within an hour. The audit results are sent back to WellCare, along with voice recordings for all provider calls that failed the compliance standard.	Review Timely Access All Standards Report.	Interventions 1-4: Amy Carr Interventions 1-2: Amy Carr Intervention 3: Amy House	Interventions 1-4: 9/30/15 Interventions 1-2: 9/30/15 – Remediate "failure points" 1 & 2. Intervention 3: 6/30/15 – Remediate "failure point" 3.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Providers that fail the compliance testing are notified by letter of the failure which specifically includes the wait time standards as well as suggested remediation for after-hours calls. The expectation is that the "failed providers" will amend their procedure to adhere to the after-hours call back standard and that when they are re-audited the following quarter, they will meet these standards. WellCare re-audits ALL failed providers the following quarter to determine if the education efforts have been successful in changing the behavior of the provider in such a way that they are now meeting members' medical after-hours needs in a timely manner. Any provider that fails the re-audit is notified by letter, and the Senior Medical Director makes recommendation for further action, if necessary. It is important to note that in reviewing the current process, we discovered 3 possible failure points that will be addressed in our future interventions: The first failure point is a lack of personal interaction for providers who fail the first audit. ◆ Beginning with the Q1 2015 audit results, the provider relations representatives will personally deliver the first "fail" letter to the PCPs who require remediation. The PR rep will educate the staff on the standards and explain that they are contractually bound to adhere to the standard because it is in place to ensure that our members'			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
medical needs are being met. The PR rep will also talk to the provider group to determine the root cause for the failure and work with the office to remove barriers to meeting the standards. The second failure point is the same lack of personal interaction for failure of the second audit. ◆ Beginning with the Q1 2015 audit results, the provider relations representatives will personally deliver the second "fail" letter to the PCPs who require remediation. The PR rep will educate the staff on the standards and explain that they are contractually bound to adhere to the standard because it is in place to ensure that our members' medical needs are being met. The PR rep will also talk to the provider group to determine the root cause for the failure and work with the office to remove barriers to meeting the standards. ◆ In addition, the Senior Medical Director will communicate with the second audit failure providers via written or verbal communication to enforce the importance of returning after-hours calls in a timely manner, emphasizing the importance of PCP-centric care and avoidance of unnecessary ER visits, which can be an unintended consequence of untimely after-hours return calls. The last failure point is a possible lack of understanding of the standards as they are currently provided. ◆ WellCare will re-vamp the Access Standards into a new, user-friendly job aid for distribution via the			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
web portal as well as in personal remediation efforts with the providers.			
Other Evidence/Documentation: Element 1f - Failed Letter_Dr. Daniel Marcadis Element 1f - Salesforce Screenshot_follow-up with provider Element 1f - Timely Access All Standards Q1-Q4 2013-2014, Q1 2015_Market Reporting 4.7.15 Element 1f, #3 - draft-New Appointment Access Standards Job Aid May 2015 Element 1f, #3 - Submission of Draft Job Aid to WC Communications Dept 5.19.15			
July 2015 Re-review Findings: WellCare continued to monitor providers returning calls after hours. WellCare provided example letters it sent to noncompliant providers when the provider did not meet the call-back time frames in this element. Specifically, during quarter 4, 2014, pediatric providers achieved 88 percent success rate when addressing after-hours returned calls. During quarter 1, 2015, 88 percent of PCPs returned nonurgent calls within the one-hour requirement.			
July 2015 Required Actions: WellCare must continue to apply current and new interventions with providers until the goal of 90 percent of its providers addressing urgent calls within 20 minutes and other calls within one hour is met.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

5. Geographic Access: *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

Findings: The CMO provided its corrective action reports for each quarter of the review period. WellCare did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCP
- Specialists
- Dental Subspecialty Providers
- Pharmacies

Required Actions: The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
As a result of reviewing the finding of the HSAG EQRO audit, WellCare acknowledges that member access to care in both the urban and rural areas of the State is of the utmost importance and that in areas	Review GEO Access CAP Report.	Intervention 1: Amy Carr	Intervention 1: 1/21/15 – Staff training completed Intervention 2:

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
where deficiencies exist, Network Development is a primary focus. There are 2 possible failure points that we have identified which, if improved upon, could lead to compliance with the geo access standards and ultimately increase member access to care. The first failure point has been the schedule of the Network Development team's review of the network. In the past, the team has reviewed geo access on a quarterly basis. We believe that additional training and more frequent review of network deficiencies will help to identify opportunities where additional providers are needed and could be recruited in to the network. The additional training of the network development team was completed in February 2015 and included the expectation that the geo access report be used as a tool to conduct daily business. In addition, the network development team will begin using an internal tool, produced on a monthly basis, called The Georgia Medicaid Access Compliance Snapshot. Because this report is produced more frequently, the expectation is that deficiencies will be identified more quickly and recruitment of new providers to the network can occur to meet access needs quickly after they are identified. The network development team will continue to work with the PR team to learn about new providers who move in to an area, and they will also continue to assist case managers and member outreach in contracting providers who are		Intervention 2: Amy House	5/19/15 – Press release about Appling Co. Health Dept. telemedicine partnership emailed to WellCare Communications Dept. Intervention 2: 6/30/15 – Pilot Programs fully implemented.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
needed for specific member care. WellCare has been working with Georgia Partnership for Telehealth since February 2013 in an effort to expand telemedicine access to our members. In reviewing our telemedicine utilization, a possible failure point has been the use of specialized programs promoting the utilization of telemedicine to close access gaps, particularly in rural areas of the state. WellCare is currently in the process of developing pilot programs that promote telemedicine in a school setting, as well as, a partnership with a public health department. The expectation is that broadening the scope of current telemedicine utilization will create access in areas where there is a shortage of either PCPs and/or specialists.			
Other Evidence/Documentation: Element 5 - 0654GEOAccessCAPReportQ115 Element 5 - 0654GEOAccessCAPReportQ314_revised Element 5 - 0654GEOAccessCAPReportQ414 Element 5, Intervention 1 - 4.20.15 GEO Access Meeting Element 5, Intervention 1 - 4.21.15 GEO Access Meeting Element 5, Intervention 1 - 4.22.15 GEO Access Meeting Element 5, Intervention 1 - GA Medicaid Access Compliance Snapshot Report_February 2015 Element 5, Intervention 1 - GMD ACS April 2015 Element 5, Intervention 1 - Staff Training-Geo Access_1.21.15 Element 5, Intervention 1 - Training Agenda-Geo Access_1.20.15 Element 5, Intervention 2 - Echols Co. Health Department (Telemedicine Effort)			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
July 2015 Re-review Findings: WellCare provided its GeoAccess Deficiencies CAP Reports for three quarters during the review period. WellCare did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories: ◆ PCP ◆ Specialists ◆ Dental subspecialty providers ◆ Pharmacies			
July 2015 Required Actions: WellCare must meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard I—Practice Guidelines

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

6. In order to ensure consistent application of the guidelines, the CMO encourages providers to utilize the guidelines and measures compliance with the guidelines until 90 percent or more of the providers are consistently in compliance.

Findings: WellCare provided its 2014 preliminary CPG compliance results, which indicated that providers were still not compliant with the CPG goal.

Required Actions: WellCare still needs to improve CPG compliance until 90 percent of the CMO's providers comply with its CPGs.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Last year, WellCare adopted a biannual rapid cycle monitoring program for those CPGs that did not meet the 90% compliance threshold. This program did not result in an increase of CPG compliance. Further drill-down revealed that the CPGs for the management of diabetes attributed to the decline in our overall score. These findings have prompted WellCare to adjust the existing biannual rapid cycle monitoring program as follows: ◆ Intervention #1 - Providers that fail the initial audit will be required to develop and implement a Corrective Action Plan over the next 90 day period. ◆ Intervention #2 – WellCare will provide coaching to failed providers during the period they are developing their Corrective Action Plan. During this 90-day period, WellCare will help Providers develop and comply with the CAP. The coaching can be done via monthly letter, phone call, or face-to-face visit with the provider. When appropriate, we will also provide tools to help providers document compliance with the CPGs. Progress will be	◆ Intervention #1 – WellCare requires the provider to submit a CAP to the health plan within 30 days. ◆ Intervention #2 – A re-audit will take place to ensure compliance. The re-audit will be scheduled once claims data is identified in the system to ensure an adequate sample is available, or within 90 of CAP implementation. ◆ Intervention #3 – Monitor provider office quality scores via Gaps in Care Report. Completed Care Gaps and pharmacy data will show CPG adherence, in addition to documentation. ◆ Intervention #4 – Monitor provider office quality scores via Gaps in Care Report. Completed Care Gaps and pharmacy data, will show CPG adherence, in addition to documentation.	◆ Dr. John Johnson ◆ Tabitha Echols ◆ Marianne Thomas	◆ Intervention 4: 4/1/15 – Widespread diabetes management education published. ◆ 6/30/15 – Initial CPG Compliance Audits will be completed. ◆ Intervention 2: 7/1/15 – 9/30/15 – Coaching on CPG Adherence will be provided to all "failed providers". ◆ Intervention 1: 9/30/15 – Corrective Action Plans are due from those providers that failed the initial audit.

Standard I—Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
tracked monthly until the CAP is no longer applied or other actions are taken. ◆ Existing Intervention that will continue – WellCare will re-audit those providers that failed the initial audit. ◆ Intervention #3 - Providers that continue to achieve scores below 80% will receive one-on-one education from the WellCare Sr. Medical Director. ◆ Intervention #4 - Widespread diabetes management education will be provided to all PCPs and Pediatricians, as these are the primary provider types responsible for CPG adherence failure.			◆ Existing Intervention: 11/30/15 – Re-audit of those failed providers will be conducted. ◆ Intervention 3: 12/31/15 – Sr. Medical Director will conduct educational interventions if re-audit reveals the providers Corrective Action Plan has not proven to be effective at improving the provider's CPG Compliance.
Other Evidence/Documentation: Element 6 - SAT Provider CPG Compliance – FINAL Element 6 - SAT Provider CPG Education – FINAL Element 6, Intervention 3 - CPG Audit Follow-up 06-25-2015 Element 6, Intervention 4 - Provider Newsletter February 2015, p.2			
July 2015 Re-review Findings: WellCare provided its 2014 CPG compliance results, which indicated that providers were not compliant with the CPG goal. Specifically, providers received excellent scores (97 percent and 100 percent, respectively) on the use of Asthma and Attention Deficit Hyperactivity Disorder (ADHD) CPGs. However, the providers' score on Diabetes CPG use (67 percent) lowered the combined score to 88 percent.			

Standard I—Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
July 2015 Required Actions: WellCare must continue its current interventions and apply new interventions with providers until 90 percent of the CMO's providers comply with its CPGs.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

6. The CMO achieved DCH-established performance targets.
State-specified element

Findings: WellCare did not meet all DCH-established performance targets for CY 2013. The following deficiencies were noted.

Measure	Targets CY2013	WellCare CY 2013 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE—6 OR MORE VISITS (HYBRID)	70.70	68.46
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE (HYBRID)	72.26	68.25
ADOLESCENT WELL-CARE VISITS (HYBRID)	49.65	43.75
CHILDREN AND ADOLESCENT ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.59	90.61
ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.52	85.05
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	77.51
CERVICAL CANCER SCREENING **(HYBRID)**	78.51	73.93
PRENATAL AND POSTPARTUM CARE **(HYBRID)**		
TIMELINESS OF PRENATAL CARE	90.39	84.07
POSTPARTUM CARE	71.05	63.24
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits **(HYBRID)**	72.99	65.93
CHLAMYDIA SCREENING IN WOMEN	58.40	49.83
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 **(HYBRID)**	80.91	74.59
APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	76.37	75.94
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	90.56	90.45
COMPREHENSIVE DIABETES CARE—All Components **(HYBRID)**		
HBA1C TEST	87.01	78.45
HBA1C CONTROL <8%	48.72	39.64
HBA1C CONTROL <7%	36.72	30.08
EYE EXAM	52.88	34.87
LDL SCREEN	76.16	69.24
LDL CONTROL	35.86	28.95
ATTENTION TO NEPHROPATHY	78.71	74.51
BP CONTROL <140/80	39.10	33.55
BP CONTROL <140/90	63.50	56.91
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	52.48	41.12
Continuation	63.11	54.18
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

7 DAY 30 DAY	69.57 84.28	52.39 72.63
AMBULATORY CARE per 1000 Member Months OP VISITS	 388.71	 361.52
PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	52.65
ANTIDEPRESSANT MEDICATION MANAGEMENT Effective Acute Phase Treatment Effective Continuation Phase Treatment	 52.74 37.31	 44.15 29.43
CONTROLLING HIGH BLOOD PRESSURE **(HYBRID)**	57.52	47.67
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT Initiation of Treatment Engagement of Treatment	 43.62 18.56	 31.37 9.38
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS Total	88.55	87.01
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	81.28
ELECTIVE DELIVERY (HYBRID)	2.00	1.00
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.30
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years Medication Compliance 50% Total Medication Compliance 75% Total	 52.31 29.14	 48.15 22.28

Required Actions: WellCare must meet all DCH-established performance targets before this element will be given a *Met* status.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
HEDIS Measure Performance Improvement is owned collaboratively by multiple areas across the WellCare organization. ◆ Provider Relations - The Clinical HEDIS Practice Advisors (CHPAs) conduct face-to-face provider education visits with Provider Relations Representatives to ensure consistent messaging and education on HEDIS measures. The CHPA Team	◆ Provider Relations – Monitor HEDIS improvement by monitoring provider office quality scores via Gaps in Care Report. Completed Care Gaps and pharmacy data on measures requiring medication adherence will show CPG compliance, in addition to appropriate documentation. ◆ Pharmacy – Utilize monthly pharmacy data reports to identify continued member non-compliance with	◆ Dr. John Johnson ◆ Marianne Thomas ◆ Myra Copeland	8/1/2015 – Completion of this year's targeted education efforts to increase Performance Measure scores.

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
will provide CPG education. Recently, WellCare began participating in rapid cycle performance improvement projects (PIPS) that align with improving multiple measures where CPG guidance is required. With each PIP, a rapid cycle process will be used to expedite the improvement in outcomes. The goal is to identify successful interventions that are working for the pilot participants and roll those interventions out on a larger scale. ◆ Pharmacy - The QI Behavioral Health Project Manager works with the Pharmacy Department by conducting face to face visits to educate Providers on ADHD measures. The CPG is based on AAP guidelines, as is WellCare's audit tool for the CPG. During the QI Behavioral Health face-to-face provider visits, WellCare educates on the HEDIS requirements for initiation and continuation follow-up visits after the medication is prescribed. WellCare has identified that the CPG tool is not in alignment with the HEDIS guidelines. Therefore, this CPG will be updated in Q2 2015 to bring it into alignment with HEDIS guidelines. By revising the CPG to reflect HEDIS guidelines, we expect to see an improvement on the ADHD audit scores as well. ◆ Health Services and Member & Provider Outreach Teams - The QI Project Manager provides specific data on members with care gaps to the Disease Management team for outreach. The Disease Management team will be making outbound calls to diabetic members in an effort to improve A1c and	ADHD medications. Encourage providers to sign up for Rx Ante as a tool to monitor member medication adherence. ◆ Health Services, Member and Provider Outreach Teams – Performance Measure Improvement will be measured by monitoring Care Gaps report and CPG quarterly audits. ◆ Member and Community Outreach – Performance Measure Improvement will be measured by monitoring Care Gaps report and CPG quarterly audits.	◆ Ginny Yates	

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
LDL-C testing and control. ◆ Member and Community Outreach Teams - Assisting with telephonic and face-to-face education, as well as, conducting health fairs throughout the community. In 2014, our Outreach Teams conducted 83 HEDIS events. A total of 776 members received education and screenings for Dental, Child/Adolescent Immunizations, Health Check, and Well Child checks. An additional 490 pregnant members received education and support through Prenatal Education Events held throughout the state.			

Other Evidence/Documentation:

July 2015 Re-review Findings: At the time of the on-site visit, WellCare's performance measures were being validated and final rates were not available for review. After the on-site visit, WellCare's performance measure rates were finalized with the following audited and final rates falling below the DCH target:

Measure	CY2014 Targets	WellCare CY2014 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE – 6 OR MORE VISITS (HYBRID)	67.98	66.93
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (HYBRID)	69.60	66.93
ADOLESCENT WELL-CARE VISITS (HYBRID)	53.47	49.54
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.85	90.35
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.32	81.76
CHILDHOOD IMMUNIZATION STATUS		
COMBO 10	38.94	38.66
ANNUAL DENTAL VISIT		
2 TO 3 YEARS	55.78	46.94
TOTAL	69.92	66.64
CERVICAL CANCER SCREENING (HYBRID)	76.64	74.56
PRENATAL AND POSTPARTUM CARE (HYBRID)		
TIMELINESS OF PRENATAL CARE	89.72	81.27
POSTPARTUM CARE	70.20	64.56

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	73.97	58.48
CHLAMYDIA SCREENING IN WOMEN	57.25	50.26
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	89.76	89.67
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HbA1c test	87.32	83.19
HbA1c Poor >9	43.02	48.75
HbA1c Control <8%	48.57	43.26
HbA1c Control <7%	34.76	32.43
Eye exam	54.43	35.44
Attention to nephropathy	79.28	76.71
BP Control <140/90 mm Hg	60.93	55.74
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	51.86	48.92
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	68.79	50.77
30 DAY	81.98	69.72
AMBULATORY CARE per 1000 Member Months		
ER VISITS	<53.98	61.04
CESAREAN DELIVERY RATE	28.70	29.73
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	49.93
PERCENTAGE OF ELIGIBLES WHO RECEIVED DENTAL TREATMENT SERVICES – Use 416 specifications; run combined PCK and Medicaid	31.50	21.76
DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE (HYBRID)	45.00	44.91
CESAREAN SECTION FOR NULLIPAROUS SINGLETON VERTEX (HYBRID)	15.23	30.36
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	7.99	9.21
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	56.17	46.92
Effective Continuation Phase Treatment	40.17	30.37
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	56.20	43.24
FLU SHOTS FOR ADULTS AGES 18–64	34.65	26.50
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT		
Initiation of Treatment	43.43	32.34
Engagement of Treatment	16.17	7.02
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.86	82.81
ELECTIVE DELIVERY (HYBRID)	2.00	24.24

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

ADHERENCE TO ANTIPSYCHOTICS FOR INDIVIDUALS WITH SCHIZOPHRENIA	61.34	33.85
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.14	20.37
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years Medication Compliance 75% for 5–11 yrs old	29.46	21.93
MATERNITY CARE-BEHAVIORAL HEALTH RISK ASSESSMENT (HYBRID)	10.42	9.95

July 2015 Required Actions: WellCare must meet all DCH-established performance targets to obtain a *Met* status for this element. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

16. The CMO has a process for evaluating the impact and effectiveness of the QAPI Program.
42CFR438.240(b)(3)
Contract: 4.12.5.2

Findings: WellCare continues to adjust its QAPI Program to ensure it evaluates the impact and effectiveness of its quality programs.

Required Actions: WellCare must incorporate DCH's suggested revisions into its QAPI report to ensure all quality elements are addressed and integrated into the overall quality program.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
WellCare will revise the annual assessment of our quality program to ensure all quality elements are addressed and integrated into the overall quality program. Oversight of the QAPI will be shared by the entire Georgia Senior Leadership Team.	The QAPI will be monitored by reviewing Performance Measure Improvement via the Care Gaps report and CPG quarterly audits. CAHPS results will be used as a guide to determine member satisfaction combined with monitoring Member Complaints.	Dr. John Johnson	6/30/2015 – File the annual QAPI with DCH

Other Evidence/Documentation:
Element 16 - 2015 QAPI Program Description

July 2015 Re-review Findings: WellCare provided its QAPI plan. Documentation which would demonstrate that the improvement of quality elements such as the performance improvement measures, care gaps reports, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results were not submitted to demonstrate the QAPI's effectiveness.

July 2015 Required Actions: WellCare must incorporate DCH's suggested revisions and continue to evaluate the overall effectiveness of the QAPI plan on the quality of healthcare provided to its members. The CMO should assess its evaluation methods and implement modifications as needed.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date