State of Georgia

Department of Community Health (DCH)

External Quality Review of Compliance With Standards

for

WellCare of Georgia, Inc.

December 2014

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016-4545

Phone 602.801.6600 ◆ Fax 602.801.6051

HSAG HEALTH SERVICES ADVISORY GROUP

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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, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid managed care and CHIP programs. The State refers to its Medicaid managed care program as Georgia Families and to its CHIP program as PeachCare for Kids®. For the purposes of this report, 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 CMO, or its external quality review organization (EQRO) must conduct a review to determine a Medicaid CMO's compliance with standards established by the state related to enrollee 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, 2013–June 30, 2014, and marked the first 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, file reviews, case reviews, and a management information system demonstration. 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 measurement and improvement standards found at 42 CFR §438.236–§438.240, and §438.242, 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: 09/2014."

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Emergency and Poststabilization Services
- Re-review of all *Partially Met* and *Not Met* elements from the prior year's review.

Additionally, HSAG performed a focused, case-specific file review of a sample of WellCare's members in the case management program between January 1, 2014, and May 30, 2014. HSAG also reviewed a sample of members enrolled in the disease management program between January 1, 2014, and May 30, 2014. Furthermore, HSAG reviewed a sample of cases involving members whose covered services/authorizations were denied between July 1, 2013, and June 30, 2014.

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 final report.
- Appendix F—The completed review tools HSAG used to evaluate WellCare's case management cases.
- Appendix G—The completed review tools HSAG used to evaluate WellCare's disease management cases.

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.
- Systems demonstrations during the on-site review.
- File review 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 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	Availability of Services	**17**	**17**	**17**	**0**	**0**	**100.0%**
II	Furnishing of Services	**22**	**22**	**19**	**3**	**0**	**86.4%**
III	Cultural Competence	**14**	**14**	**13**	**1**	**0**	**92.9%**
IV	Coordination and Continuity of Care	**21**	**21**	**17**	**4**	**0**	**81.0%**
V	Coverage and Authorization of Services	**25**	**25**	**22**	**3**	**0**	**88.0%**
VI	Emergency and Poststabilization Services	**20**	**20**	**20**	**0**	**0**	**100%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**6**	**6**	**0**	**6**	**0**	**0.0%**
	Total Compliance Score	**125**	**125**	**109**	**16**	**0**	**87.2%**

*** 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—Availability of Services

Performance Strengths

WellCare monitored its provider network to ensure all services were available to Georgia Families members. The CMO conducted an analysis each quarter to test for variations in travel times and distances between members and providers. WellCare maintained an adequate network of providers such that most services were available within the network. When services were not available within the network, the CMO coordinated the services with the out-of-network provider and the member. WellCare monitored providers to ensure they were accepting new patients and ensured continuity of care was maintained if and when a member needed to obtain services from other non-contracted providers. When out-of-network providers were needed, the CMO coordinated payment such that the member was not balance-billed and attempted to contract with those providers to make the provider network more robust.

Areas Requiring Corrective Action

HSAG identified no opportunities for improvement that required WellCare to implement corrective actions for this standard.

Standard II—Furnishing of Services

Performance Strengths

WellCare monitored aspects of network access to ensure members were able to obtain timely services. The CMO ensured that its contracted providers offered access to services for Georgia Families members consistent with Georgia Medicaid fee-for-service or commercial members. When an issue arose and a provider needed to be monitored to ensure contract compliance, the CMO had a corrective action process to communicate needed improvement.

Areas Requiring Corrective Action

The State established a goal that 90 percent of providers must meet appointment wait time requirements. WellCare monitored these wait times based on the State standard. The CMO's network providers did not meet the 90 percent goal for the following appointment wait time targets:

- Scheduled in-office appointment wait times of no more than 60 minutes
- Monitoring of in-office work-in or walk-in appointment wait times of no more than 90 minutes
- Timeliness—Returning Calls After Hours
- After-hours urgent calls returned within 20 minutes and other calls within one hour

Also, WellCare was required to meet certain time and distance geographic access standards in both urban and rural areas. The CMO did not meet the following geographic access standards:

- PCPs
  - Urban areas: Two within eight miles.
  - Rural areas: Two within 15 miles.
- Specialists
  - Urban areas: One within 30 minutes or 30 miles.
  - Rural areas: One within 45 minutes or 45 miles.
- Dental subspecialty providers
  - Urban areas: One within 30 minutes or 30 miles.
  - Rural areas: One within 45 minutes or 45 miles.
- Pharmacies
  - Urban areas: One 24 hours a day, seven days a week within 15 minutes or 15 miles.
  - Rural areas: One 24 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.

Standard III—Cultural Competence

Performance Strengths

WellCare established expected standards and provided guidance for delivering services to its member population in a culturally competent manner by educating staff and providers on the diverse member population needs. WellCare provided a summary of its Cultural Competency Plan in the provider handbook. Provider contracts also included references on non-discrimination.

Member materials were produced in English and Spanish, and alternative formats were stated as being available as needed. The Member Handbook provided information on accessing alternative formats, and members were able to call member services if they needed assistance in understanding the materials. The CMO contracted with linguistic services and made them available to members and providers as needed. These services were free to the member and provider.

Areas Requiring Corrective Action

The most current version of WellCare's cultural competency plan was not available to providers on the CMO's Web site.

Standard IV—Coordination and Continuity of Care

Performance Strengths

WellCare's obstetrics (OB) case management program monitoring and follow-up was focused and specific to the member's identified needs. OB case management case notes were comprehensive and specific to the services being provided to members.

Areas Requiring Corrective Action

During the file review, HSAG identified that new case managers were not consistently adhering to the continuity of care procedure. In review of case management files, HSAG found evidence that for some members, the case managers failed to complete linkage for requested services. During the file review, HSAG noted that the care plans were not consistently member-centered and measurable. In addition, problems identified in the care plans did not always match the member's currently reported diagnosis, and goals were often not linked to the identified interventions.

Overall, HSAG did find evidence that the case managers were providing care plans to the members' primary care providers (PCPs). However, HSAG found no documented follow-up with the member's PCP or specialist after the care plan was faxed. In addition, there were instances where the case manager did not follow up with members or their families after receiving calls from them.

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 aligned with current resources. However, for cases involving member hospitalization, HSAG noted during its file review that no discharge planning was documented.

Standard V—Coverage and Authorization of Services

Performance Strengths

Overall, WellCare staff demonstrated strong knowledge of Utilization Management (UM) policy and process, with consideration of both behavioral and medical health needs. There was strong evidence of medical director involvement and demonstration of Utilization Management Committee reporting and oversight.

In the local facilities, WellCare field staff members fostered positive provider relationships, which in turn supported the CMO's ability to understand and appropriately respond to local needs and identify appropriate community resources.

Areas Requiring Corrective Action

While WellCare's policy demonstrated compliance with the notice of action (NOA) for authorization requests that had exceeded required time frames, the CMO's stated practice conflicted with the policy. WellCare's practice was to be "member friendly" and approve authorization requests that exceeded the timely review requirements. Operational practice should be consistent with written policy.

Denial File Review Summary

Overall, WellCare demonstrated compliance with the expectations of timeliness, notification, and appropriate clinical review for prior authorization requests. Cases reviewed were representative of both WellCare's internal utilization review files and those of the CMO's delegated vendors. One pharmacy denial was reviewed, and no NOA was provided to the member. The provider did receive timely notice. The CMO needs to ensure the member is provided notice of pharmacy denials.

Standard VI—Emergency and Poststabilization Services

Performance Strengths

WellCare ensured that members were able to access emergency services 24 hours a day, seven days a week to treat emergency medical conditions. The CMO provided payment, based on contractual agreements, for any emergency services regardless of network status and ensured payment for all triage/screening services.

Areas Requiring Corrective Action

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

Case and Disease Management Focused Review

Case Management

HSAG performed case-specific file reviews that focused on members in case management. The review focused on assessment of the member's needs, the development of the care plan, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The review looked for gaps in the assessment, the care plan, monitoring and follow-up, presentation of the member in a multidisciplinary setting, and process for handling transitions of care including discharge planning.

Methodology

HSAG developed a case management evaluation guide in collaboration with DCH, which HSAG used to conduct the review at the individual case level. The case management evaluation guide covered the following areas:

- Identification
- Assessment
- Care Plan Development
- Monitoring and Follow-up
- Transition of Care and Discharge Planning

HSAG selected eight member sample cases, plus an oversample of three cases to review. The sample cases were pulled from a file provided by the CMO and contained members with open enrollment in the case management program between January 1, 2014, and May 30, 2014. HSAG provided the CMO with the selected sample cases HSAG would review on-site by uploading the information to the HSAG file transfer protocol (FTP) site on June 30, 2014. The CMO was responsible for assuring the identified sample cases were available for the reviewers during the on-site review.

An HSAG audit team, composed of clinicians with care management experience, reviewed case documentation from the selected cases. Members of WellCare management were included in the case review process, to present the case to the HSAG audit team, navigate through the CMO's care management system, and respond to any questions.

Identification

HSAG reviewed the CMO's process for identifying members who could benefit from case management services.

Observations:

Members were identified for case management through data mining/predictive modeling, staff or utilization management (UM) referral, and provider or caregiver referral. Members were also able to self-refer. No issues with identification of members for case management were noted.

Recommendations:

HSAG has no recommendations at this time.

Assessment

Observations:

The assessments and notes for pediatric, adult, and OB members in case management were completed within the appropriate time frames and provided documentation such as physical history, social history, and demographics. The initial assessment case note that accompanied the system-generated comprehensive assessment results provided an overall comprehensive assessment of the member.

Recommendations:

HSAG has no recommendations at this time.

Care Plan Development

Observations:

Overall, HSAG noted that WellCare sent completed care plans to members' PCPs. In many cases, HSAG observed challenges with care plan development, including the following:

- The care plan lacked member-centeredness.
- Goals were not measurable.
- Intent of the goal did not accurately represent the member's identified needs and did not link to the intervention being provided by the case manager.
- Problems identified by the case manager in the care plan did not accurately reflect the member's current diagnosis.

Recommendations:

- Ensure that all care plans are member-centered, goals are measurable, the intent of the goal accurately represents the member's identified needs, and the interventions being provided to the member and problems identified in the care plan accurately represent the member's current diagnosis and needs.

Monitoring and Follow-up:

Observations:

HSAG noted during the case file review that monitoring of members aligned with the CMO's acuity levels assigned by the case manager. However, other than faxing of the care plan, HSAG noted limited contact with members' providers in the ongoing management of members. In one instance, HSAG identified that timely follow-up was not provided to a member's parent who had reached out for assistance. HSAG also noted that all reviewed cases lacked a multidisciplinary team approach.

Recommendations:

- Engage members' providers throughout the monitoring and follow-up period to ensure members are following through with provider recommendations for care.
- Utilize a multidisciplinary team approach for consultation and review of services being provided to ensure all service options available to the member can be addressed.
- 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 member needs.

Transition of Care and Discharge Planning:

Observations:

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.

Recommendations:

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

Disease Management

HSAG performed case-specific file reviews which focused on members in disease management. The review focused on identification for disease management, assessment, education, monitoring, and measureable outcomes.

Methodology

HSAG conducted a file review of eight disease management cases. The review sample consisted of asthma, diabetes, hypertension, depression, and chronic obstructive pulmonary disease (COPD) disease management cases. Overall, HSAG found that the disease management process had improved since the last review period; however, opportunities for further improvement remain.

Program Type and Identification

Observations:

The CMO's case and disease management system, Enterprise Medical Management Automation (EMMA), had limitations. HSAG found identification of members for disease management within the case documentation, but the system did not capture disease management episodes; therefore, the initial identification was always the date of enrollment and the date of assessment. This made reviewing the members' assessment needs and status with each episode difficult. Documentation related to the assessment date and most recent disease management episode did not always coincide.

HSAG noted that, for all members in disease management, the CMO was moving toward active disease management instead of enrolling them into passive disease management; therefore, the leveling of members no longer appeared necessary since all members were contacted for active enrollment.

Recommendations:

- The CMO should explore system enhancements to address the disease management system's identification practice.
- The CMO should consider reviewing and revising its process for stratification of members since it has implemented active management of all members identified for disease management, and the stratification process to determine who should receive passive versus active disease management is no longer necessary.

Assessment and Guidelines

Observations:

HSAG found the disease management assessment process to be sufficient; the assessments captured appropriate elements of disease-specific conditions. A notification letter was typically sent to the PCP for members enrolled in the disease management program, and the letter content was noted as a strength. The provider notification letter included information about enrollment into the disease management program, and it solicited input from the provider specific to the member's condition.

Recommendations:

HSAG identified no recommendations for this area.

Education

Observations:

WellCare staff used *Living with Illness* workbooks as the primary mode of education. HSAG found evidence that the education provided in the workbook was reviewed with members telephonically to reinforce the educational message.

Recommendations:

HSAG identified no recommendations for this area.

Monitoring

Observations:

Several observations were made in the area of monitoring and included the following:

- HSAG noted that a care plan was developed for all members enrolled in active disease management; however, the review showed that most goals were standardized and primarily included a goal for educating members on the disease process and a goal for verbalization of

signs and symptoms of exacerbations. Recently, the CMO began creating custom goals for members. While these goals still appeared to be somewhat broad, the customization was more likely to result in positive outcomes.

- Case note documentation indicated that much of the work that disease case managers were completing with members showed a connection to clinical guidelines.
- Member engagement was identified as a challenge for WellCare. Cases were opened with one-to-two contacts; members were usually then moved to passive enrollment after three unsuccessful contact attempts.
- One case reviewed was closed before goals were met.
- HSAG found strong evidence that asthmatic child members received hypoallergenic bedding, and confirmed that members received the appropriate durable medical equipment (DME) such as blood pressure cuffs, glucometers, scales, etc.

Recommendations:

- Develop care plans that include customized goals, with input from the member.
- Consider care plan goals that focus on improved health outcomes and controlled management of chronic diseases.
- Ensure goals are met before the case is closed out.

Measureable Outcomes

Observations:

The system had limitations for tracking progress indicators such as blood glucose levels, blood pressure readings, etc. The overall disease management program lacked ways to measure success. For members enrolled in the disease management program, the CMO reported the percentage of members having each disease, with the CMO achieving a very low penetration level of members in active disease management. HSAG identified no measurement of health outcomes.

Recommendations:

- Consider system enhancements to enable member-level tracking of health indicators/status over time.
- Establish metrics to evaluate the overall effectiveness of the disease management program that focus on measuring health outcomes.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

WellCare continued its efforts to address follow-up items; however, all six areas still require action before achieving a *Met* status.

Areas Requiring Corrective Action

Six areas still require corrective action. WellCare must revise the annual assessment of its quality program to ensure all quality elements are addressed and integrated into the overall quality program. The CMO did not meet all DCH-established performance goals, and it did not meet the clinical practice guideline (CPG) provider compliance goal. WellCare did not demonstrate evidence of ongoing monitoring of its staff related to discharge planning. WellCare also did not demonstrate that discharge plans were documented for all members discharged from an inpatient setting.

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, 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.

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—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. Availability of Services—Establishing and Maintaining an Adequate Network of Providers: *42 CFR 438.206(b); Contract 4.8.1.2; 4.8.1.6* The care management organization (CMO) has written provider selection and retention policies and procedures and maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the CMO considers:		
(a) The anticipated Medicaid/Georgia Families (GF) enrollment.	• C7ND MD-001 Network Development Policy, pp. 1,2, 9 • C6NI-001 GeoAccess Reporting Policy, p. 12 • GA 2013 QI Evaluation, pp. 3, 7 • 2013 Q4 Georgia Provider Network, Entire document • 2013 Q4 Georgia Provider Network.PDF	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO conducted a quarterly GeoAccess review of its provider network, and these reports indicated that the network was adequate for current and anticipated members to obtain required services.		
Required Actions: None.		
(b) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the CMO.	• WellCare Cultural Competency Plan, Entire Document • GA Medicaid Cultural Needs Assessment, Entire Document • C7ND MD-001 Network Development Policy, p.8	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO conducted a quarterly GeoAccess review of its provider network, and that reporting indicated the network was adequate to ensure current and anticipated members obtain required services.		
Required Actions: None.		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(c) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.	WellCare demonstrates compliance with this standard with the following documents: • C7ND MD-001 Network Development Policy, pp. 2, 9, 18- 20 • C7CR-001 Credentialing and Re-Credentialing Policy, Entire Document • Case Example Cactus Print Screen • 2013 Q4 Georgia Provider Network, Columns 6 & 8 • 2013 Q4 Georgia Provider Network.PDF	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO conducted a quarterly GeoAccess review of its provider network, which helped WellCare determine that the network had the appropriate number and types of providers needed within the network.		
Required Actions: None.		
(d) The number of network providers who are not accepting new Medicaid patients.	• C7ND MD-001 Network Development Policy, p. 21 • Provider Listing Report_Q0413_Open and Closed Panels, Column Z • GA 2013 QI Evaluation, p 81	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO submitted its Provider Listing Report, which indicated which provider panels were open or closed. Staff members indicated that they contacted providers with closed panels to determine if the panel was able to be reopened.		
Required Actions: None.		
(e) The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.	• C7ND MD-001 Network Development Policy, pp. 19, 20 • C6NI-001 GeoAccess Reporting Policy, p. 12 • Site Inspection Evaluation Survey Tool for Unaccredited Facilities, p. 2 • C6CS-039 Medicaid Non-Emergent Transportation, pp. 1, 2, 5 • 2013 Q4 Georgia Provider Network, Entire document	☒ Met ☐ Not Met ☐ N/A

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 I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The CMO conducted a quarterly GeoAccess review of its provider network, and that analysis determined the distance and time traveled between member and provider.		
Required Actions: None.		
2. Availability of Services—Direct Access to Women's Health Specialist: *42 CFR 438.206(b)(2); Contract 4.8.3.1* The CMO provides female members with direct in-network access to a women's health specialist for covered care necessary to provide a woman's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	WellCare provides open access for female members to a woman health specialist for covered routine and preventive health care services as evidenced by OB/GYN access being above the 90%. • C7UM MD 4.16 Self-Referral For Well-Woman Examination Policy, pp. 1, 2 • C7UM MD 4.5 Care Coordination Continuity of Care and Transition of Care Policy, p 9 • Provider Handbook, p. 31 • Member Handbook, p. 38 • 2013 Q4 Georgia Provider Network, p. 3 • GA Medicaid Cultural Needs Assessment, p. 15	☒ Met ☐ Not Met ☐ N/A
Findings: The provider handbook indicated that female members had direct in-network access to women's health specialists for covered routine and preventive health care.		
Required Actions: None.		
3. Availability of Services—Direct Access to Specialists: *42 CFR 438.208(c)(4); Contract 4.8.3.2* The CMO has a process in place that ensures that (i) members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the member's condition and identified needs, and (ii) the CMO Medical Director oversees this process.	• C7UM-MD 4.4 Standing Referrals for Chronic and Disabling Conditions Policy, pp. 2, 5 • C7UM-MD 3.3 Medical Director Physician Advisory Review and Specialist Consultation, pp. 1, 2, 7 • Provider Handbook, pp. 31, 53	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook informed the member that if a course of treatment was needed, members had direct access to specialists, ensuring continuity of care.		
Required Actions: None.		

Standard I—Availability of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
4. Availability of Services—Direct Access/Treatment Plans: *42 CFR 438.208(c)(3)(i-iii); Contract 4.8.3.3* The CMO ensures that members who are determined to need a course of treatment or regular care monitoring have a treatment plan and that the treatment plan is: (i) developed by the member's PCP with member participation, and in consultation with any specialists caring for the member; and (ii) approved in a timely manner by the CMO medical director and in accord with any applicable State quality assurance and utilization review standards.	As evidenced by the documents below, WellCare provides authorizations for services for members as determined through a treatment plan to need a course of treatment in a timely manner. • C7UM-MD 4.4 Standing Referrals for Chronic and Disabling Conditions Policy, pp 2, 5 • C7UM MD 4.5 Care Coordination Continuity of Care and Transition of Care Policy, p 1, 9 • C7UM 4.12 Prior Authorization Precertification Review Policy, pp. 2, 7 • C7UM-MD 2.1 Service Authorization Decisions Policy, pp. 2, 15 • C7UM-MD 2.2 Adverse Determinations Proposed Actions Policy, p 2 • Provider Handbook, p 21	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook informed the member that if a course of treatment was needed, members had direct access to specialists, ensuring continuity of care. Staff members indicated that when an authorization for a member to see a specialist was issued, the PCP would receive a copy of the prior authorization documentation.		
Required Actions: None.		
5. Availability of Services—Second Opinion: *42 CFR 438.206(b)(3); Contract 4.11.7.1-3* The CMO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.	• C7UM 4.2 Second Surgical Medical Opinion, pp. 1, 5 • Provider Handbook, p 28 • Member Handbook, p 39	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook indicated that a member was able to receive a second opinion within the network at no cost to the member. If the second opinion was not available within the network, the CMO would generate an authorization enabling the member to obtain the second opinion outside the network.		
Required Actions: None.		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
6. Availability of Services—Coverage Out of Network: *42 CFR 438.206(b)(4); Contract 4.8.19.1* If the CMO's network is unable to provide necessary services, covered under the contract, to a particular member, the CMO: ◆ Adequately and in a timely manner covers these services out of network for the member, for as long as the CMO is unable to provide them. ◆ Informs the out-of-network provider that the member cannot be balance billed.	• C7UM 6.3 Referrals to Non-Contracted Provider Policy, pp. 1-2, 6 • Case Example Single Case Agreement, p 1, 2 • Member Handbook, p 25	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook indicated that if a service was not provided within the network, the CMO would approve services outside the network and attempt to contract with the out-of-network provider. The single case agreement document indicated the agreed-upon payment and that this payment would be the final payment the provider would receive.		
Required Actions: None.		
7. Availability of Services—Out-of-Network Provider Payment and Cost to Member: *42 CFR 438.206(b)(5); Contract 4.8.19.2* The CMO, consistent with the scope of contracted services, requires out-of-network providers to coordinate with the CMO with respect to payment.	• C7UM 6.3 Referrals to Non-Contracted Provider Policy, pp. 1- 2 • Member Handbook, pp. 20, 25, 39, 47 • Sample: Single Case Agreement, Page 1, Section C	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook indicated that if a service was not provided within the network, the CMO would approve services outside the network and attempt to contract with the out-of-network provider. The single case agreement document indicated the agreed-upon payment and that this payment would be the final payment the provider would receive.		
Required Actions: None.		
8. Availability of Services—Out-of-Network Provider Payment and Cost to Member: *Contract 4.8.19.2* The CMO coordinates with out-of-network providers regarding payment according to the following DCH contract provisions:		

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 I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(a) If the CMO offers the service through an in-network provider(s), and the member chooses to access the service (i.e., it is not an emergency) from an out-of-network provider, the CMO is not responsible for payment.	• C12PD-004 Medicaid Member Handbook Policy, pp. 3, 5 • Member Handbook, p 20, 25, 39, 47	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook indicated that the CMO was not responsible for payments if the member chooses to access services outside the network.		
Required Actions: None.		
(b) If the service is not available from an in-network provider, but the CMO has three documented attempts to contract with the provider, the CMO is not required to pay more than Medicaid fee for service (FFS) rates for the applicable service, less ten percent (10%).	• C7UM 6.3 Referrals to Non-Contracted Provider Policy, pp. 2, 6 • Geo Access CAP Report Q0413, Column J & L • OON Professional Claim, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO staff indicated there were times when a provider did not want to contract with WellCare. Network development staff members document the attempts and track timeliness of contracting inquiries. After three months, they again attempt to contract with the provider.		
Required Actions: None.		
(c) If the service is available from an in-network provider, but the service meets the emergency medical condition standard, and the CMO has three documented attempts to contract with the provider, the CMO is not required to pay more than the Medicaid FFS rates for the applicable service, less ten percent (10%). *(Note: When paying out-of-state providers in an emergency situation, the CMO does not allow members to be held accountable for payment under these circumstances.)*	WellCare adheres to the prudent layperson definition for emergency medical treatment. WellCare of Georgia does not deny emergency room (ER services), triage or stabilization. In the event that a Prudent Layperson response is not demonstrated when reviewing both presenting symptoms and discharge diagnosis, the facility is paid according to the contractually agreed upon rates and not more than Medicaid FFS rates less ten percent. The member is held harmless. • Geo Access CAP Report Q0413, Column J & L • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 11 • Case Example GA Emergent Claim Out of State, Entire Document • Provider Handbook, pp. 115, 120	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO staff indicated there were times when a provider did not want to contract with WellCare. Network development staff members documented the attempts and tracked timeliness of contracting inquiries. After three months, they again attempted to contract with the provider. The Referrals to Non-Contracted Providers Policy indicated that the member would not be charged more than the member would have been charged if the services were furnished within		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
the network.		
Required Actions: None.		
(d) If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the CMO and the out-of-network provider.	As evidenced by the documents below, WellCare will provide necessary services covered under the contract with an out of network provider if unable to provide services through a network provider. If the member was referred for the services, payment amount is determined between the provider and WellCare, the member is held harmless for any amounts over the benefit plan cost shares. • C7UM 6.3 Referrals to Non-Contracted Providers Policy, p 6 • Case Example Single Case Agreement, p 2 • Member Handbook, p 25	☒ Met ☐ Not Met ☐ N/A
Findings: If a service was not available within the network, the member would be referred to an out-of-network provider. The single case agreement document indicated that the member could not be pursued for additional payment.		
Required Actions: None.		
9. Services Not Available In-Network—Cost to Member: *42 CFR 438.206(b)(5); Contract 4.8.19.3* In the event that needed services are not available from an in-network provider and the member must receive services from an out-of-network provider, the CMO ensures that the member is not charged more than it would have if the services were furnished within the network.	As evidenced by the documents below, WellCare will provide necessary services covered under the contract with an out of network provider if unable to provide services through a network provider and the member is held harmless for any amounts over the benefit plan cost shares. • C7UM 6.3 Referrals to Non-Contracted Provider Policy, p 6 • Case Example Single Case Agreement, p 2 • Member Handbook, p 25	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook informed members that if a service was not available within the network, the member was able to receive services outside the network and that the CMO would not charge the member more than it would have charged for the same services received within the network.		
Required Actions: None.		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
10. Credentialing: *42 CFR 438.206(b)(6); 42 CFR 438.214(b)2; Contract 4.8.1.2; 4.8.15.1* The CMO ensures that all providers are appropriately credentialed and maintain current licenses by following a documented process and having written policies and procedures for credentialing and recredentialing its in-network providers using standards established by the National Committee for Quality Assurance (NCQA), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or American Accreditation Healthcare Commission/URAC.	• C7CR-001 Credentialing and Recredentialing Policy, Entire Document • C7CR-001-PR-001 Credentialing and Recredentialing Procedure, Entire Document • C7CR-007 Corrective Action Policy, Entire Document • C7CR-007-PR-001 Corrective Action Procedure, Entire Document • C7CR-009 Assessment of Organizational Providers Policy, Entire Document • C7CR-009-PR-001 Assessment of Organizational Providers Procedure, Entire Document • C7CR-019 Credentialing Committee Peer Review Policy, Entire Document • C7CR-019-PR-001 Credentialing Committee Peer Review Procedure, Entire Document • C7CR-020-PR-001 Hearing & Appellate Procedure, Entire Document • C7CR-024 Medicare & Medicaid Sanctions Policy, Entire Document • C7CR-025 Reporting Adverse Actions Policy, Entire Document • C7CR-046 On-Going Monitoring Policy, Entire Document • C7CR-046-PR-001 On-Going Monitoring Procedure, Entire Document • C7CR-049 Non Discrimination Policy, Entire Document • Credentialing Program Description, Entire Document	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: WellCare staff provided its credentialing and recredentialing policies for review. The CMO staff indicated that licenses were verified and monitored for expiration. Upon renewal, licenses were checked to ensure they were current.		
Required Actions: None.		

Standard I––Availability of Services Results						
Met	=	17	X	1.00	=	17.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0		*N/A*		*N/A*
Total Applicable	=	17	**Total Score**		=	100.0%

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
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:		
(a) **Provider Office Hours—Comparable for Medicaid Members:** *42 CFR 438.206(c)(1)(ii); Contract 4.8.14.1* The CMO requires that all its network providers offer hours of operation that are no less than the hours of operation offered to commercial and FFS patients and encourages the providers to offer after-hours office care in the evenings and on weekends.	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p, 1, 8 • Provider Handbook, p 19, 22-23 • PCP Contract Sample, p 6	☒ Met ☐ Not Met ☐ N/A
Findings: The provider handbook and contract sample indicated that providers must offer hours of operations that are no less than the hours offered to all other patients.		
Required Actions: None.		
(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.	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy p, 8 • Provider Handbook, 22 • Timely Access New Standards Q1 2014, QI New Standards Tab, Rows 12-13, 17-18, 23-24, 29-30	☐ Met ☒ Not Met ☐ N/A
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 times standards.		
Required Actions: WellCare must ensure its providers meet the wait time standards in this element.		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(c) **Appointment Wait Times:** *Contract 4.8.14.2* The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:		
(i) PCPs (Routine Visits)—14 calendar days	• Appt Call Script PCP, p 3 • Appt Call Script Peds, p 3 • C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Provider Handbook, p 22 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 12-13, 20 -21	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its providers met the requirements for routine PCP visits during the review period.		
Required Actions: None.		
(ii) PCP (Adult Sick Visit)—24 hours	• Appt Call Script PCP, p 2 • C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Provider Handbook, p 22 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 10-11	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its providers met the requirements for PCP adult sick visits during the review period.		
Required Actions: None.		
(iii) PCP (Pediatric Sick Visit)—24 hours	• Appt Call Script Peds, p 3 • C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Provider Handbook, p 22 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 18-19	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its providers met the requirements for PCP pediatric sick visits during the review period.		
Required Actions: None.		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(iv) Specialist—30 calendar days	• Appt Call Script Specialist, p 3 • C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Provider Handbook, p 22 • Timely Access Report Q1 2014, Specialist Summary Tab, Row 21	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its specialists met the requirements in this element during the review period.		
Required Actions: None.		
(v) Dental Providers (Routine-21 calendar days; Urgent-48 hours)	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 27-30 • GA Medicaid QIC Minutes April 2 2014, p 3	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its dental providers met the requirements in this element during the review period.		
Required Actions: None.		
(vi) Non-emergency Hospital Stays—30 calendar days	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access New Standards Q1 2014, QI New Standards Tab, Rows 20, 26 • Appt Call Script OBGYN, p 3 • Appt Call Script Specialist, p 3	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its providers met the requirements for non-emergency hospital stays during the review period.		
Required Actions: None.		
(vii) Mental Health Providers—14 calendar days	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 37-38 • Provider Handbook, p 100	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its mental health providers met the requirements in this element during the review period.		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
(viii) Urgent Care Providers—24 hours	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 41-42 • Provider Handbook, p 129 • Appt Call Script Urgent Care, p 2	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its urgent care providers met the requirements in this element during the review period.		
Required Actions: None.		
(ix) Emergency Providers—Immediately (24 hours a day, 7 days a week) and without prior authorization	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 11 • Provider Handbook, p 153	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored appointment wait times, and its emergency providers met the requirements in this element during the review period.		
Required Actions: None.		
(d) **Timelines–Visits for Pregnant Women:** *Contract 4.8.14.5* The CMO provides adequate capacity for initial visits for pregnant women within 14 calendar days of enrollment into the CMO plan.	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 33-34 • Appt Call Script OBGYN, p 3	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare monitored this timeliness standard for pregnant women, and its providers met the standard during the review period.		
Required Actions: None.		
(e) **Timelines—Visits for Children Eligible for Health Checks:** *Contract 4.8.14.5* The CMO provides adequate capacity to provide initial visits for children eligible for health checks within ninety (90) calendar days of enrollment into the CMO plan.	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access Report Q1 2014, Timely Access Template Tab, Rows 22-23 • Appt Call Script Peds, p 4 • Provider Handbook, p 22	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Member Handbook, p 13	
Findings: WellCare monitored timelines of visits for children eligible for health checks, and its providers met the requirements in this element during the review period.		
Required Actions: None.		
(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	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Timely Access New Standards Q1 2014, QI New Standards Tab, Rows 10-11, 15-16, 21-22, 27-28 • Provider Handbook, p 23 • Appt Call Script PCP, p 3 • Appt Call Script Peds, p 4 • Appt Call Script OBGYN, p 3&4 • Appt Call Script Specialist, p 3	☐ Met ☒ Not Met ☐ N/A
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.		
2. Services Available Twenty-Four/Seven: *42 CFR 438.206(c)(1)(iii); Contract 4.6.1.1; 4.6.2.1; 4.9.5.5* The CMO makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	As evidenced by the documents below, WellCare does not deny any claims for emergency services, triage or stabilization. WellCare adheres to the prudent layperson standard: possessing an average knowledge of medicine and health could reasonable expect the absence of immediate medical attention to result in serious jeopardy to a person's health, bodily function, or disfigurement. • C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 8 • Provider Handbook, p 23, 53 • PCP Contract Sample, p 6 • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 1, 11	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: WellCare's provider handbook indicated that services were available 24 hours a day, seven days a week when medically necessary. Additionally, the CMO had a 24-hour nurse line that members were able to call for advice on medical issues.		
Required Actions: None.		
3. Ensures Compliance: *42 CFR 438.206(c)(1)(iv-v); Contract 4.8.1.11* The CMO has mechanisms to monitor and ensure the CMO and its providers comply with the access and timeliness requirements and that members have timely access to quality care.	• C6NI-002 _Provider_Appointment_Accessibility_and_After-Hours_Coverage_Policy, pp. 1-4, 8-9 • Appointment Availability Tip Sheet, p. 3 • Appointment Availability Letter, Entire Document • PCP Contract Sample, p. 6	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO had policies and procedures in place to monitor and ensure providers comply with the access and timeliness requirements and that members had timely access to quality care.		
Required Actions: None.		
4. Takes Corrective Action: *42 CFR 438.206(c)(1)(vi); Contract 4.8.14.6* The CMO takes corrective action if there is a failure to perform in compliance with the timely access requirements.	• C6NI-002 Provider Appointment Accessibility & After Hours Coverage Policy, p 9 • CAP Failed Letters, entire document • Provider Tip Sheet • PCP Contract Sample, p 10	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO had policies and procedures in place and the staff described WellCare's corrective action process for providers that fail any of the timeliness requirements. The process required the provider to reply with a corrective action plan to resolve the issue.		
Required Actions: None.		

Standard II—Furnishing of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
5. Geographic Access: *Contract 4.8.13.1* The CMO meets the following geographic access standards for all members:	• C7ND MD-001 Network Development Policy, p 19-20 • 2013 Q4 GMD Georgia Provider Network o PCP's, p 13 o Specialists, p 13 o Pharmacies, p 16 o Hospitals, p 13 o Dental, p 16 o Mental Health, p 13	☐ Met ☒ Not Met ☐ N/A

	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 Subspeciality 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.

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
6. Assurances of Adequate Capacity and Services: *42 CFR 438.207(a)* The CMO assures DCH and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DCH's standards for access to care and in accordance with the following requirements:		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(a) **Nature of Supporting Documentation:** *42 CFR 438.207(b)(1-2); Contract; 4.18.6.1; 5.7–8* The CMO submits documentation to DCH in a format specified by the State to demonstrate that it complies with the following requirements:	• Timely Access Report Spec, Entire Document • Timely Access Report Q1 2014, Entire document • GA 2013 QI Evaluation, p 7	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO submitted its adequate capacity reports to DCH, and the CMO had the capacity to provide services to its members as needed.		
Required Actions: None.		
(i) Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area.	• C7ND MD-001 Network Development Policy, p 2 • C6NI-001 GeoAccess Reporting Policy, p 12 • 2013 Q4 Georgia Provider Network, entire document	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO had an appropriate range of preventive, primary care, and specialty services adequate for its current and anticipated membership.		
Required Actions: None.		
(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	• Provider Handbook, p 91, 94-96 • 2013 Q4 Georgia Provider Network, entire document • Ga Medicaid Cultural Needs Assessment, p 15	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare maintained a network of providers that was sufficient in number, mix, and geographic distribution to meet the needs of the current and anticipated membership.		
Required Actions: None.		
(b) **Timing of Documentation:** *42 CFR 438.207(c)(1-2); Contract 5.7-8* The CMO submits the DCH-required documentation according to the DCH contract requirements, but no less frequently than at any time that there has been either of the following: ◆ A significant change (as defined by DCH) in the CMO's operations that would affect adequate capacity and services including changes in the CMO's services, benefits, geographic service area, or	• C7ND MD-001 Network Development Policy, p 20 • Case Example Memorial Term Work Plan, entire document	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
payments ◆ Enrollment of a new population		
Findings: The CMO submitted documents to DCH according to its contract. WellCare's capacity was sufficient to provide the services needed for its membership.		
Required Actions: None.		

Standard II––Furnishing of Services Results						
Met	=	19	X	1.00	=	19.0
Not Met	=	3	X	.00	=	0.0
Not Applicable	=	0		*N/A*		*N/A*
Total Applicable	=	22	**Total Score**		=	86.4%

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Furnishing of Services—Cultural Considerations: *42 CFR 438.206(c)(2)* The CMO participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds as demonstrated by the following:		
1. Comprehensive Written Plan: *Contract 4.3.9.1* The CMO has a comprehensive written cultural competency plan that describes how the CMO ensures that services are provided in a culturally competent manner to all members, including those with limited English proficiency.	• C9CC-007 Cultural Competency Plan Policy, p. 1 • WellCare Cultural Competency Plan , Entire Document • 2013 QIPD Committee Structure, p. 4 • Certified Languages International Language Line Report for April 2014, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare staff provided the CMO's comprehensive written cultural competence plan for review, and it complied with the requirements.		
Required Actions: None.		
2. Comprehensive Written Plan—Content: *Contract 4.3.9.1* The CMO's cultural competency plan describes how providers, individuals, and systems within the CMO plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each.	• C9CC-007 Cultural Competency Plan Policy, p.1 • WellCare Cultural Competency Plan, Entire Document GA Medicaid Cultural Needs Assessment, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare staff provided the CMO's comprehensive written cultural competency plan for review, and it complied with the requirements. The provider manual indicated that providers will perform services to people of all cultures, races, ethnic backgrounds, and religions in an appropriate manner consistent with the policy.		
Required Actions: None.		
3. Plan Submitted to DCH: *Contract 4.3.9.2* The CMO submits its cultural competency plan to DCH for review and approval as updated.	• C9CC-007 Cultural Competency Plan Policy, p. 2 • GA DCH Submission of Cultural Competency Plan, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare staff indicated that changes to the cultural competency plan were submitted to DCH annually. The DCH provided feedback, suggested		

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
changes, and the CMO submitted the final document to DCH for approval.		
Required Actions: None.		
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.	The following documents demonstrate WellCare compliance to provide a summary of its cultural competency plan to in network providers, which includes information on how the providers (i) may access the full plan on the CMO's website and (ii) can request a hard copy from the CMO at no charge to the provider. • C9CC007 Cultural Competency Plan Policy, p 1-2 • Provider Handbook, p. 96	☐ Met ☒ Not Met ☐ N/A
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.		
5. Provides Oral Interpretation: *42 CFR 438.10(c)(4); Contract 4.3.10.1* The CMO provides oral translation services of information to any member who speaks any non-English language regardless of whether a member speaks a language that meets the threshold for "prevalent non-English" language.	• C6CS-056 Medicaid Interpreter Services Policy, Entire Document • Certified Languages International Language Line Invoice, Entire Document • Certified Languages International Language Line Data Report, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: Both the member and provider handbook indicated that oral translation services were available for non-English-speaking members.		
Required Actions: None.		
6. Notifies Members—Oral Interpretation: *42 CFR 438.10(c)(5); Contract 4.3.10.1* The CMO notifies members of the availability of oral interpretation services and informs them of how to access the services.	• C12PD-001 Medicaid Post-Enrollment Member Materials, pp. 1,2 • GOV18PD-006 Medicaid Written Member Materials and Marketing Materials Review and Approval Process, p. 10 • Member Handbook, p. 16	☒ Met ☐ Not Met ☐ N/A
Findings: Both the member and provider handbook indicated that oral translation services were available for non-English-speaking members. Either the member or the provider was able to call the CMO to arrange those services.		

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
7. Oral Interpretation—Free to Members: *42 CFR 438.10(c)(4); Contract 4.3.10.1* The CMO does not charge members for translation services.	- C6CS-056 Medicaid Interpreter Services Policy, p. 2	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook informed the member that translation services were free of charge.		
Required Actions: None.		
8. Written Materials—Alternative Formats: *42 CFR 438.10(d)(1)(ii); Contract 4.3.2.1* The CMO makes all written member materials 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.	• C12PD-001 Medicaid Post-Enrollment Member Materials, pp. 1, 2 • GOV18PD-006 Medicaid Written Member Materials and Marketing Materials Review and Approval Process, p. 10 • Member Handbook, p. 16	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO's member handbook and its Medicaid Written Member Materials and Marketing Materials Review and Approval Process indicated that member materials were available in alternative formats. Staff members indicated that the Flesch-Kincaid application ensured the materials were written at a fifth-grade reading level.		
Required Actions: None.		
9. Informs Members—Alternative Formats: *42 CFR 438.10(d)(2); Contract 4.3.2.1* The CMO notifies all members and potential members that information is available in alternative formats and how to access those formats.	• C12PD-001 Medicaid Post-Enrollment Member Materials, p. 1, 2 • GOV18PD-006 Medicaid Written Member Materials and Marketing Materials Review and Approval Process, p. 10 • Member Handbook, p. 16	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook notified members that information was available in alternative formats and how to gain access to these documents.		
Required Actions: None.		
10. Written Materials—Available Languages: *42 CFR 438.10(c)(3); Contract 4.3.2.2* The CMO makes all written information available in English, Spanish, and	• C12PD-001 Medicaid Post-Enrollment Member Materials, p. 1, 2, 4, 6 & 8 • GOV18PD-006 Medicaid Written Member Materials and Marketing Materials Review and	☒ Met ☐ Not Met ☐ N/A

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
all other prevalent non-English languages, as defined by DCH (i.e., a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State).	Approval Process, p. 10 • Member Handbook, p. 16	
Findings: The member handbook and WellCare policies indicated that written information was available in English, Spanish, and all other prevalent non-English languages.		
Required Actions: None.		
11. Written Materials—Language Block: *Contract 4.3.2.3* All written materials the CMO distributes to members 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 CMO to request the document in an alternative language or to have it orally translated.	• GOV18PD-006 Medicaid Written Member Materials and Marketing Materials Review and Approval Process, p. 10 • Member Handbook, p. 3	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook contained a language block, printed in Spanish, which directed the member to call the CMO to request documents.		
Required Actions: None.		
12. Written Materials—Understandable: *42 CFR 438.10(b)(i); Contract 4.3.2.4* The CMO has and follows processes to ensure that its written member materials are worded such that they are understandable to a person who reads at the fifth (5th) grade level.	• C12PD-001 Medicaid Post-Enrollment Member Materials, p. 4, 6, 8, 10 & 15 • GOV18PD-006 Medicaid Written Member Materials and Marketing Materials Review and Approval Process, p. 10, 11	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO used the Flesch-Kincaid application to verify that materials were written at a fifth-grade reading level.		
Required Actions: None.		
13. Medicaid Members Not Segregated: *Contract 4.8.16.1* The CMO ensures that all in-network providers (i) accept members for treatment, unless they have a full panel and are accepting no new GF or commercial patients and (ii) do not intentionally segregate members in any way from other persons receiving services.	The documents below demonstrate that WellCare ensures that all in network providers (i) accept members for treatment, unless they have a full panel and are accepting no new GF or commercial patients and (ii) do not intentionally segregate members in any way from other persons receiving services. • Provider Handbook, p 19	☒ Met ☐ Not Met ☐ N/A

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• PCP Contract Sample, p 8	
Findings: The provider handbook and provider contract sample indicated that providers must not intentionally segregate members in any way from other persons receiving services.		
Required Actions: None.		
14. Nondiscrimination: *42 CFR 438.6(d)(iv); 42 CFR 438.100(d); Contract 4.8.16.2* The CMO ensures that members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.	The documents below demonstrate that WellCare ensures that members are provided services without regard to race, color creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status or physical or mental disability. • PCP Contract Sample, p 8 • Provider Handbook, p 19	☒ Met ☐ Not Met ☐ N/A
Findings: The provider handbook and provider contract sample indicated that members must be provided services without regard to race, disability, religion, sex, health, ethnicity, creed, age, or national origin.		
Required Actions: None.		

Standard III––Cultural Competence Results						
Met	=	13	X	1.00	=	13.0
Not Met	=	1	X	.00	=	0.0
Not Applicable	=	0		*N/A*		*N/A*
Total Applicable	=	14	**Total Score**		=	92.9%

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. CMO Responsibilities: *42 CFR 438.208(b); Contract 4.11.8.1–2* The CMO assumes responsibility for care coordination that is designed to ensure and promote timely access to care/services, continuity of care, and coordination/integration of care.	• C7CM_MD_1_2_Case_Management_Program_ Description, p. 1 • 2014Integrated Care Management Program Description, pp. 3-8 • C7UM-4.5 Care Coordination Continuity of Care and Transition of Care • PCP contract 4.3.1	☒ Met ☐ Not Met ☐ N/A
Findings: After reviewing all documents provided by WellCare and interviewing CMO staff during the on-site audit, no areas of concern were noted for this element. WellCare staff reported during the on-site interview that Tampa case managers (physical and behavioral health) were broken out by regions, and all of their outreach was done telephonically with Georgia members. Staff reported that the obstetrics/gynecology (OB/GYN) case managers were local and worked with members face-to-face and/or telephonically. At this time, WellCare staff reported that the CMO was working to build integrated teams that will provide members improved coordination and continuity of care for both physical and behavioral health issues.		
Required Actions: None.		
2. Policies and Procedures: *42 CFR 438.208(b); Contract 4.11.8.3* ◆ The CMO has policies and procedures designed to accommodate the specific cultural and linguistic needs of its members and include, at a minimum: ◆ Provision of an individual needs assessment and diagnostic assessment; development of an individual treatment plan, as necessary, based on the needs assessment; establishment of treatment objectives; monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary. ◆ A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning. ◆ Procedures and criteria for making referrals to specialists and sub-specialists. ◆ Procedures and criteria for maintaining care plans and referral services when the member changes PCPs. ◆ Capacity to implement, when indicated, case management functions	WellCare has implemented policy and procedures to ensure and promote access to care/services and transition of care through Case Management, Disease Management, Discharge Planning, and identification of transition of care needs during the prior authorization process. The Case management assessment and care plan is developed based on the member's specific needs. • C9CC-007 (New Policy number C12PD-007) Cultural Competency Plan Policy, p. 1 • C7UM- 4.5 Care Coordination Continuity of Care, and Transition of Care Policy, p. 9 • Georgia Medicaid Quick Reference Guide, p. 3 • Provider Handbook, pp. 22, 23 • C7QI-015 Medical Record Review Policy, p. 6 • C7CM_MD_1_2_Case_Management_Program_ Description, pp.1- 2	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
such as individual needs assessments, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plans.	• 2014 Integrated Care Management Program Description, pp. 4, 6, 10, 14-16, 27 • C7CM MD 1.2-PR-004 Case Management Medical Comprehensive Assessment and Planning	
Findings: After reviewing all documents provided by WellCare and interviewing CMO staff during the on-site audit, no areas of concern were noted for this element. During the case file review, it was identified that complex case management and OB case notes/assessments were comprehensive and clearly identified members' physical, behavioral, and psychosocial needs along with any cultural or linguistic needs.		
Required Actions: None.		
3. Ongoing Source of Primary Care: *42 CFR 438.208(b)(1); Contract 4.1.2; 4.8.2.1; 4.8.2.3; 4.8.2.5* The CMO: ◆ Has written PCP selection policies and procedures describing how members select their PCP. ◆ Ensures that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished.	WellCare has established that the PCP is the medical home for care coordination. The PCP is the source for health care needs and is responsible for coordinating health care services. • C7UM- 4.5 Care Coordination, Continuity of Care, and Transition of Care Policy, p. 9 • C6EN MD-006 Provider Auto-Assignment Policy, p. 3 • C6CS-009 Change of Primary Care Physician Policy, p. 8	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare provided policies and procedures that outline how members select a PCP. WellCare staff reported during the on-site audit that the CMO worked to ensure that members who were auto-assigned to a PCP were linked with an appropriate provider or clinic that would meet their health care needs.		
Required Actions: None.		
4. PCP Responsibility for Coordinating Care: *42 CFR 438.208(b)(1); Contract 4.8.2.5* The CMO ensures that the primary care providers fulfill their responsibilities for: ◆ Supervising, coordinating, and providing all primary care to each	WellCare has established that the PCP is the medical home for care coordination. The PCP is the source for health care services. • C7UM 4.5 Care coordination Continuity of Care and Transition of Care Policy, p 1, 9	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
assigned member. ◆ Coordinating and/or initiating referrals for specialty care (both in and out of network). ◆ Maintaining continuity of care. ◆ Maintaining member medical records, which includes documenting all services provided by the PCP as well as the specialty services.	• C7QI-025 Medical Record Review Policy p 1-2 • PCP Contract Sample, p 1, 6, 23 • Provider Handbook 22, 24, 31, 36	
Findings: WellCare staff reported during the on-site audit that the CMO worked in collaboration with the member and the provider to ensure that all member health needs were met. Providers in WellCare networks were educated on being a medical home and building a team approach with the CMO to ensure continuity of care for the members.		
Required Actions: None.		
5. Coordination and Transition Across Providers/Settings, Including Other CMOs, PIHPs, PAHPs: *42 CFR 438.208(b)(2); Contract 4.8.17.1; 4.11.4.1* The CMO's care coordination system includes:		
(a) Advocating for and linking or transitioning members to services as necessary across providers and settings, including, as applicable, other CMOs, PIHPs, PAHPs, and Fee-for-Service providers.	WellCare supports collaboration between various providers and settings. WellCare coordinates care with other entities as needed to provide members with transitional healthcare needs. • C7UM 4.5 Care Coordination Continuity of Care and Transition of Care Policy, p 10 • C7CM_MD_1_2_Case_Management_Program_Description, pp. 1-4 • C7CM_MD_1_2_PR-004_Case_Management_Comprehensive_Assessment_Planning_Procedure, pp. 2-3 • 2014 Integrated Care Management Program Description, pp.3-8	☒ Met ☐ Not Met ☐ N/A
Findings: After reviewing all documents provided by WellCare and interviewing CMO staff during the on-site audit, no areas of concern were noted for this		

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
element. During the on-site audit, WellCare staff reported that case managers collaborate with providers and members to ensure that members were linked to identified services and transitioning members had continuity of care during the transition period.		
Required Actions: None.		
(b) Coordinating the member care with these other entities.	WellCare coordinates care with other entities to ensure continuity of care. • C7UM 4.5 Care Coordination Continuity of Care and Transition of Care Policy, p 10 • C7CM_MD_1_2_Case_Management_Program_Description, pp. 1-4 • C7CM_MD_1_2_PR-004_Case_Management_Comprehensive_Assessment_Planning_Procedure, pp. 2-3 • 2014 Integrated Care Management Program Description, pp.7, 8	☒ Met ☐ Not Met ☐ N/A
Findings: During the on-site audit, WellCare staff reported that the case managers had actively participated in interagency teams for children in the case management program. Case managers and UM staff worked together to help transition members back into the community setting.		
Required Actions: None.		
6. Coordinates and Shares Information With Other Organizations Serving the Member (e.g., CMOs, PIHPs, and PAHPS, Education, etc.): *42 CFR 438.208(b)(3); Contract 4.8.17.1–5* The CMO coordinates and shares information with: ◆ All divisions within DCH, as well as with other State agencies, and with other health plans operating within the same service region. ◆ Local education agencies in the referral and provision of children's intervention services provided through the school to ensure medical necessity and prevent duplication of services. ◆ The services furnished to its members with the service the member receives outside the CMO plan, including services received through any	WellCare coordinates care with other entities as needed to provide members with healthcare needs. If Non Emergent Transportation is needed, the request is referred to Customer Service to coordinate transportation services with the transportation provider. • C7UM- 4.5 Care Coordination, Continuity of Care and Transition of Care Policy, p 10	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
other managed care entity. ◆ Non-Emergency Transportation (NET) Providers. ◆ Ideally, with CMO-contracted providers of essential community services who would normally contract with the State as well as other public agencies and with non-profit organizations that have maintained a historical base in the community.		
Findings: After reviewing all documents provided by WellCare and interviewing CMO staff during the on-site audit, no further information was needed for this element. During the on-site audit, WellCare staff reported that when members move from one CMO to another, WellCare alerts the CMO accepting the member of any current authorizations and encourages the member to contact the new CMO to ensure a smooth transition of care.		
Required Actions: None.		
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.	• C7CM_MD-1.2-PR-007_Case_Management_Consent_Disclosure_Procedure, p. 1	☐ Met ☒ Not Met ☐ N/A
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 the 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 protected health information (PHI).		
8. Care Coordination Functions: *Contract 4.11.8.1* 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	WellCare of Georgia, Inc. has a new Transition of Care program that launched on June 27. This new program is designed to identify and outreach to members either in the hospital during discharge planning or recently discharged that are high risk for readmission to ensure discharge plans are safe and provide case management during the post hospital period. If continued case	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
◆ Discharge Planning	management is needed, the member is referred to case management for continued care coordination. Case Management • C7CM_MD_1_2_Case_Management_Program_Description, p.1 • 2014 Integrated Care Management Program Description, pp. 3, 4, 6, 7 Disease Management • 2014 Integrated Care Management Program Description, pp. 3, 4, 6, 7 Transition of Care • C7UM- 4.5 Care Coordination Continuity of Care and Transition of Care Policy, pp. 10-12 Discharge Planning • C7UM-5.3 Discharge Planning Policy pp. 1, 2, 5	
Findings: WellCare provided policies and procedures that outlined the CMO's case management, disease management, transition of care, and discharge planning programs. WellCare staff reported continued growth and development within these additional functions. The new team structure will provide a more integrated approach consisting of nurses, behavioral health clinicians, and nonclinical staff that provide support and intervention to members.		
Required Actions: None.		
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:		
(a) Early identification of members who have or may have special needs.	• 2014 Integrated Care Management Program Description, pp. 4, , 18, 19 • C7CM_MD-4.8_Individuals_with_Special_Health_Care_Needs, pp. 1-2, 5-6	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• C7CM_MD-1.2-PR-009_Case_Managment_Member_Identification_Medical, pp. 1-2	
Findings: WellCare provided policies and procedures that outlined the use of a proprietary algorithm which stratified members based on service utilization, severity of illness, and cost. During the interview HSAG noted that WellCare staff members were able to identify the use of an algorithm to identify members with special needs.		
Required Actions: None.		
(b) Assessment of member's risk factors.	• 2014 Integrated Care Management Program Description, pp. 9, 18 • C7CM_MD_1_2_Case_Management_Program_Description, pp. 1-4, 7-8, 22 • C7CM_MD_1_2_PR-004_Case_Management_Medical_Comprehensive_Assessment_and_Planning Procedure, pp. 1-3 • C7CM_MD-1.2-PR-008_Case_Management_Program_Description_Process_Comp_Assessment_Planning_Program_Procedure, pp. 1-2 • C7CM-1.2-PR-020_Case_Management_Behavioral_Health_Screenings_Procedure, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare provided policies and procedures that outlined the assessment of a member's risk factors. WellCare used predictive modeling to assess members' risk factors. This proprietary algorithm incorporated the Chronic Illness and Disability Payment System (CDPS) to target members for care management. WellCare staff reported that the CMO utilized a comprehensive assessment for members enrolled in case management.		
Required Actions: None.		
(c) Development of a care plan.	• 2014 Integrated Care Management Program Description, pp. 15, 22, 23 • C7CM_MD_1_2_Case_Management_Program_Description, pp. pp. 1, 2, 4, 22 • C7CM_MD_1_2_PR_004_Case_Management_C	☐ Met ☒ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	omprehensive_Assessment_Planning_Procedure, pp. 1-3	
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 represents 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 areas or concerns. Goals need to be individualized (based on reported member needs), measurable, realistic, and attainable by target dates.		
(d) Referrals and assistance to ensure timely access to providers.	• 2014 Integrated Care Management Program Description, pp. 22 • C7CM_MD_1_2_Case_Management_Program_ Description, pp. 4-6, 22 • C7CM_MD_1_2_PR_004_Case_Management_C omprehensive_Assessment_Planning_Procedure, pp. 1-2	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare provided policies and procedures that outlined the process for referrals and assistance for timely access to providers. Overall, the case file reviews reflected the approved process with the exception of a case managed by a new case manager.		
Required Actions: None.		
(e) Coordination of care actively linking the member to providers, medical services, residential, social and other support services where needed.	• 2014 Integrated Care Management Program Description, pp. 4, 21, 22 • C7CM_MD_1_2_Case_Management_Program_ Description, pp. 2-4, 22	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare provided documentation that outlined the CMO's coordination of ongoing member care and linkage to community referrals. Overall, the case file reviews reflected the approved process with the exception of a case managed by a new case manager.		
Required Actions: None.		
(f) Monitoring.	• 2014 Integrated Care Management Program Description, pp. 3, 4, • C7CM_MD_1_2_Case_Management_Program_ Description, pp. 1-2, 4, 7, 8, 9, 22 • C7CM_MD-1.2-PR-	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	015_Case_Management_Care_Monitoring, Entire Document	
Findings: WellCare provided documentation that outlined the stratification and acuity leveling of members for the current case management and disease management programs. During the case management file review, it was identified that the monitoring of the members aligned with the acuity level identified by the case manager.		
Required Actions: None.		
(g) Continuity of care.	• 2014 Integrated Care Management Program Description, pp. 4, 15-16, 21 • C7CM_MD_1_2_Case_Management_Program_ Description, pp. 1-4, 6, 8, 22	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare provided the CMO's integrated care management program description for review, which provided the CMO's procedure for continuity of member care. Overall, the case file reviews reflected the approved process with the exception of a case managed by a new case manager. Identification of the need for additional training with new case managers was discussed.		
Required Actions: None.		
(h) Follow-up.	• 2014 Integrated Care Management Program Description, pp. 4, 15-16, • C7CM_MD_1_2_Case_Management_Program_ Description, pp. 4, 8, 22	☐ Met ☒ Not Met ☐ N/A
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 member needs.		
(i) Documentation.	• 2014 Integrated Care Management Program Description, p. 4, 14, 29 • C7CM_MD_1_2_Case_Management_Program_	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Description, pp. 1, 2, 4, 22	
Findings: During the case file review, HSAG noted that documentation by the OB/GYN case managers was comprehensive and clearly articulated the case manager's interventions, education, and support provided to pregnant members in case management. WellCare staff members reported that they were developing note templates that will improve overall documentation for the case management program.		
Required Actions: None.		
10. Case Management—Identify Members With the Greatest Need: *42 CFR 438.208(c); Contract 4.11.9.3* ◆ The CMO makes a special effort to identify members who have the greatest need for case management, including those who have catastrophic or other high-cost or high-risk conditions, including pregnant women under 21, high risk pregnancies, and infants and toddlers with established risk for developmental delay.	• C7CM_MD_1_2_Case_Management_Program_Description, pp.1-4, 22 • 2014 Integrated Care Management Program Description, pp. 7, 9, 17- 20 • C7CM_MD-4.7_Developmental Disabilities, pp. 1-2 • C7CM_MD-4.7-PR-001_Developmental Disabilities, pp. 1-2 • C7CM_MD-4.8_Individuals_with_Special_Health_Care_Needs, pp. 1-2, 5-6 • C7CM_MD-4.8-PR-001_Individuals_with_Special_Health_Care_Needs, Entire Document • C7CM_GA-7.0_Interpregnancy_Care_Management, Entire Document • C7CM_GA-7.0-PR-001_Interpregnancy_Care_Management_Procedure, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: Members were identified for case management through data mining/predictive modeling, staff or UM referral, and provider or caregiver referral. Members were also able to self-refer.		
Required Actions: None.		

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
11. Disease Management: *Contract 4.11.10.1-3* ◆ The CMO has disease management programs for individuals with chronic conditions that include, at a minimum: ◆ Programs for members with diabetes and members with asthma ◆ Two additional programs from among the following: perinatal case management, obesity, hypertension, sickle-cell disease, or HIV/AIDS.	• 2014 Integrated program Description, pp. 4, 5 • DM Policy, Entire Document • HTN Module, Entire Document • Asthma Module, Entire Document • Diabetes Module, Entire Document • Diabetes CPG Adult, Entire Document • Diabetes CPG Children, Entire Document • Obesity CPG Adult, Entire Document • Obesity CPG Child, Entire Document • HTN CPG, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare had the required disease management programs for members with diabetes and asthma. In addition, the CMO had two additional disease management programs for hypertension and perinatal case management.		
Required Actions: None.		
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.	WellCare begins discharge planning at the beginning of the admission and has discharge planning procedures which include a continuous evaluation of the member's needs and services to ensure a safe discharge plan to another level of care. In addition to discharge planning, WellCare of Georgia, Inc. has a new Transition of Care program that launched on June 27, 2011. This new program is designed to identify and outreach to members either in the hospital during discharge planning or recently discharged that are high risk for readmission to ensure discharge plans are safe and provide case management during the post hospital period. If continued case management is needed, the member is referred to case management for continued care coordination. • C7UM-5.3 Discharge Planning Policy, p. 5 • C7UM- 4.5 Care Coordination Continuity of	☐ Met ☒ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Care and Transition of Care Policy, pp. 10-12	
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.		

Standard IV––Coordination and Continuity of Care Results					
Met	=	17	X 1.00	=	17.0
Not Met	=	4	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	21	**Total Score**	=	81.0%

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. Comparable Coverage: *42 CFR 438.210(a)(2); 42 CFR 440.230; Contract 4.5.1.1* The CMO provides to members DCH-contracted medically necessary services in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services to beneficiaries under fee-for-service Medicaid.	WellCare has established a Utilization Management Program to ensure that members receive medically necessary services in an amount, duration, and scope as covered by fee-for-service Medicaid. • C7UM MD 2.1 Service Authorization Decisions Policy, p 15 • UM Program Description, pp. 4, 10	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO's UM program description outlined the prior authorization process and medical necessity review process, which were both no more restrictive than fee-for-service Medicaid.		
Required Actions: None.		
2. Sufficiency of Services: *42 CFR 438.210(a)(3)(i); Contract 4.5.4.1* The CMO has and follows processes to ensure that the services provided to each member are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are provided.	WellCare has developed processes to ensure that services provided achieve the expected outcome and purpose for which they were provided. • C7UM MD 2.1 Service Authorization Decisions Policy, p 15. • UM Program Description, p. 10	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO ensured that any medical necessity decision to deny a service request was made by a health professional with appropriate clinical expertise. Over- and underutilization trends were monitored to identify opportunities for process and quality improvement.		
Required Actions: None.		
3. Prohibited Reasons for CMO Decisions: *42 CFR 438.210(a)(3)(ii); Contract 4.5.1.1* The CMO does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	WellCare has developed processes to ensure that decisions made to deny or reduce are not because of diagnosis, type of illness, or member's condition. Medical reviews and decisions are based on coverage criteria and/or accepted practice guidelines for the service requested.	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• C7UM MD 2.1 Service Authorization Decisions Policy, p 15 • UM Program Description, pp. 4, 14 • C7UM- 3.4 Application of Criteria Policy and Procedure, p 2	
Findings: The written documentation and staff interviews demonstrated compliance with this element. During the staff interview, the medical director indicated that no denial of services would be based on diagnosis, illness, or condition; a medical necessity review and determination would be completed.		
Required Actions: None.		
4. Decisions Based on Medical Necessity: *42 CFR 438.210(a)(3)(i-iii); Contract 1.4; 4.5.1.1; 4.5.4.1-3; 4.11.1.1* The CMO provides all medically necessary services that meet the criteria as defined by DCH in its definition of "medical necessity" included in its contract with the CMO.	WellCare has developed processes to ensure that services provided meet the medically necessary criteria as established by DCH. • C7UM MD- 2.2 Adverse Determinations Proposed Actions Policy, p. 12 • C7UM MD 2.1 Service Authorization Decisions Policy, p 15. • Provider Handbook, pp. 43, 44 • Member Handbook, p. 20 • UM Program Description, pp. 2, 6, 10	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO's medical necessity definition was consistent with the DCH definition. Medical necessity review related to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements was acknowledged by the medical director.		
Required Actions: None.		
5. Written Policies and Procedures: *42 CFR 438.210(b)(1); Contract 4.11.1.1* The CMO has and follows written utilization management policies and procedures that include protocols and criteria for evaluating medical necessity and authorizing initial and continuing services.	WellCare has developed policies and procedures that include protocols and criteria that include protocols and criteria for evaluating medical necessity and authorizing initial and continuing services. • C7UM-3.4 Application of Criteria Policy and Procedure, p. 2 • C7UM MD 2.2 Adverse Determination	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Proposed Actions Policy, p. 3 • C7UM-5.4 Inpatient Concurrent Review Policy and Procedure, pp. 1,2,3 • C7UM-3.3 Medical Director Physician Advisor Review and Specialist Consultation Policy pp. 1, 2 • Provider Handbook, p	
Findings: The written policies and procedures and staff interviews demonstrated compliance with this element. The operationalized practice described by staff was consistent with policy and was evidenced in case file reviews.		
Required Actions: None.		
6. Written Policies and Procedures—Authorizations and Reviews: *42 CFR 438.210(b)(1); Contract 4.11.1.1* The CMO's written policies and procedures address which services require prior authorization and how requests for initial and continuing services are provided, and which services will be subject to concurrent, retrospective, or prospective review.	WellCare has developed policies and procedures that address which services require pre-authorization, how requests for initial and continuing services are received, and which services are subject to concurrent, retrospective, or prospective review. • C7UM- 4.12 Prior Authorization/Precertification Review Policy, p. 2 • C7UM- 5.4 Inpatient Concurrent Review Policy, pp. 2, 3 • C7UM- 5.4 –PR-001 Inpatient Concurrent Review Procedure, pp. 2, 3 • Georgia Medicaid Quick Reference Guide, p. 3 • Member Handbook, p. 37 • Provider Handbook, pp. 99, 111, 120, 121 which services require prior authorization • C7UM MD 2.1 Service Authorization Decisions Policy, p 16	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	how requests for initial and continuing services are provided • C7UM MD 2.1 Service Authorization Decisions Policy, pp. 16 which services will be subject to concurrent, retrospective, or prospective review • C7UM MD 2.1 Service Authorization Decisions Policy pp. 16	
Findings: The written policies and procedures, handbooks, and staff interviews demonstrated compliance with this element. The operationalized practice described by staff was consistent with current policy. The prior authorization requirements were no more restrictive than fee-for-service Medicaid. EMMA was the system used for UM documentation.		
Required Actions: None.		
7. Authorization of Services—Consistent Application of Review Criteria: *42 CFR 438.210(b)(2)(i); Contract 4.11.1.1* The CMO has mechanisms to ensure consistent application of review criteria.	WellCare has established an inter-rater review process that ensures decisions made are based on consistent application of review criteria. Interrater Reliability (IRR) testing is testing which measures the correctness and consistency of reviewer decision making using clinical review criteria. This testing is completed annually to ensure consistency in decision making. • C7UM-3.4 Application of Criteria Policy and Procedure, p. 2 • C7UM MD- 2.1 Service Authorization Decisions Policy, p. 16 • C7UM-1.5 Interrater Reliability Policy, Entire Document	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• C7UM-1.5-PR-001 Interrater Reliability Procedure, Entire Document • 2013 Interrater Reliability Test Results, Entire Document • UM Program Description, p. 10 • IRR Medical Directors Updates	
Findings: The written documentation and staff interviews demonstrated compliance with this element. Additional documentation provided on-site demonstrated compliance with the inter-rater reliability (IRR) process for the full review team.		
Required Actions: None.		
8. Authorization of Services—Consults With Requesting Physician: *42 CFR 438.210(b)(2)(ii); Contract 4.11.2.6* The CMO's policies and procedures include consulting with the requesting physician when appropriate.	WellCare has established a process to ensure the Plan reviewer includes consulting with the requesting physician when appropriate. • C7UM MD 2.1 Service Authorization Decisions Policy, p 16. • C7UM-3.4 Application of Criteria Policy and Procedure, p 2.	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. UM staff working within the various facilities had fostered improved communication with local service providers. Behavioral health staff worked closely with providers and had discussions regarding needed services before the initial decision was rendered.		
Required Actions: None.		
9. Required Clinical Expertise: *42 CFR 438.210(b)(3); Contract 4.11.2.4; 4.14.3.1* The CMO ensures that: ◆ Prior authorization and pre-certification is conducted by a currently licensed, registered, or certified health care professional who is appropriately trained in the principles, procedures, and standards of utilization review.	WellCare has also established processes to ensure decisions are made by a physician that has the appropriate clinical expertise as the requesting physician that is treating the member. WellCare has different clinical expertise in the Medical Directors, and has contracted with Medical Review Institute of America, (MRIoA), to provide clinical expertise reviews. • C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, p 12, 13	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
◆ All proposed actions (i.e., any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested) are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member's condition or disease.	• UM Program Description, pp. 3, 10-11 & 15 • Consultant Approval Example p 2, 10, 12, 13 • Consultant Denial Example p 2, 3, 5, 6. • Job Descriptions Corporate Medical Director and Nurses, Entire Document (Medical Director pp. 1-4; Inpatient Care Nurse pp. 5-7; Outpatient Care Nurse pp. 8-10) • Job Description Behavioral Care Manager, Entire Document	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO utilized licensed practical nurses (LPNs) for telephonic reviews, following established written guidelines. The CMO utilized registered nurses (RNs) for any-member facing UM activities. Licensed clinical social workers were additionally utilized for behavioral health reviews. Reviewers had a wide variety of clinical backgrounds. If a like specialist was needed for a specialty review, an external vendor was utilized for the independent review.		
Required Actions: None.		
10. Utilization Management (UM) Committee: *Contract 4.11.1.3* The CMO has a utilization management committee comprised of network providers within each service area (which could be one committee if each service area is represented on the committee) that is accountable to the Medical Director and governing body of the CMO.	WellCare has established a Utilization Management Advisory Committee (UMAC) with representatives from each internal operational area that reports to the Medical Director. The committee is comprised of network providers within each service area as demonstrated by the list of GA UMAC Network Physicians. Appendix C of the Quality Improvement Program Description (QIPD) shows that the UMAC is accountable to the QIC and the QIC is accountable to the WellCare Health Plan Board governing body. • C7UM MD-GA-1.11 Utilization Management Committee Policy, pp. 1, 2. • 2013 QIPD Committee Structure, pp. 3, 4, 7, 9 • 2013 Georgia UMAC Network Physicians, Entire Document	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The written documentation and staff interviews demonstrated compliance with this element. The committee was representative of the service areas, with medical director oversight.		
Required Actions: None.		
11. UM Committee Meetings and Records: *Contract 4.11.1.3* The CMO's UM committee(s) meets on a regular basis and maintains records of activities, findings, recommendations, and actions.	WellCare has established a UMAC with representatives from each operational area that reports to the Medical Director. This committee meets regularly as evidenced in the recorded meeting minutes. • C7UM MD-GA-1.11 Utilization Management Committee Policy, p. 3 • 2013 QIPD Committee Structure, pp. 7-8,9 • UMAC Minutes - February 19 2014, pp. 2, 4, 19 • UMAC Minutes - May 21 2014, pp. 2, 17, 18, 22, 26, 30 • UMAC Minutes – AdHoc meeting December 4, 2013 • UMAC Minutes – November 21, 2013 • UMAC Minutes - August 21, 2013	☒ Met ☐ Not Met ☐ N/A
Findings: The UM Committee minutes were detailed and robust, with medical director oversight. The committee reported to the Quality Improvement Committee (QIC); the QIC meeting minutes demonstrated approval of the UM Program Description as documented.		
Required Actions: None.		
12. Timelines—Standard Authorization Decisions and Notifications: *42 CFR 438.210(d)(1); Contract 4.11.2.5.1; 4.14.3.4.5* The CMO makes prior authorization decisions and provides notice to the provider and member for non-urgent services as expeditiously as the member's health care condition requires and within 14 calendar days of receipt of the request for service.	WellCare has Policies and Procedures that establish a 14 calendar day review time-frame for prior authorization for non-urgent service requests and decision notification to the provider and member. • C7UM MD 2.1 Service Authorization Decisions Policy, p 16, 18	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, p. 14 • Case Example Standard Request, Entire Document • Standard (Routine) Prior Authorization Processing Status Aging Report • Pharmacy Monitoring Report	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The Authorization Metric Report was reviewed during the on-site visit, which demonstrated monitoring and oversight for timely review. Documentation was date/time stamped and scanned into the system if not received electronically.		
Required Actions: None.		
13. Timelines—Extension for Standard Authorization Decisions and Notifications: *42 CFR 438.210(d)(1)(i-ii); Contract 4.11.2.5.1* The CMO may extend the timeline for up to an additional 14 calendar days if: ◆ The member or the provider requests an extension of the timeline, or ◆ The CMO justifies to DCH a need for additional information and how the extension is in the member's interest.	WellCare established a process for a member or provider to request up to a 14-day extension to the 14-day review time-frame. If approved through DCH the Plan may also request an extension to the 14-day review time frame when in the member's best interest. • C7UM MD 2.1 Service Authorization Decisions Policy, pp. 16, 18 • C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, pp. 14 • GA Extension Template-Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The Service Authorization Decisions policy demonstrated compliance with this element. During staff interviews it was noted that the CMO had received no extension requests from members or providers, and none had been requested by the CMO.		
Required Actions: None.		
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	WellCare established an expedited review time-frame for services where following the standard timeframes could jeopardize the member's life or health, and a decision notification within 24 hours.	☐ Met ☒ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
timeframes could seriously jeopardize the member's life or health, the CMO makes an expedited authorization determination and provides notice within 24 hours.	• C7UM MD 2.1 Service Authorization Decisions Policy, p 16, 18 • C7UM MD 2.2- Adverse Determinations Proposed Actions Policy, p 15 • Case Example Expedited Request, Entire Document	
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 for 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.		
15. Timelines—Extension for Expedited Authorizations Decisions and Notifications: *42 CFR 438.210(d)(2)(ii); Contract 4.11.2.5.2* The CMO may extend the 24 hour timeframe for up to five business days if: ◆ The member or the provider requests an extension, or ◆ The CMO justifies to DCH a need for additional information and the extension is in the member's interest.	WellCare established a process for the member or provider to request an extension to the expedited review time-frame up to 48 hours. This extension is a requirement of NCQA and more stringent than the EQRO standard. If approved through DCH the Plan may request an extension to the expedited review time frame for prior authorization requests. To date WellCare has not had to request justification from DCH to extend the timeframes for an Expedited Authorization Decision and has not received any requests from a provider or member to extend an Expedited Authorization Decision review time frame. • C7UM MD 2.1 Service Authorization Decisions Policy, p. 16, 19 • C7UM MD 2.2- Adverse Determinations Proposed Actions Policy, p 15	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• GA Extension Template-Entire Document	
Findings: The written documentation and staff interviews demonstrated compliance with this element. During staff interviews it was noted that the CMO had no extension requests from members or providers, and none had been requested by the CMO.		
Required Actions: None.		
16. Authorization for Services Delivered: *Contract 4.11.2.5.3* The CMO makes authorization determinations involving health care services that have been delivered within 30 calendar days of receipt of the necessary information.	WellCare has established a post service review time-frame for services already provided and a decision notification within 30 calendar days. • C7UM 2.1 Service Authorization Decisions Policy, pp. 19 • C7UM MD 2.2- Adverse Determinations Proposed Actions Policy, p. 15 • Case Example Post Service Request, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. Based on review of meeting minutes, timeliness of decision-making was identified as compliant for retrospective reviews.		
Required Actions: None.		
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.	WellCare provides written notification of a proposed decision to deny a service request to both the member and the provider. • C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, pp. 11-12, 13 • Case Example Standard Request, p. 4	☐ Met ☒ Not Met ☐ N/A
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.		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
18. Notice of Proposed Adverse Action—Language and Format: *42 CFR 438,404(a); Contract 4.14.3.2* As applicable**,** the CMO's written notice of adverse action to the member meets the language and format requirements of 42 CFR 438(10)(c) and (d) and Contract 4.3.2.	WellCare provides written notification of a proposed decision to deny a service request compliant with DCH language and format requirements. Prior to submission to DCH for review, the letter is reviewed to ensure the language meets the fifth grade reading level as required by DCH. • C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, p 13. • Case Example Standard Request, Entire Document • NOA Letter, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and file reviews demonstrated compliance with this element. The NOA narrative within the denial file reviews was understandable with effort to maintain a fifth-grade reading level.		
Required Actions: None.		
19. Content of Notice of Proposed Adverse Action: *42 CFR 438,404(b)(1-7); Contract 4.14.3.3* The CMO's notice of adverse action contains the following: ◆ 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 the basis for the action which must have a factual basis and legal/policy basis. ◆ The member's right to file an administrative review through the CMO's internal grievance system as described in Contract 4.14. ◆ The provider's right to file a provider complaint as described in Contract 4.9.7. ◆ The requirement that the member exhaust the CMO's internal	WellCare provides written notification of a proposed decision to deny a service request compliant with DCH language and format requirements. Prior to being delivered, the letter template is reviewed to ensure the notice contains what service has been denied and why, the member and provider appeal rights, and the members right to request a State administrative hearing once the Plan's grievance process has been exhausted. • C7UM MD-2.2 Adverse Determinations Proposed Actions Policy, pp. 13-14 • Member Handbook, p. 67 • NOA Letter, Entire Document	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
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 administrative review with the CMO, member instructions on how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.		
Findings: The written documentation and file reviews demonstrated compliance with this element. While the letter contained language to address continuation of benefits, the letter did not specify that the continuation of benefits was in reference to only those previously approved services that had been terminated, reduced, or suspended. The continuation of the benefit did not apply if the denial was in reference to a new request for services, such as for ongoing therapy or home health services. The reviewer did not assess appeals to determine if the language was impactful to the appeal process. However, the CMO indicated that this was model language directed by the State.		
Required Actions: None.		
20. Notice of Proposed Action Timeframe—Termination, Suspension, or Reduction of Previously Authorized Covered Services: *42 CFR 438 404(c)(1); Contract 4.14.3.4.1–4* For proposed actions to terminate, suspend, or reduce previously authorized covered services, the CMO mails the notice of proposed action at least 10 calendar days before the date of the proposed action or not later than the date of the proposed action in the event of one of the following exceptions: ◆ The CMO has factual information confirming the death of a member. ◆ The CMO 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 that 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 CMO mail directed to the member indicating no forwarding address. ◆ The member's provider prescribes a change in the level of medical care.	It is not WellCare's policy to terminate, suspend, or reduce previously authorized covered services; however, should the situation arise that such action is necessary; the Company has in place an Adverse Determination policy and procedure to ensure members receive advance notice of a decision to terminate, reduce, or deny continued services. WellCare will notify the member of an adverse decision by advance notice, as soon as practicable and/or before services end, and within times frames as required by the DCH contract. • C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, p. 15	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
◆ The date of action will occur in less than 10 calendar days in accordance with 42 CFR 483.12(a)(5)(ii). ◆ The CMO may shorten the period of advance notice to five calendar days before the date of action if the CMO has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources.		
Findings: The written documentation and staff interviews demonstrated compliance with this element. The staff indicated that no approved services had been reduced, suspended or terminated.		
Required Actions: None.		
21. Notice of Proposed Action Timeframe—Denial of Payment: *42 CFR 438 404(c)(2); Contract 4.14.3.4.5* The CMO provides notice of action at the time of any action/proposed action affecting the claim.	• C7UM MD 2.2- Adverse Determinations Proposed Actions Policy, p. 7-8 • C6CL GA-001 GA Claims Process and Finalize Flow Policy, p. 4 • Sample EOB, Entire Document • NOA Letter Template, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. Claim denials were not included in the denial files review sampling.		
Required Actions: None.		
22. Written Notice of Reasons—Decisions to Extend Timeframes: *42 CFR 438.404(c)(4)(i); Contract 4.14.3.4.7* If the CMO extends the timeframe for decision and sending the notice of action/proposed action according to Section 4.11.2.5, the CMO gives the member written notice of the reasons for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with the decision.	WellCare has policies and procedures which describe the process for Plan's extension of authorization decision timeframes. WellCare has instituted a Corrective Action Plan to ensure that the request is clearly documented. We have an extension letter which is used to notify the member of the extension request and a policy which describes the process. • C7UM MD 2.1 Service Authorization Decisions Policy, pp. 20- 21	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. During staff interviews it was not determined what		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
corrective action plan was instituted as noted in the evidence. However, as previously noted, the CMO had not requested extensions.		
Required Actions: None.		
23. Extensions of Timelines—CMO Responsibility: *42 CFR 438.404(c)(4)(ii); Contract 4.14.3.4.7* If the CMO extends the timeframe for decision and sending the notice of action/proposed action, the CMO carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	WellCare ensures the decision for an extension is within the best interest of the member and conducted timely as the member's health condition requires and will not exceed 14 calendars days. • C7UM MD 2.1 Service Authorization Decisions Policy, p. 17	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. As noted previously, the CMO had not requested extensions.		
Required Actions: None.		
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**.**	WellCare ensures that if a decision is not reached within the required review timeframes constitutes an adverse decision and a notice of action will be delivered by the date the review timeframe ends. Managers receive an inventory report on a daily basis that identifies what day of the review time frame the service request review is on and any pending decision on day thirteen and fourteen are made that day. • C7UM MD 2.1 Service Authorization Decisions Policy, p. 16 • C7UM MD 2.2 Adverse Determinations Proposed Actions Policy, p 16. • Prior Authorization Inventory Report, Entire Document • Sample Service Authorization, Entire Document	☐ Met ☒ Not Met ☐ N/A
Findings: The written documentation indicated that an adverse decision was rendered when the review time frame ends. During interviews, staff indicated that a		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
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.		
25. Compensation for Utilization Management Activities: *42 CFR 438.210(e); Contract 4.11.1.4* The CMO does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member (i.e., the CMO, and any delegated utilization review agent), and does not permit or provide compensation or anything of value to its employees, agents, or contractors based on: ◆ Either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment, or ◆ Any other method that encourages the rendering of a proposed action.	WellCare does not permit or provide compensation or anything of value as an incentive to deny, limit, or discontinue medically necessary services. • C7UM MD- 2.2 Adverse Determinations Proposed Actions Policy, p. 16 • Provider Handbook, p. 45 • Member Handbook, p. 38	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The medical directors complete an Attestation of No Financial Incentive. A sample was viewed during the on-site review.		
Required Actions: None.		

Standard V—Coverage and Authorization of Services Results						
Met	=	22	X	1.00	=	22.0
Not Met	=	3	X	.00	=	0.0
Not Applicable	=	0		*N/A*		*N/A*
Total Applicable	=	25		**Total Score**	=	88.0%

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. Availability of Emergency Services: *42 CFR 438.206(c)(1)(iii); Contract 4.6.1.1* The CMO has emergency services available 24 hours a day, seven days a week to treat an emergency medical condition.	WellCare members have access to emergency services available 24 hours a day, seven days a week without a prior authorization requirement. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 11 • Provider Handbook, pp. 53, 115 • Member Handbook, p. 21 • PCP Sample Contract, p. 6	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization and did not restrict access based on network status.		
Required Actions: None.		
2. Definition of Emergency Medical Services and Condition: *42 CFR 438.114(a)(1-3); Contract 1.4; 4.6.1.2* The CMO defines emergency services and an emergency medical condition consistent with the DCH contractually required definition.	WellCare defines emergency services and an emergency medical condition consistent with the DCH contract. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 11 • Provider Handbook, p. 126 • Member Handbook, p. 40	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO's definitions of an "emergency medical condition" and "emergency services" were consistent with the DCH definition.		
Required Actions: None.		
3. Does Not Limit/Define Emergency Medical Condition: *42 CFR 438.114(d)(i); Contract 4.6.1.2* The CMO does not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.	WellCare adheres to the prudent layperson definition for emergency medical treatment and does not require prior authorization for Emergency Medical services. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 11 • Provider Handbook, p. 126 • ER Claims Algorithm 1 -2	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• ER Monitoring Report	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO used algorithms in the processing of emergency service claims. The contractual arrangements established with facilities determined reimbursement levels.		
Required Actions: None.		
4. Prior Authorization Not Required: *Contract 4.6.1.3; 4.6.3* The CMO does not require prior authorization or pre-certification for emergency or urgent care services.	WellCare does not require prior authorization for Emergency Medical or Urgent Care services. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 2 • Provider Handbook, p.53 • Member Handbook, pp. 38, 40 • Georgia Medicaid Quick Reference Guide, p.4	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for any emergency services, regardless of network status.		
Required Actions: None.		
5. Coverage Decisions—Prudent Layperson Standard: *42 CFR 438.114(a); Contract 4.6.1.2; 4.6.1.4* The CMO bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.	WellCare adheres to the prudent layperson definition for emergency medical treatment. WellCare does not require prior authorization for emergent or urgent medical services. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 12 • Provider Handbook, p. 115	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. Coverage decisions and facility reimbursement were based on contractual arrangements. The facility may be reimbursed at the triage/screening level of service. The facility had opportunity to submit medical records to justify a higher level of reimbursement. The review was completed by an appropriately qualified clinician, with a second-level appeal available as needed. The ER Monitoring Report was reviewed during the on-site visit.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
6. Coverage and Payment—Providers: *42 CFR 438.114(c)(i); Contract 4.6.1.3* The CMO covers and pays for emergency services when furnished by a qualified provider, regardless of whether that provider is in the CMO's network.	WellCare covers and pays for emergency services, both in network and out-of network. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 11 • Provider Handbook, p. 115 • Case Example Claim Non-Par Paid ER, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not restrict payment for emergency services based on network status. Payment was based on place of service and revenue codes.		
Required Actions: None.		
7. Coverage and Payment—Screening Examination: *42 CFR 438.114(d)(2); Contract 4.6.1.3* The CMO pays for any screening examination services conducted to determine whether an emergency medical condition exists.	WellCare covers/pays for emergency services, including the screening to determine that an emergency condition exists. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 11 • Provider Handbook, p 115 • Case Example Triage Claim Paid, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. At a minimum, the CMO would always pay the triage/ screening level of reimbursement for emergency services.		
Required Actions: None.		
8. Coverage and Payment—Duration: *42 CFR 438.114(d)(3); Contract 4.6.1.3* The CMO pays for all emergency services that are medically necessary until the member is stabilized.	WellCare covers/pays for emergency services until the emergency condition is stabilized. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 11 • Provider Handbook, p. 115 • Case Example Triage Claim Paid, p.3	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Case Example ER to INP Paid Claim, p. 3 • Case Example Claim Par Paid ER, p. 3 • Case Example Claim Non-Par Paid ER, p. 3	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for poststabilization services. The CMO did require notification of subsequent inpatient admissions for review and evaluation of medical necessity.		
Required Actions: None.		
9. Determining Status of Members' Conditions: *42 CFR 438.114(d)(3); Contract 4.6.1.5* The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CMO. (*Note: The CMO, however, may send one of its physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangements do not delay the provision of emergency service.)*	WellCare ensures that the attending emergency room physician or treating provider determines disposition of the member once the member's condition is stable for transfer or discharged. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 12	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO deferred to the treating physician for determination of member stability. The CMO did not send a physician to assume responsibility of member care.		
Required Actions: None.		
10. Retroactive Claim Denial Prohibited: *42 CFR 438.114(c)(1)(ii)(A); Contract 4.6.1.6* The CMO does not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.	WellCare does not retrospectively deny emergency care services. WellCare adheres to the prudent layperson standard. • C6CL MD-005 Emergency Room and Urgent Care Services Policy, p. 8 • Case Example Triage Claim Paid, p. 3	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO indicated it would not take back payment or retroactively deny a claim based on the medical record review. The CMO, at a minimum, would always pay the triage/screening level of reimbursement.		

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
11. Determining Factor for Payment Liability: *42 CFR 438.114(c)(1)(ii)(A); Contract 4.6.1.6* If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the determining factor for the CMO payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation, in which case the CMO pays for all screening and care services provided.	In the event that a Prudent Layperson response is not demonstrated when reviewing both presenting symptoms and discharge diagnosis, the facility is paid according to contractually agreed upon rates, the member is held harmless. • C7UM MD 6.1 Emergency and Post – Stabilization Services Policy, p. 12 • C6CL MD-005 Emergency Room and Urgent Care Services Policy, p. 8	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO, at a minimum, would always pay the triage/screening level of reimbursement.		
Required Actions: None.		
12. May Not Deny Coverage/Payment—Member Instructed to Seek Emergency Services: *42 CFR 438.114(c)(1)(ii)(B); Contract 4.6.1.8* The CMO does not deny coverage/payment of services if a representative of the CMO instructs the member to seek emergency services and is responsible for payment for the medical screening examination and for other medically necessary emergency services without regard to whether the member's condition meets the prudent layperson standard.	WellCare does not deny any claims for emergency services if WellCare instructs the member to seek emergency services. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 2 • C6CL MD-005 Emergency Room and Urgent Care Services Policy, p. 8	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO, at a minimum, would always pay the triage/screening level of reimbursement. Payment would be based on the contractual arrangement with the facility. The CMO did not track if the member was sent for emergency services by a member of its staff.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
13. May Not Deny Coverage/Payment—Provider Failure to Notify CMO: *42 CFR 438.114(d)(1)(ii): Contract 4.6.1.7* While the CMO may establish guidelines and timelines for submittal of notification regarding provision of emergency services, the CMO does not refuse to cover an emergency service based on the emergency room provider, hospital, or fiscal agent's failure to notify the member's PCP, CMO plan representative, or DCH of the member's screening and treatment within those guidelines/timelines.	• C6CL MD-005 Emergency Room and Urgent Care Services Policy, p. 9	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO, at a minimum, would always pay the triage/screening level of reimbursement. No prior authorization or notification was required for emergency services. The CMO required notification of inpatient admissions for review of medical necessity.		
Required Actions: None.		
14. Member Not Liable: *42 CFR 438.114(d)(2); Contract 4.6.1.9* The CMO ensures that members who have an emergency medical condition are not liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member.	The member is held harmless or financially responsible for subsequent screening and treatment needed to diagnose a condition or stabilize them. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 2 • C6CL MD-005 Emergency Room and Urgent Care Services Policy, p. 9	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO indicated that members were held harmless for payments. Situations in which a member was billed by a provider would be managed through the grievance process.		
Required Actions: None.		
15. Poststabilization Services—Availability: *42 CFR 422.113(c); 42 CFR 438.114(c); Contract 4.6.2.1* The CMO provides poststabilization care services 24 hours a day, seven days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, pursuant to 42 CFR 438.114(e), to improve or	WellCare provides post stabilization care services 24 hours a day, seven days a week, related to an emergency medical condition. Post stabilization services are covered until the member's condition has stabilized. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 12	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
resolve the member's condition.	• Provider Handbook, p.53 • Case example ER to INP Paid Claim, Entire Document	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization of emergency or poststabilization services. The CMO required notification of inpatient admits for medical necessity review.		
Required Actions: None.		
16. Financial Responsibility—Prior Authorized Services: *42 CFR 422.113(c)(2)(i); 438.114(c); Contract 4.6.2.2* The CMO is responsible/pays for poststabilization services that are prior authorized or pre-certified by an in-network provider or organization representative, regardless of whether they are provided within or outside the CMO's network of providers.	WellCare is responsible for prior authorized post stabilization medical services, regardless of provider network status. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 12 • Case example ER to INP Paid Claim, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization and paid for poststabilization services regardless of network status.		
Required Actions: None.		
17. Financial Responsibility—Services to Maintain Stabilization: *42 CFR 422.113(c)(2)(ii); 42 CFR 438.114(c); Contract 4.6.2.3* The CMO is financially responsible for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network that are administered to maintain the member's stabilized condition for one hour while awaiting response on a pre-certification or prior authorization request.	WellCare is responsible for post stabilization medical services, regardless of provider network status for one hour while awaiting prior authorization review response. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p 12 • Case example ER to INP Paid Claim, Entire Document • Case example Claim Non-Par Paid ER, Entire Document	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization and paid for poststabilization services regardless of network status.		

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
18. Financial Responsibility—Services Not Prior Authorized: *CFR 422.113(c)(2)(iii)(A–C); 42 CFR 438.114(c); Contract 4.6.2.4.1-3; 4.6.2.4* The CMO is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ The CMO does not respond to the provider's request for precertification or prior authorization within one (1) hour. ◆ The CMO cannot be contacted. ◆ The CMO's representative and the attending physician cannot reach an agreement concerning the member's care and a CMO plan physician is not available for consultation. In this situation the CMO shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a CMO plan physician is reached or one of the criteria in Contract 4.6.2.5 are met.	WellCare is responsible for post stabilization medical services, regardless of provider network status, that are not prior authorized and the Company does not respond within an hour of the providers authorization request, WellCare cannot be reached, or there is agreement between the attending physician and a WellCare Medical Director. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p12-13	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization and paid for poststabilization services regardless of network status.		
Required Actions: None.		
19. End of Financial Responsibility: *42 CFR 422.113(c)(3); 42 CFR 438.114(c); Contract 4.6.2.5* The CMO retains financial responsibility for poststabilization services it has not approved until one of the following occurs: ◆ An in-network provider with privileges at the treating hospital assumes responsibility for the member's care;	WellCare is responsible for post stabilization medical services until an in-network provider can assume care either at the admitting facility or the member by transfer to an in network facility, an agreement between the treating physician and the WellCare Medical Director on care is made, or the member is discharged.	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
◆ An in-network provider assumes responsibility for the member's care through transfer; ◆ The CMO's representative and the treating physician reach an agreement concerning the member's care; or ◆ The member is discharged.	• C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, pp. 13	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization and paid for poststabilization services regardless of network status. Reimbursement was based on the contractual arrangements or out-of-network status.		
Required Actions: None.		
20. Limit on Charges for the Member: *42 CFR 422.113(c)(2)(iv); 42 CFR 438.114(c); Contract 4.6.2.6* In the event the member receives poststabilization services from a provider outside the CMO's network, the CMO does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider.	WellCare is responsible for post stabilization services provided by an out-of-network provider and will not charge the member more then he/she would have had to pay had he/she received services through an in network provider. • C7UM MD 6.1 Emergency and Post-Stabilization Services Policy, p. 13 • Member Handbook, .p. 41	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO did not require any member payment.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services Results					
Met	=	20	X 1.00	=	20.0
Not Met	=	0	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	20	**Total Score**	=	100.0%

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 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 CPG Compliance spreadsheet, which was used to score the CMOs for compliance on each of the three CPGs. The analysis indicated that 67 percent of providers complied with the Diabetes CPG, 90 percent complied with the Asthma CPG, and 100 percent complied with the ADHD CPG. The CMO also submitted its Methodology for CPG Reviews documentation, which summarizes the calculation process. Those providers who are issued a CAP are not specifically reevaluated for compliance with adherence to the CPGs. They are returned to the pool of providers the next year and may not be re-reviewed.

Required Actions: WellCare must improve CPG compliance until 90 percent of the CMO's providers comply with its CPGs. In addition, while WellCare conducts the analysis for compliance with CPGs and issues a CAP when needed, the CMO does not track and reevaluate providers until they are compliant with the CPG standard. WellCare must monitor and reevaluate providers until they are compliant with the WellCare CPGs.

Evidence/Documentation Submitted by the CMO

Compliance with tracking and re-evaluating providers until they are compliant with the Clinical Practice Guidelines (CPG) is evidenced by:

- CPG Re-Audit Workflow
- Providers that failed the audit in June 2013 were re-audited in 2013. All providers that were re-audited, were compliant except three (3).
- The three (3) providers that were not compliant will be audited again by 3/31/14. They will continue to be re-audited until they are compliant with the applicable CPG standard(s).

Additionally,

- The QI Department and Provider Relations will work closely with the providers that failed the re-audit to provide additional education and assistance to increase compliance. If the provider continues to fail, the Credentialing Committee will take action as needed.

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.

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 staff provided a spreadsheet with the CMO's rates compared to the DCH target. A review of the rates showed that the CMO fell short of the performance targets for most measures.

Required Actions: While WellCare uses the DCH-established targets and performs well compared to the goals, it does not meet the DCH goal for each measure. WellCare must meet or exceed the target in order to comply with this element.

Evidence/Documentation Submitted by the CMO

To meet or exceed the DCH established targets for the multiple measures, WellCare has:

- A Healthcare Effectiveness Data and Information Set (HEDIS®)[B-1] Steering Committee
- An interdisciplinary team to conduct provider HEDIS and gaps in care face to face educational visits. 115 visits to high volume Medicaid providers were completed from June to November 2013. The team included QI Provider Relations, Member Outreach, and the Sr. Medical Director as applicable.
- A provider incentive program is planned for 2014.
- Provider HEDIS/CAHPS Webinar Training classes were held weekly in October for providers who did not receive a visit by the team.
- HSAG QI Training in September 2013 with the WellCare QI staff
- Partnerships with OB/GYN Society, the Pediatric Society and others to help increase rates.
- A Member Advisory Committee to seek input from members on interventions for them, barriers, and suggestions to address the barrier(s) was created in 2013.

Our HEDIS Steering Committee meets regularly with representatives from multiple departments to review current HEDIS rates, progress, barriers, and interventions.

The new leadership at WellCare is dedicated and focused on quality. As a result of this focus and dedication, the QI Department recently received approval for additional staff. Once the new staff is hired, more face to face encounters/visits with providers to remove or eliminate barriers to success will be their primary focus.

[B-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standard II—Quality Assessment and Performance Improvement

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 POSTPARTUM CARE	 90.39 71.05	 84.07 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 HBA1C CONTROL <8% HBA1C CONTROL <7% EYE EXAM LDL SCREEN LDL CONTROL ATTENTION TO NEPHROPATHY BP CONTROL <140/80 BP CONTROL <140/90	 87.01 48.72 36.72 52.88 76.16 35.86 78.71 39.10 63.50	 78.45 39.64 30.08 34.87 69.24 28.95 74.51 33.55 56.91
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION Initiation Continuation	 52.48 63.11	 41.12 54.18
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS 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

Standard II—Quality Assessment and Performance Improvement

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.

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: The 2013 Medicaid QI Program Description indicated that WellCare conducts an annual evaluation of the Quality Program. WellCare also provided its QI Program Evaluation where it summarized the program's effectiveness; however, the evaluation report does not bring together all quality elements or provide an integrated assessment of the overall performance.
Required Actions: WellCare should revise the format of its annual assessment of its quality program to ensure all quality elements are addressed and that they are integrated in terms of overall program impact.
Evidence/Documentation Submitted by the CMO
Draft QAPI new specifications were received by the CMOs on 12/12/13. The new specifications were discussed and approved in January. WellCare will work with HSAG and others to ensure that compliance with this standard is fully met by the June 30 submission date.
Findings: WellCare continues to adjust its Quality Assessment and Performance Improvement (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.

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: The CMO partially met this requirement. WellCare's documents are evidence that the CMO has policies and procedures describing its case management, disease management, transition of care, and discharge planning activities.

As part of a focused study, CMO staff members were interviewed; and an on-site file review of five case management files and five disease management files was completed. Staff interviews and file reviews revealed that WellCare has case management and disease management staff performing many of the activities outlined in the CMO's policies and procedures. WellCare has implemented numerous process improvements over the last several years including adding assessments and re-designing existing ones to better meet members' needs. In 2012, WellCare initiated a field case management program aimed at providing members with face-to-face visits from case management staff. Additionally, WellCare staff reported that a new TriZetto system is scheduled to go live on January 1, 2013, using a phased-in approach. This new system will increase the CMO's ability to track, trend, and report on its case management and disease management processes and health outcomes. Currently, both case management and disease management staff are able to access and use claims, utilization, and pharmacy data via the CMO's EMMA system. The CMO stipulated that EMMA has significant reporting limitations in analyzing member health outcomes as a result of participating in disease management and case management. Absent from the documentation presented by the case management and disease management staff was discharge information pertaining to recent member hospitalizations. The lack of discharge planning information and its absence from the care plan and monitoring activities was evident in the cases reviewed.

Required Actions: The CMO must ensure that its policies and procedures pertaining to case management, disease management, transitions of care, and discharge planning are being operationalized to perform all of the activities described within its written documentation. Additionally, the CMO should consider implementing more member and provider incentive programs and adding reward programs for member care plan accomplishments or other significant accomplishments.

Evidence/Documentation Submitted by the CMO

Compliance with policies and procedures are being operationalized to perform all of the activities described within our written documentation pertaining to case management, disease management, transitions of care, and discharge planning, is evidenced by:

- Revised OB Audit Tool
- OB Audit Scores January thru June 2013
- Initial OB Assessment Tool

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- Case Example – Snapshot of OB Case Management documentation in a concurrent review file
- Training - Complex OB and DM EQRO Training 2013, entire document

Compliance with the CMO considering implementing more member and provider incentive programs and adding reward programs for member care plan accomplishments or other significant accomplishments, is evidenced by:

- Provider Pay 4 Performance (P4P) Letter
- P4P Program Description
- Weight Watcher letter w 6 month extension
- Workflow - Weight Watcher DM Workflow

Before implementing any additional member incentives, members were asked what incentive/reward would they prefer

- Report – Member Incentive Results

Findings: WellCare provided documentation of several examples of its revised process and implementation of HSAG's recommendations. The CMO adequately demonstrated implementation of numerous member incentive programs, such as its Weight Watchers program, including a plan for evaluation effectiveness. The CMO's program documentation was updated to better align the programs with each other. This was evidenced by the CMO's revised OB audit tool, assessment tool, and training program.

Based on the file review, the findings showed that the CMO did not fully demonstrate that the case management program was operationalized to perform all activities. Specifically, the cases reviewed showed an inconsistent and inadequate follow-up in addressing members' needs.

Required Actions: The standard remains *Not Met*. The CMO needs to implement a process to monitor its case managers' performance to ensure that members' needs are addressed.

Evidence/Documentation Submitted by the CMO

WellCare implemented processes to monitor case managers' performance to ensure that member needs are addressed.

Processes implemented to ensure and monitor:

- Revision of Compliance audit tool and implementation of a Quality audit tool. The tools are utilized by Supervisors to review cases for accuracy and quality related to CM process and the care provided to the member. The measures that are reviewed include: member contact; assessment, coordination, care plan, and discharge planning. The tool helps to ensure that member needs are being addressed.

- The audits results are shared with the associates in their regular monthly 1:1 meetings.

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◆ Compliance for care coordination standard 4.11.8.1 to monitor case managers performance is evidenced by: ◆ Job Aide for use of Chart Audit tool ◆ (attachment A) ◆ Short term case management and OB teams chart audits results Sept 2013 – Dec 2013[attachment B] ◆ Complex CM Audit review example ◆ [attachment B 1] ◆ Revised Quality Audit Tool ◆ [attachment C] ◆ Case example - # 2 [attachment E]
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 discharging 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.

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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
- Documentation

Findings: The CMO did not meet this requirement. WellCare's documents evidenced that the CMO has policies and procedures describing its case management activities of identification, assessment, care plan development, and monitoring as listed in the element above.

On-site interviews with staff and file reviews of five case management cases revealed that the majority of cases identified and referred for case management are pregnant women. Overall, the CMO had adequate assessment tools; however, they did not capture an assessment of activities of daily living (ADLs) and a comprehensive treatment history. Care plans contain problems, goals, and interventions with start dates. The care plans reflect whether the status is met or closed to the member. The case managers are monitoring cases and have been successful at reducing barriers to members receiving durable medical equipment (DME) and needed services and in making referrals to community resources. Additionally, as of January 1, 2013, WellCare will transition all of the behavioral health case management services from Magellan back to WellCare. Magellan will no longer be a delegated entity. The case managers were not documenting the use of utilization data and how the CMO uses these data as part of the care plan. Additionally, the engagement of members for case management services was mixed. There was no consistent evidence of the case managers obtaining or using discharge plans to identify member needs and incorporating them as part of the care plan.

Required Actions: The CMO should ensure that during the assessment process, the member's complete medical/behavioral health history, treatment history, medication history, and activities of daily living (ADL) levels are obtained, that member utilization data are reviewed and incorporated into the assessment process, that discharge plans and discharge planning needs are incorporated into the member care plans and monitoring activities to ensure that there are no gaps in care for the member, and that the case manager's follow-up intervals and activities match the member's needs. Lastly, WellCare is encouraged to build on its field case management program's process to increase the frequency and utilization of face-to-face interactions as a mechanism to complete assessments and to increase member engagement in the case management program.

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Evidence/Documentation Submitted by the CMO

Compliance with the CMO ensuring that during the assessment process, the member's complete medical/behavioral health history, treatment history, medication history, and activities of daily living (ADL) levels are obtained; and the CMO ensuring that member utilization data are reviewed and incorporated into the assessment process, that discharge plans and discharge planning needs are incorporated into the member care plans and monitoring activities to ensure that there are no gaps in care for the member, and that the case manager's follow-up intervals and activities match the member's needs are evidenced by:

- Revised OB Audit Tool
- Initial OB Assessment Tool
- Report - OB Audit Scores January thru June 2013
- Case Example – OB Case Mgr documentation in a concurrent review file
- Training - Complex OB and DM EQRO Training 2013, p. 4 thru 7

There were challenges in the past with identifying members for face to face visits. To increase frequency/utilization of face to face visits, the WellCare implemented the following initiatives: CM algorithm was adjusted to identify more members, hospital daily census are used to identify members before discharge, Member Outreach referring members to CM, and Welcome Home Program and CM teams refocused on opportunities for face to face visits.

Compliance with the encouragement for the CMO to build on its field case management program's process to increase the frequency and utilization of face-to- face interactions as a mechanism to complete assessments and to increase member engagement in the case management program, is evidenced by:

- Workflow - SCM Team face to face requirements
- Report - Sample Daily Census Report
- Case Example – face to face interaction
- Workflow – CM & Welcome Home Involvement
- Report – 2013 Face to Face Visits By Month

Findings: WellCare provided its new OB Audit Tool, which indicated that the CMO makes every attempt to obtain a full medical history and any discharge plans. The CMO provided its case management work flow that indicated to ask the member for a face-to-face meeting; and the staff supplied its case management home visits tracking log. The file reviews did not show consistent discharge planning, obtaining the discharge plan from the hospital, or follow-up post discharge.

Required Actions: The standard remains *Not Met*. The CMO needs to strengthen its discharge planning process to ensure that discharge planning and follow-up are done consistently.

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Evidence/Documentation Submitted by the CMO

To ensure consistent discharge plans and member post discharge follow up, WellCare has strengthen its discharge planning process as evidenced by the following:

Any member on the discharge report that is being actively case managed is transferred to the assigned Case Manager (CM) for immediate outreach.

Staff trained and new processes implemented on 01/07/2014.

- Discharge planning needs are addressed by the CM staff in all areas through the use of the Care Coordination tool. Discharge planning needs are communicated in the case note documentation and the member's care plan for complex care management.
- Care Plan training was held on 08/22/13, 09/04/13, 10/09/13 and 10/30/13. Trainers reviewed identifying in the care plan intervention sections, documenting discharge plans and ED or inpatient visits.
- The revised Care Coordination tool was implemented October 1, 2013. This tool is utilized to document all care coordinated and care gaps for the member including any health care needs identified in the discharge plan.
- Revisions completed Nov 15, 2013 to Short Term Case (SCM) management and OB case note documentation templates to show the discharge planning assessment and transitions of care functions performed.
- Measures of Effectiveness presentation/training held on 11/20/2013 and 11/21/2013, trainers covered 'best practices' to contact members and assessing discharge plans once inpatient to avoid re-admission, [Attachment I]
- WellCare implemented an improved process for interactions between the Concurrent Review Nurse

(CRN) and the CM nurse when a member is hospitalized and in active case management:

- Transitional Utilization Management (TUM) Note – Utilization Management utilizes this note type when they are collaborating with the member's assigned CM regarding discharge plans. TUM Note type went live on 01/01/14.

- Transitional Care Management (TCM) Note – Case Management utilizes this note type when they have obtained information regarding their member from UM. This could contain information regarding the hospitalization or discharge planning. Use of TCM Note started by case management after training on 11/13/2013.

- Quality Audits implemented to include member follow up. Updated tool rolled out 10/29/2013

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Additional training: Coordination of training around the CMs use of QMAIL for alert/initial notification of hospitalization of a member. QMAIL is also sent to CM whenever an authorization is updated. Training was provided to new hires as well as refreshers for staff periodically throughout the year.

Process improvements were also made in the following areas:
1. Creation and use of enhanced case note documentation implemented 11-15-2013 for Short Term Case Managers (SCM) and OB Case Managers.
2. Implementation of Transitional Utilization Management went live on 01/01/14.
3. Coordinated training for the Corporate Case Management Staff, State Case Management Staff , and Utilization Management staff for QMAIL (Electronic Medical Management System Email), Service Authorization History, Medication History, and Case Notes
4. Implementation of Onsite Concurrent Review Nurses
   a. Transitioning staff as of 11/01/2013 into Atlanta Metro area at select hospitals in four of the Plan's six regions to work with hospital staff for proactive discharge planning and intervention and to perform soft transfer and to case management while member in hospital should they demonstrate immediate Case Management Needs. The nine hospitals are located in the Atlanta, Central, East and Southeast regions. The hospitals are:
   b. University Hospital
   c. Medical Center of Central Georgia
   d. Grady Memorial Health System
   e. Memorial University Medical Ctr
   f. Children's Healthcare of Atl- Egleston
   g. Children's Healthcare of Atl- Scottish Rite
   h. Medical College of Georgia
   i. Wellstar of Kennestone
   j. Emory Midtown

Compliance with standard 4.11.9.1 -2 is supported by the following documents:

- Revised Care Coordination Tool [attachment G]
- Revised SCM Field Case Note template[attachment H]
- Revised OB Case Note templates for initial assessment and discharge planning and [attachment I & J]
- QMail communication example[attachment N]
- CM Claims Review for ER and Inpatient stay example [attachment P]
- Care Plan training [attachment Q]
- Measuring Effectiveness Training [attachment R]

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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.

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: The CMO partially met this requirement. Document review evidenced that WellCare has a discharge planning program that includes a comprehensive assessment of member needs and identification of the services and supplies the member requires following discharge. The CMO's program includes a Welcome Home Team consisting of non-clinical staff members who call the member post-discharge to check in with the member. If the member verbalizes unmet needs, the staff member refers the member to the case management program. Additionally, the Concurrent Review Team members are responsible for discharge planning to ensure that the member is linked with post-discharge needs by setting up the initial authorization and performing follow-up to ensure services are in place. On-site interviews with staff members and file reviews revealed that WellCare's case management staff members are not consistently obtaining member discharge plans and incorporating them into the case management care plan and monitoring activities.

Required Actions: The CMO must improve transitions of care by ensuring that discharge plans and discharge planning needs are communicated to or obtained by the case manager and are included in the member's care plan. HSAG recommends that the CMO consider having case managers follow members enrolled in case management across the care continuum instead of delegating tasks such as concurrent review, discharge planning, and transitional care among multiple CMO personnel.

Evidence/Documentation Submitted by the CMO

The CMO improved transitions of care by ensuring that discharge plans and discharge planning needs are communicated to or obtained by the case manager and are included in the member's care plan as evidenced by:

- Workflow - Discharge Planning
- Case Example – Case Mgr following concurrent review member
- PCP Letter Care Plan – OB Field CM
- PCP Introductory Letter – OB Field CM
- Revised OB Audit Tool

Findings: The file review showed inadequate transitions of care for members discharging from an inpatient facility.

Required Actions: The standard remains *Not Met*. The CMO must improve transitions of care by ensuring that discharge plans and discharge planning needs are communicated to or obtained by the case manager and are included in the member's care plan.

Evidence/Documentation Submitted by the CMO

WellCare has improved transitions of care by identifying and communicating discharge planning and needs.

Discharge planning needs are addressed by the CM staff in all areas through the use of the Care Coordination tool. Discharge planning needs are

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communicated in the case note documentation and the member's care plan for complex care management. WellCare implemented an improved process for interactions between the Concurrent Review Nurse (CRN) and the CM nurse when a member is hospitalized and in active case management: ◆ Transitional Utilization Management (TUM) Note – Utilization Management utilizes this note type when they are collaborating with the member's assigned CM regarding discharge plans. TUM Note type went live on 01/01/14. ◆ Transitional Care Management (TCM) Note – Case Management utilizes this note type when they have obtained information regarding their member from UM. This could contain information regarding the hospitalization or discharge planning. Use of TCM Note started by case management after training on 11/13/2013. ◆ Quality Audits implemented to include member follow up. Updated tool rolled out 10/29/2013 Implementation of Onsite Concurrent Review Nurses ◆ Transitioning staff as of 11/01/2013 into Atlanta Metro area at select hospitals in four of the Plan's six regions to work with hospital staff for proactive discharge planning and intervention and to perform soft transfer and to case management while member in hospital should they demonstrate immediate Case Management Needs. The nine hospitals are located in the Atlanta, Central, East and Southeast regions.
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.

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 24–25, 2014

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	Jennifer Lenz , MPH, CHCA	Executive Director, State & Corporate Services
Reviewer	Rachel Costello, PhD, MS, PCC-S	Senior Project Manager
Reviewer	Terry Huysman, RN, BSN, CHC	Director, State & Corporate Services
Reviewer	Maureen McGurrin, BA	Executive Director, State & Corporate Services
Reviewer	Steve Kuszmaul, MBA	Project Manager, State & Corporate Services
WellCare of Georgia, Inc. Participants		**Title**
Joshua Luft		Director, Regulatory & Analytics
Bennie Woodard		Project Manager, Quality Improvement
Heather Gore		Project Manager, Quality Improvement
Andre'a Washington		Quality Improvement Specialist
Dr. Traci Ferguson		Vice President, Clinical Services Management
Brian Pogue		Senior Director, Claims
Abby Abramson		Operations Compliance Specialist
Patrick Amato		Manager, Claims
Jessica Hemmers		Supervisor, Behavioral Health Utilization Management
Cindy Hankin		Director, Utilization Management
Angel Pellot		Manager, Inpatient Clinical Services
Vanessa Lawrence		Project Manager, Quality Improvement
Toranka Busch		Credentialing
Victoria Fernandez		Manager
Clarice Thomas-Roberts		Supervisor, Case Management
Chris Vermulen		Manager, Provider Communications
Roman Kulich		Region President
Jacqueline Collins		Senior Quality Improvement Director
Akan Iyamu		Supervisor, Field Service Coordinator
Natalie Davis		Supervisor, Field Services Coordination

Table C-2—HSAG Reviewers and WellCare of Georgia, Inc./Other Participants	
Amy Carr	Senior Manager, Nurtur Management
Mark Fost	Senior Manager, Clinical Care
Kathy Pressley-Lints	Manager, Disease Management
Renee Metts	Supervisor, Disease Management
Felicia Thomas	Director, Medicaid
Shellee Brown	Prenatal Case Manager
Michelle Jungling	Manager, Case Management
LaDonna Battle	Vice President, Field Health Services
Marcia Welch	Vice President, Clinical Services
Tabbatha Echols	Quality Improvement Specialist
Melinda Mosser	Manager, Delegation Oversight
Deirdre Rogers	Manager, State Pharmacy
Lisa Downey	Director, Pharmacy Medicaid Operations
Cynthia Cook	Project Analyst
Department of Community Health Participants	**Title**
Kimberly Foster, RN, BSN, MBA	Director
Terri Portis, MPA	Project Director
Tiffany Simmons, BSN	Compliance Auditor
Jacqueline Koffi	Program Auditor
Marvis Butler	Director of Provider Services, Division of Medicaid

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—Availability of Services
- Standard II—Furnishing of Services
- Standard III—Cultural Competence
- Standard IV—Coordination and Continuity of Care
- Standard V—Coverage and Authorization of Services
- Standard VI—Emergency and Poststabilization Services
- Case and Disease Management Focused Review
- Follow-up on areas of partial compliance or 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 first 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 of case management, disease management, and service denial cases for the on-site CMO audit from the list of such members submitted to HSAG from the CMO.

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

[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.

- 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 HSAG requested that the CMOs have available on-site.
- A review of the member cases HSAG requested from the CMO.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

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, 2013–June 30, 2014
Information obtained through interviews	July 1, 2013—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, 2013–June 30, 2014

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 document 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 six standards and an overall percentage-of-compliance score across the reviewed 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
- 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 final 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 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.

Interventions Planned	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.

Interventions Planned	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 Subspeciality 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.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard IV—Coordination and Continuity of Care
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
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.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard IV—Coordination and Continuity of Care		
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)		
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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard IV—Coordination and Continuity of Care		
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)		
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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**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.		
Interventions Planned	**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 POSTPARTUM CARE	 90.39 71.05	 84.07 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 HBA1C CONTROL <8% HBA1C CONTROL <7% EYE EXAM LDL SCREEN LDL CONTROL ATTENTION TO NEPHROPATHY BP CONTROL <140/80 BP CONTROL <140/90	 87.01 48.72 36.72 52.88 76.16 35.86 78.71 39.10 63.50	 78.45 39.64 30.08 34.87 69.24 28.95 74.51 33.55 56.91
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION Initiation Continuation	 52.48 63.11	 41.12 54.18

Standard II—Quality Assessment and Performance Improvement

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

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS 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.

Interventions Planned	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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Appendix F. **Case Management File Review Tool**

Following this page is the Case Management File Review Tool HSAG used to evaluate WellCare's cases.

Case Management File Review Tool—WellCare

Case Identifier: Case 1
Diagnosis: Hypertension (HTN) and gestational diabetes mellitus (GDM)
Synopsis: Member is a pregnant female who was referred for case management because of high-risk pregnancy.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- 5/9/2014: Received referral from Alere that listed the triggers—HTN, GDM, pregnancy-induced hypertension (PIH), financial issues, preterm delivery, hyperemesis, edema of feet, hands, and obesity.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Case management – level 3

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 5/9/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)

Case Management Evaluation Guide

- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:

- High-risk pregnancy.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Member was assessed on 5/14/2014 using the prenatal comprehensive assessment.
- Based on the assessment, member reported history of smoking, reported that she was smoking less than a pack per day with minimal interest in quitting.
- Member has history of HTN and previous GDM.
- Current OB/GYN provider is Jocelyn D. Rogers.
- Member reported that she has a history of asthma, had a Caesarean section (C-section) for last pregnancy for failure to progress during labor.
- Member reported that she is on prenatal vitamins and has no allergies to medications.
- Member reported no hospitalizations during this pregnancy.
- CAGE assessment completed, member reported no current or past use of drugs or alcohol,
- PHQ9 completed, no risk of depression noted, member reported feeling down but denied any issues with daily functioning.
- Current medications: albuterol, methyldopa, and prenatal vitamins.
- Member is single and her family is not involved, member reported that she lives in a house with her daughter and her friends are able to help with rent, has food stamps, but has difficulty paying her utilities.
- 7/23/2014—second and third trimester and postpartum assessment: This assessment looks at support for the baby (home preparation) - member had selected a doctor for the baby, not identified in the assessment by the case manager (CM), member reported no changes in support system. CM discussed feeding issues with the child and discussed with member how the she is doing bonding with the baby, does she like being a parent, CM discussed with member what stressors to look for and provided member with book – Journey through Pregnancy and other educational material.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Case Management Evaluation Guide

Observations:
- No cultural or linguistic needs identified for this member.

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- No over- or underutilization of services noted for this member.

Recommendations:
- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:
- Member reported during the assessment that her family is not currently in her life.

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:
- No communication with the member's provider was noted during review of the case file.

Recommendations:
- Include the member's provider in the assessment process to ensure all of the member's medical needs are being addressed.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- Care plan developed on 5/14/2014: Problems identified—knowledge deficit for asthma, deficit of HTN knowledge, medication and nutritional supplement interactions, deficit of pregnancy-related symptoms, member is a smoker, inability to secure basic need utilities.
  Goals:
  1. Member able to verbalize understanding of potential outcomes of continued tobacco use on current pregnancy. Case manager rated the tobacco use goal as high when member reported no desire to stop smoking.
  2. Member able to verbalize understanding potential danger to existing pregnancy related to HTN and GDM.
- Staff reported during the interview that the CM will pick two main goals and put in as many goals as possible under one heading. If the member has an identified social need, the social work referral would go to the social worker and the social worker will take over that part of the member's treatment.

Case Management Evaluation Guide

- Treatment plan was updated on 7/23/2014 to reflect member's delivery of the baby. Documentation reviewed noted that member delivered her baby on 7/8/2014.
- Initial goal identified for the member was identified by the case manager to be high priority. This goal reflected member's current use of tobacco products during pregnancy and increasing the members understanding of potential outcomes of continued tobacco use on current pregnancy. Member identified that she had minimal interest in addressing her tobacco use during the assessment.

Recommendations:

- Individualization of the care plan and inclusion of members in the care planning process. Goals need to be individualized (based on reported member needs), measurable, realistic, and reachable by target dates.
- Use member input to identify goals and priority of goals in the care plan. This will increase the member-centeredness of the care plan and give the member more ownership of their treatment process.
- Update the care plan to reflect changes in member's status when the status change has been identified. (i.e., 7/8/2014 – delivery date vs. 7/23/2014 – postpartum follow-up call with member.)

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- Staff reported that family members are brought in for the teenagers/minors, not for the adult population. This is based on the member's choice on who the member wants to bring into the multidisciplinary team. This would be documented under the contact tab and would present any individuals who are part of that member's team.
- Per documentation reviewed, no family member was identified by the member as part of her multidisciplinary team.
- No communication was identified in documentation reviewed that showed the case manager included the member's OB/GYN provider in the development of the care plan.
- Staff identified that once the care plan is completed, the care plan is faxed to the OB/GYN for review.

Recommendations:

- Outreach to the member's provider, prior to completion and faxing of the care plan, to gather information concerning the member's care to ensure that all member needs are met.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- No care gaps identified for the member.

Recommendations:

Case Management Evaluation Guide

- The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 5/14/2014 initial assessment note: Member is a gravida (G): 4 para (P): 1, spontaneous abortion (SAB): 2, medication reconciliation- member currently on albuterol, methyldopa, and prenatal vitamins, problem identification - history of HTN, member reported depression but declined referral, hospitalized one time for diabetes one month prior to the referral. Member reported that she was started on insulin while in the hospital and was to continue insulin use post hospitalization, member reported that she is currently working as a secretary and has no contact with her family. Member identified her next OB appointment as 5/20/2014. No care gaps identified during the initial assessment. DME ordered – blood pressure (BP) cuff. CM provided member with education on current medical problem and scheduled follow-up with member on 5/28/2014 to review care plan compliance, assess symptoms or medical complication, and ensure provider appointments are met.
- 5/28/2014: CM followed up with member, reviewed needs, current symptoms, member received the BP cuff and was checking her BP and member still smoking. Denied any issues, education provided, follow-up set up for 6/10/2014.
- 6/9/2014: Member called CM reported that she was having weekly non-stress tests (NST) and she was seeing Dr. Edwards and was late for her last appointment and she was not seen and had to reschedule her appointment, next OB appointment 6/17/2014. CM scheduled next contact with member for 6/19/2014.
- 6/19/2014: CM outreached to member who reported that she is concerned about her BP and was still smoking. Selected Sumter Pediatrics, delivered education and scheduled next follow up 7/1/2014.
- 7/1/2014: CM outreached to member who reported that she was doing okay and continued to get her weekly NST.
- 7/8/2014: CM received system alert that member delivered on 7/4/2014. CM contacted member who identified no needs at this time. Member moved to a level 1.
- 7/23/2014: CM outreached to member for postpartum follow-up. Member reported that the baby is doing well but a heart murmur was noted during his well-baby appointment. Member reported that she was started on new HTN medication and CM encouraged the member to discuss with provider. Member reported no issues with blood sugars. Member has stopped smoking. Currently getting Women, Infants, and Children (WIC) assistance. Postpartum appointment scheduled 7/16/2014 and 7/30/2014 with final follow-up on 8/21/2014. CM will close member's case at this time.
- During review of documentation it was identified that the member identified she was placed on insulin during hospital stay prior to being referred for case management. CM did not identify any prescribed insulin during medication reconciliation with member during 5/14/2014 contact. CM had no other discussion with member concerning her GDM, insulin use, or monitoring of glucose levels. During the 6/19/2014 contact with the member, CM noted that the member was concerned about her BP. However, the CM did not document any attempt to determine what the member's concern was and the CM did not document any conversation with the member concerning what her BP has been (member monitors her BP).

Recommendations:

Case Management Evaluation Guide

- Medication reconciliation – identification of all medications prescribed to and picked up by member. Discuss medication usage and any side effects being experienced by the member.
- Monitoring of all medical conditions identified in the treatment plan.
- Address all identified member concerns and document interventions/counseling/education provided to member that address the member's concerns identified at time of outreach.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- Provider letter sent on 6/10/2014 to let provider know member is in case management.
- 6/10/2014: CM faxed the member care plan to the OB doctor.
- 6/19/2014: CM called to Dr. Edwards' office, spoke with the nurse, received details on member's BP and ultrasound.
- Documentation reviewed identified that the member is diagnosed with HTN and GDM. CM documented that the 6/19/2014 contact with the doctor's office included discussion about HTN and the member's ultrasound. There is no documented contact with the member's OB doctor to discuss the member's reported use of insulin or GDM diagnosis.

Recommendations:

- Greater outreach to providers (PCP/specialists) for coordination and continuity of member care.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

- Member did not identify any family members as part of her multidisciplinary team. No communication of member's care plan was completed with the family members.

Recommendations:

- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- Documentation reviewed identified that the member was offered referral for behavioral health, but member declined.

Recommendations:

- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds

Case Management Evaluation Guide

- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

- According to staff members, case was not reviewed with the multidisciplinary team.

Recommendations:

- The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- Member reported one hospitalization for diabetes one month prior to referral for case management.
- No noted review by CM concerning member's reported hospitalization.

Recommendations:

- Consider reviewing member-reported hospitalizations that are linked to current diagnosis and reason for referral to case management. Document any review of this information in the member's record.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- No discharge plans noted in the member's record. According to documentation, member reported that she was released from the hospital on insulin. There is no documented follow-up by the CM that addresses the member's glucose levels, the member having a prescription for insulin or picking up a prescription for insulin from the pharmacy, or verification of information that member reported to the CM.

Recommendations:

- Consider obtaining discharge orders for hospitalizations that triggered member referral to CM.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- During the file review it was noted that the CM discussed the transition of the member out of CM due to delivery of her baby.

Recommendations:

- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:

- During the file review it was noted that the CM was following up with the member based on her identified need.

Case Management Evaluation Guide

Recommendations:

- None.

Case Identifier: Case 2
Diagnosis: GDM
Synopsis: Member was referred for high-risk OB case management by the prior authorization department.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:
- Referred by prior authorizations department on 5/8/2014 due to GDM and history of giving birth to stillborn twins at 24 weeks.

Recommendations:
- None.

2. What level of case management or program type is the member enrolled in?

Observations:
- CM – Level 3

Recommendations:
- None.

3. When was the member enrolled in the CMO's case management program?

Observations:
- 5/9/2014.

Recommendations:
- None.

4. Was the member identified as having any of the following special needs?
- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:

Case Management Evaluation Guide

- High-risk pregnancy.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Member was assessed on 5/9/2014. Member reported that her current OB provider is Dr. Diamond, reported that her last appointment was 5/1/2014. Member is a G 3 P 1 with history of C-section for twins (stillborn). Member reported that she is allergic to penicillin (PCN) and has a history of preterm labor. Member reports no hospital stays for this pregnancy. CAGE completed. Member reported no alcohol or drug use, PHQ9 completed, no issues of depression noted.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- Member reported no cultural or linguistic needs.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- No over- or underutilization of services noted for this member.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- No discussion with family noted in the assessment.

Recommendations:

- Increase family participation in the member's assessment process.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

Case Management Evaluation Guide

- No discussion with provider noted in the assessment.

Recommendations:

- Include the member's provider in the assessment process to ensure that member's needs are met.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- Care plan developed on 5/9/2014, problems identified were high-risk pregnancy, improper use or potential complication of medications. On 7/23/2014, problem was identified as knowledge deficit concerning diabetes.
- Goals:
    1. Recognize danger signs of pregnancy and notify the provider.
    2. Member able to adhere to prescribed medication regime
    3. Member understands the symptoms of hyper- or hypoglycemia and when to take appropriate action. (According to staff added on 7/23/2014)

Recommendations:

- None.

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- No caregiver or provider participation noted in the development of the care plan.

Recommendations:

- Include the member's family and provider in the development of the care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- No care gaps noted for this member.

Recommendations:

- The CMO should incorporate a process for assessing care gaps.

Case Management Evaluation Guide

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 5/9/2014 assessment note: Member has history of gestational diabetes and history of stillbirth - twins in 2010 at 24 weeks – Expected Date of Confinement EDC is 8/22/2014, G 3 P1 with SAB 1, current medication—prenatal vitamins, Lortab and Albuterol. Member is married, reported no major medical issues, no behavioral health issues, no tobacco use, has transportation, receives WIC but not food stamps. Currently lives with her child, reported that her family and friends are involved and she is able to take care of her bills. Member has a bachelor of science in nursing (BSN) but not working; went to the emergency department (ED) for shortness of breath (SOB). Discussed the five wishes.
- 6/6/2014: CM attempted to contact member; no contact left message.
- 6/20/2014: CM attempted to contact member, left message, unable to reach, letter sent.
- 7/23/2014: CM contacted member and was able to speak with the member. Member is now 35 weeks and the CM discussed pregnancy changes, birth control (BC) – bilateral tubal ligation (BTL) member is keeping her appointments, next OB 7/31/2014 and growth scan on 8/7/2014, blood sugar has been within normal limits and blood pressure was fine, no issues with asthma, reported that she has had a dental and vision assessment. The member selected a pediatrician for the child. Member reported that she had developed an umbilical hernia and had consulted a surgeon outside of network.
- 7/23/2014: CM contacted member, she reported that she is following through and taking her blood pressure and blood sugar as prescribed.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 5/19/2014: CM faxed OB letter for member being placed into CM to member's OB provider.
- 5/19/2014: CM faxed care plan OB, doctor signed it on 5/20/2014 and faxed it back to the CM.
- 7/23/2014: CM reached surgeon's office about the single case agreement and the provider does not have a Medicaid number.
- 7/23/2014: E-mail to provider relations concerning this single case agreement.

Recommendations:

- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Case Management Evaluation Guide

Observations:
- CM had no contact with member's family.

Recommendations:
- Include the member's family in the treatment process.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- Member self-referred to a surgeon for an umbilical hernia, the surgeon member self-referred to as not in network. CM was working to complete a single case agreement with the provider for this member's care for the umbilical hernia.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Staff reported that member's case was not presented during a multidisciplinary team meeting.

Recommendations:
- The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- 7/15/2014: Member reported to CM that she went into the ER for abdominal pain and decreased fetal movement, member thought she was having a placental abruption but was not.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:
- Member had no inpatient stays.

Case Management Evaluation Guide
Recommendations: ◆ None.
20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?
Observations: ◆ Member care plan addressed the member's needs for care coordination and targeted the member's knowledge of her diabetes, pregnancy-related problems, and medication adherence.
Recommendations: ◆ None.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ CM continually reached out to the member to provide support, education, and linkage needs.
Recommendations: ◆ None.

Case Identifier: Case 3
Diagnosis: Human Immunodeficiency Virus (HIV)
Synopsis: Member was referred for CM due to HIV diagnosis.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:
- Referred by Alere on 4/19/2014 for HIV during pregnancy.

Recommendations:
- None.

2. What level of case management or program type is the member enrolled in?

Observations:
- Case management – level 3

Recommendations:
- None.

3. When was the member enrolled in the CMO's case management program?

Observations:
- 4/22/2014.

Recommendations:
- None.

4. Was the member identified as having any of the following special needs?
- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:
- High-risk pregnancy.

Case Management Evaluation Guide

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Assessment completed on 4/22/2014. Member is a G 3 P 0 AB 2 for medical issues, with a history of HIV.
- Member was originally referred for CM on 1/29/2014 by OB provider.
- Member's EDC is 8/12/2014; member reports no allergies to medications.
- CAGE completed with member - no alcohol and drug use reported during screening,
- PHQ9 completed with member – no issues with depression noted.
- Member reported that she is able to obtain food, has no safety or financial issues, has no transportation issues, and is currently on prenatabs, Kaletra, and Combivir; Alere reported that member has been referred to the Grady Clinic for HIV treatment.
- Dr. Martin is her OB; member has a genetic disorder TRISOMY 18.
- Member reported that she is from Zambia and has no family in the area.
- Member reported that she is able to pay her bills.
- Member reported no ER or hospitalizations.
- CM ordered DME BP cuff and scale for this member. Education was delivered, acuity level 3, no care gaps, no over- or underutilization, no referrals were made. Member reported that she was not currently on WIC; CM mailed WIC information to member.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- Member is from Zambia, reported no cultural or linguistic needs during the assessment.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- No over- or underutilization of services noted for this member.

Recommendations:

- None.

Case Management Evaluation Guide

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- Member reported that she has no family members in the United States. Member reported that her boyfriend is in her life but she does not want him to be a part of the assessment.

Recommendations:

- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- No discussion with member's provider noted in the assessment or assessment note.

Recommendations:

- Inclusions of member's provider in the assessment process to ensure all member's medical needs are covered.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- 5/1/2014: care plan completed; problems identified are risk for neonatal intensive care unit (NICU) baby, medication interactions, high-risk pregnancy, and HIV/AIDS.
- Goals: full-term delivery and recognizing signs and symptoms of preterm labor.

Recommendations:

- None.

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- No provider participation noted in the development of the care plan.

Recommendations:

- Include the provider in member care plan development.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Case Management Evaluation Guide

Observations:

- No care gaps noted for this member.

Recommendations:

- The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 4/21/2014: CM attempted to contact member, appointment was made to complete the assessment on 4/22/2014.
- 4/22/2014: CM completed assessment with member telephonically.
- 5/8/2014: CM outreach to member who reported no issues with the pregnancy or with her HIV, next appointment is 5/25/2014, member has WIC, at this time member still being followed by the doctor at the Grady Hospital, HIV levels are undetectable, boyfriend is in her life and he does know about the positive HIV diagnosis. Acuity level changed to a 4, staff reported that the case manager wanted to see the member face-to-face which increased the number of times the member would be contacted that month. Staff reported that the acuity level was changed to add the extra contact with the member, not due to a change in the member's health care status. The case manager set an appointment for 5/15/2014.
- 5/13/2014: CM called to ensure the member would meet her on 5/15/2014.
- 5/15/2014: CM met with member in a face-to-face visit at McDonalds, they reviewed information and provided education on pregnancy-related topics.
- 5/30/2014: CM contacted member who reported that she is doing okay, reviewed member's OB visits; member reported that she failed her 1-hour blood glucose test and will need to take the 3-hour test. Planning to bottle feed due to HIV status.
- 5/30/2014: CM called Cobb County Health Dept. to get information for the member, determined the process to get into the clinic, support groups, and therapist, called member and gave her this information.
- 6/13/2014: CM tried to contact member who was at work, member reported that she needed to speak to the nurse but could not talk at the time and she would call back.
- 6/25/2014: CM called member but was not able reach her, left message.
- 6/29/2014: CM tried to contact member, left message.
- 7/7/2014: CM contacted member who reported no issues, reported that her viral levels are still undetectable and baby is active. Member reported that she is maintaining good nutrition and next contact scheduled for 7/22/2014.
- 7/7/2014: Case transferred to new CM.
- 7/23/2014: New CM called member who was unable to discuss issues, next call to be 7/28/2014.
- CM noted member's report that she failed her 1 hour glucose test on 5/30/2014; no follow-up was completed with the member concerning her glucose test. CM did not document actions taken to ensure member confidentiality during the face-to-face visit at McDonalds.

Recommendations:

Case Management Evaluation Guide

- When member reported that she needed to complete a 3-hour glucose test, CM needs to follow-up to ensure that this is completed. Ensure documentation shows the steps taken to ensure confidentiality for the member in a public setting.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:
- 5/1/2014: CM faxed member's care plan to her OB provider.
- 7/23/2014: CM left message with provider officer to determine the blood sugar results of third test.
- Outreach to the provider concerning the member's blood glucose test was done in July; this is two months after the member reported that she had failed the 1-hour glucose test.

Recommendations:
- Ensure follow-up for the member's medical concerns are completed in a timely manner. Ensure that the care plan is discussed with the member's provider.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:
- Member's family does not live in the United States. Member reported that her boyfriend is in her life but she does not want the CM to contact him.

Recommendations:
- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- Member provided information about WIC, and CM reached out to the county's health district for information on how the member can link for treatment after she delivers, provided this information to member. No other referral needs identified for this member.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Case Management Evaluation Guide

Observations:
- Staff reported that the member's case was not presented to the multidisciplinary team.

Recommendations:
- The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- Member had no identified ER visits or hospitalizations.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:
- No hospitalizations occurred for this member.

Recommendations:
- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:
- Care plan addressed the member's needs for treatment during pregnancy.

Recommendations:
- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:
- CM did not follow up with member's report that she had failed her 1-hour blood glucose test and would need to complete the 3-hour test. This was not addressed again until a new CM took over the case two months after it was first reported to the CM.

Recommendations:
- Complete all follow-up in a timely manner.

Case Identifier: Case 4
Diagnosis: Hyperemesis
Synopsis: Member was referred by ED diversion program due to ER visit for hyperemesis.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:
- Member was referred on 3/13/2014 through ED diversion program.

Recommendations:
- None.

2. What level of case management or program type is the member enrolled in?

Observations:
- Case management – ED referral – level 3

Recommendations:
- None.

3. When was the member enrolled in the CMO's case management program?

Observations:
- 3/21/2014.

Recommendations:
- None.

4. Was the member identified as having any of the following special needs?
- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:

Case Management Evaluation Guide

- High-risk pregnancy.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Initial assessment was attempted on 3/21/2014; member was referred for case management after ER visit for hyperemesis.
- On 4/11/2014, CM was able to finish the assessment.
- Member reported that she is seeing Dr. Dean for her pregnancy, EDC is 7/1/2014; this is the first pregnancy for this member.
- Member reported no family of genetic disorders, member reported that she has no medical issues, and she is currently taking prenatal vitamins.
- Member had multiple ER visits in the 30-day time frame for hyperemesis and was placed on Reglan and Zofran for the vomiting and nausea.
- Member reports that she has support of family and friends,
- PHQ9 completed, member reported some issues with depression;
- CAGE completed with member, no alcohol or drug use noted.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- No cultural or linguistic needs noted.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- Overutilization of ER for vomiting.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- No discussion with member's family during the assessment noted.

Case Management Evaluation Guide

Recommendations:
- Include the member's family in the assessment process.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:
- No discussion with member's OB provider noted during the assessment.

Recommendations:
- Include the member's OB provider in the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- 3/27/2014: Care plan developed – problems identified were knowledge deficit of vomiting, pregnancy-related symptoms, and persistent vomiting.
- Goal able to recognize danger signs of pregnancy and when to notify provider; member to understand symptoms of vomiting and when to take action.

Recommendations:
- None.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- Care plan completed prior to the completion of the full assessment, and no documentation noted that care plan was completed/discussed with the member, the family, or the provider.

Recommendations:
- Include the member and provider in the care planning process, include family members when possible.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- No care gaps noted for this member.

Recommendations:
- The CMO should incorporate a process for assessing care gaps.

Case Management Evaluation Guide

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 3/13/2014: CM attempted to contact member, left message.
- 3/14/2014: CM attempted to contact member, no contact sent letter,
- 3/21/2014: CM contacted member, attempted to complete the assessment, member required referral for social worker (SW) due to depression.
- 3/24/2014: SW CM reached out to member, no answer, left message, sent a letter.
- 3/26/2014: SW CM reached out to member, left message.
- 4/2/2014: SW CM received call from the member, another PHQ9 and CAGE assessment were completed, no issues noted.
- 4/11/2014: CM contacted member and completed assessment, discussed pregnancy, discussed birth control. Member reported no issues with pregnancy, still level 3.
- 5/2/2014: CM attempted to contact member, left message.
- 5/16/2014: CM attempted to contact member, left message and sent unable to reach letter.
- 6/16/2014: CM attempted to contact member, has had no contact with member since 4/11/2014, closed member to CM at that time This member's case was referred to quality department staff, who completed outreach to the member.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 3/27/2014: Welcome letter sent and care plan sent to OB.
- No other contact noted with member's OB provider.

Recommendations:

- Greater outreach to the member's provider to ensure that the member's needs are being met.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

- No outreach to member's family completed.

Case Management Evaluation Guide

Recommendations:
- Complete outreach to family or document why there is no outreach to the member's family.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- The member was provided a referral to SW for reported issues with depression. Social work case manager contacted member and identified no areas of need.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Staff reported that member's case was not presented during the multidisciplinary team meeting.

Recommendations:
- The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- Member had multiple ER visits for hyperemesis prior to entering case management. No ER visits or hospitalizations noted for member while in case management.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:
- N/A.

Recommendations:
- None.

Case Management Evaluation Guide
20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?
Observations: ◆ The member's care plan reflected the member's knowledge deficit of vomiting, pregnancy-related symptoms, and persistent vomiting. During the review of the member's file, staff reported that member was referred to CM for reduction in ER utilization.
Recommendations: ◆ Develop s care plan that addresses the member's care coordination needs.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ CM was unable to contact member after completion of the assessment on 4/11/2014, and member was closed out of CM.
Recommendations: ◆ None.

Case Identifier: Case 5
Diagnosis: Aortic Aneurysm, Multiple Sclerosis (MS), and Migraines.
Synopsis: Member was referred by provider after being hospitalized for suicidal ideations.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member was referred on 2/24/2014 by her provider; the hospital called while member was inpatient for suicidal ideation during pregnancy. Member was in the hospital from 2/22/2014 to 2/24/2014. Member is having difficulty with her boyfriend and reported that she wanted a boy but was having a girl, was thinking about abortion but is 23 weeks along. Diagnosed with adjustment disorder, disturbed mood and behaviors, cluster B traits. Health—Aortic aneurysm, MS, migraines.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Case Management – Level 3

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- Member consented and was enrolled on 2/24/2014; member then opted out at assessment on 3/7/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy

Case Management Evaluation Guide

- Infant/toddler with risk for developmental delays

Observations:

- None.

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Member opted out of case management after being referred. No assessment completed for this member.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- N/A.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- N/A.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- N/A.

Recommendations:

- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- N/A.

Recommendations:

Case Management Evaluation Guide

- None.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- Member opted out of case management; no care plan completed.

Recommendations:
- None.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- N/A.

Recommendations:
- None.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- N/A.

Recommendations:
- None.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:
- Case manager contacted member on 3/7/2014 to discuss the case management referral and program. Member opted out of case management at that time.

Recommendations:
- None.

Case Management Evaluation Guide
14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists? (Insert case manager contact with providers.)
Observations: ◆ N/A.
Recommendations: ◆ None.
15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family? (Insert case manager contact with caregiver/family.)
Observations: ◆ N/A.
Recommendations: ◆ None.
16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?
Observations: ◆ N/A.
Recommendations: ◆ None.
17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following? ◆ Grand rounds ◆ Care team meetings ◆ Case conferencing ◆ Member rounds ◆ Multidisciplinary work pods/groups
Observations: ◆ N/A.
Recommendations: ◆ None.
V. Transition of Care and Discharge Planning
18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant

Case Management Evaluation Guide
information.
Observations: ◆ Member was hospitalized for suicidal ideations from 1/22/2014 to 1/24/2014. Member opted out of case management when contacted by CMO case manager.
Recommendations: ◆ None.
19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?
Observations: ◆ N/A.
Recommendations: ◆ None.
20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?
Observations: ◆ N/A.
Recommendations: ◆ None.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ N/A.
Recommendations: ◆ None.

Case Identifier: Case 6
Diagnosis: HIV
Synopsis: Member was referred for high-risk pregnancy.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member was referred for case management on 1/22/2014 by Alere for history of preterm labor, low birth weight baby, HIV, vaginal bleeding, pelvic pressure, low back pain, and soreness in legs.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Case management – high-risk OB - Level 3

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 1/22/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:
- High-risk pregnancy.

Recommendations:
- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:
- Member was assessed on 1/22/2014; G 5, P 4, 2 vaginal deliveries and 2 C-sections, member reported that baby number 4 was in NICU one week.
- Member reported that she had no allergies to medication and she is seeing Dr. Martin for her HIV.
- Member reports that she is single but father of baby involved with this pregnancy.
- Member reported that she was diagnosed with HIV in 2007.
- Member reported that she is a nurse's aide and is currently working.
- Member reported that her family is not involved in her life but her friend and boyfriend help her.
- Member was seen in the ER on 1/7/2014 for vaginal bleeding and dizziness and was kept for observation on 1/2/2013 for contractions.

Recommendations:
- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:
- No linguistic or cultural needs noted.

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- No over- or underutilization of services noted.

Recommendations:
- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:
- Member reported that her family is not in her life at this time. Member did not identify the boyfriend as a contact.

Case Management Evaluation Guide

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:
- No documentation of discussion with provider during the assessment process.

Recommendations:
- Include the member's provider during the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- 1/24/2014: Care plan developed, identified problems—high-risk pregnancy, HIV, vaginal bleeding, medication and nutritional issues, and complication of the pregnancy.
- Goals:
  1. Able to recognize danger signs of pregnancy.
  2. Understanding of HIV symptoms and verbalizing understanding.

Recommendations:
- None.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- Care plan was faxed to the member's provider but no inclusion of the provider in the development of the care plan was noted.

Recommendations:
- CMO should include the member's provider and any specialist in the development of the member's care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- No care gaps noted for this member.

Case Management Evaluation Guide

Recommendations:

- The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 1/22/2014: Assessment completed telephonically with member, follow-up call scheduled for 2/11/2014.
- 2/3/2014: Member was in outpatient setting for hemorrhaging.
- 2/11/2014: CM contacted member. Member reported no issues, shared her next OB appointment as 2/17/2014, reported no ED visits, next contact set up for 3/4/2014.
- 3/4 /2014: CM attempted to contact member, left message.
- 3/17/2014: CM attempted to contact member, left message.
- 3/31/2014: Member contacted CM, reported no problems, stated she was progressing well and having no complications. Reported next OB appointment as 4/8/2014, member has not identified a pediatrician for the baby, and member reported that she would be bottle feeding the child. CM scheduled next contact with member on 4/21/2014.
- 4/21/2014: CM unable to contact member, left voicemail.
- 5/5/2014: CM received system notification that member had delivered on 4/28/2014 through C-section. CM tried to contact member, no answer, left message.
- 5/19/2014: CM contacted member for three week follow-up. Member reported that baby is being bottle fed and was doing well and was seen for the 2-week well-baby check. Member reported that her postpartum appointment is to be scheduled.
- 6/16/2014: CM attempted to contact member for the 7-week postpartum follow-up. Member was closed to CM.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 1/24/2014: Letter and care plan faxed to OB provider.

Recommendations:

- Greater outreach to provider to ensure that member's needs are met.

Case Management Evaluation Guide

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:
- Member reported that her family is not part of her life.

Recommendations:
- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- No referral needs noted for this member.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Staff reported that member's case was not presented during any multidisciplinary team meetings.

Recommendations:
- The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- Member had two ER visits: 1/7/2014 for vaginal bleeding and dizziness, and on 1/2/2014 she was kept for observation for contractions.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Case Management Evaluation Guide
Observations: ◆ No hospitalizations noted for this member.
Recommendations: ◆ None.
20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?
Observations: ◆ Care plan addressed member's needs for care while pregnant.
Recommendations: ◆ None.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ CM follow-up with member based on acuity level.
Recommendations: ◆ None.

Case Identifier: Case 8
Diagnosis: Obesity and ADHD
Synopsis: Member's mother called WellCare requesting support for having the member tested for dyslexia.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Child's mother called into member services on 5/23/2014 requesting help to have the member tested for dyslexia. Member's mother was transferred to the case management department.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- CM - complex – Level 1: CM will contact at least once per month.

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 5/23/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:
- High-risk condition.

Recommendations:
- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:
- Assessment was completed on 6/3/2014. Member is a 13-y/o female who is having issues with obesity, member diagnosed with obesity and ADHD, member is in the sixth grade, lives with family in a house, no safety issues or concerns. No ER visits, allergies to shell fish, currently on Adderall,
- Member has DME – nebulizer but she does not use it.
- Member does have a PCP and is completing her well-care visits.
- Member has had no A1C, no LDL, HDL tests. Wears glasses.
- Member does see her dentist, last seen 6/2013.
- Member's mother reported that the member was seen 2/7/2014 at her pediatrician's office for a dislocated patella.
- Mother reported that the member's appetite is excellent.
- CM noted that no CAGE or PHQ9 was completed due to child's age.
- Mother of member reported that the member's immunizations are up-to-date.
- No information noted in the assessment concerning the original request for dyslexia testing.

Recommendations:
- Review of information concerning the request for dyslexia testing.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:
- No cultural or linguistic needs identified by the mother.

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- No over- or under-utilization of services noted for this member.

Recommendations:
- None.

Case Management Evaluation Guide

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- Member's mother completed the assessment with the case manager; CM did not inquire about including the member in the assessment process, which may have been beneficial for this teenager.

Recommendations:

- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- No discussion with member's provider noted.

Recommendations:

- Include the member's PCP during the assessment process to ensure all member's needs are identified.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- 6/16/2014: Care plan completed, problems were identified as neurological, decline in health status, medication purpose and side effects, body image, not following CDC guidelines for current age.
- Goals:
    1. Health status will improve or remain the same
    2. Member will enroll in a weight loss program, enroll in YMCA or exercise program – Intervention discussed barriers to getting to PCP appointments (started 7/16/2014; closed out).
    3. Caregiver will verbalize understanding of member's condition – neurological goal and low priority.
    4. Mother will verbalize understanding of medication and side effects.
    5. Caregiver will verbalize importance of weight loss.
- First goal identified for the care plan does not identify any member need; the goal is not realistic, not client-centered, and identifies no area for change.
- Problems identified by the case manager: One of the problems identified is neurological. No neurological disorders were noted in the assessment. Member does have ADHD but this diagnosis is better explained as a behavioral health diagnosis. Also no current health declines noted in the assessment and no body image issues noted in the assessment. Concern that the identification of these problems is based on CM decisional balance and not on member's reported issues.

Recommendations:

- Goals need to be individualized (based on reported member needs), measurable, realistic, and reachable by target dates.

Case Management Evaluation Guide

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- Member was not part of the care plan development, and no inquiry to mom as to possibly including the member in development of care plan, which could have been beneficial for this teenager.

Recommendations:

- None.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- No care gaps noted for this member.

Recommendations:

- The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 5/23/2014: Member's mother called into the MEU team requesting dyslexia testing for her daughter. Mother of member was transferred to the case management department and mom agreed to case management and reported that member needed testing for dyslexia.
- 5/27/2014: CM attempted to contact member's mother and file review completed.
- 5/29/2014: CM attempted to contact member's mother, left message.
- 6/2/2014: CM contacted member's mother, set up time for assessment completion on 6/3/2014.
- 6/3/2014: CM completed assessment telephonically, offered referral for behavioral health but the mother declined, mother reported that member is able to complete all ADLs. CM reviewed community resources and identified barriers as lack of understanding of the benefits of losing weight, no care gaps or utilization issues identified.
- 6/4/2014: CM sent educational material on obesity to member's mother.
- 6/16/2014: CM completed referral for Weight Watchers.
- 6/24/2014: CM attempted to contact member's mom, left message.

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- 7/1/2014: Member's mom called CM, left message, mom called back same day, left message.
- 7/3/2014: MEU contacted member's mom to complete the member satisfaction survey.
- 7/10/2014: CM contacted member's mother. The mother requested referral for GI, Weight Watchers, and testing for dyslexia. Mother told to follow up with the member's PCP for the referral to Weight Watchers.
- Referral completed on 6/16/2014 for Weight Watchers; this was not communicated to the member's mother as evidenced by the mother's request for a referral to Weight Watchers on 7/10/2014. During this telephone contact on 7/10/2014, member's mother was told to follow up with PCP for Weight Watchers. No referral was completed or information gathered for the member's mother concerning dyslexia testing for the member. Testing for dyslexia was the original reason the mom called and the request was not addressed by the CM.
- Concern that member's telephone calls are not being returned in a timely manner as evidenced by the mother's call into the case manager two times on 7/1/2014 with no return telephone call to the member's mother until 7/10/2014.

Recommendations:

- Educate case managers on the process for linking an adolescent member to the Weight Watchers program and ensure that requested referrals are completed for members if needed. If a referral for the care requested is not necessary, educate the member or caregiver/guardian/family on the steps to complete their request for linkage.
- Explore ways to ensure that calls made to the CM are answered in a timely manner.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 6/24/2014: CM faxed care plan and welcome letter to provider.
- 7/25/2014: Member's pediatrician signed and returned the care plan.

Recommendations:

- Ongoing inclusion of the member's provider in the member's care planning process.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

- Member's mother was actively involved in the member's case management services.

Recommendations:

- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Case Management Evaluation Guide

Observations:

- During a review of the file, it was noted that the CM made a referral to Weight Watchers on 6/10/2014 with no communication with the member's mother. However, the member's mother requested a referral for Weight Watchers, a GI specialist, and testing for dyslexia. The CM noted that she told the mother to follow up with the PCP for the Weight Watchers referral. The mother's request for referrals for a GI specialist and testing for dyslexia were not addressed in the note.

Recommendations:

- Educate all case managers on the importance of ensuring continuity of care for members and the importance of completing timely requests for linkage and referral to facilitate positive health outcomes for members.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

- Staff reported that the member's case was not presented during a multidisciplinary team meeting.

Recommendations:

- The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- No ER or hospitalizations noted for this member.

Recommendations:

- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- No hospitalizations noted for this member.

Recommendations:

- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Case Management Evaluation Guide
Observations: ◆ During the file review it was noted that the problems identified in the care plan are not reflected in the assessment. It was also noted that the mother requested on multiple occasions testing for dyslexia, and this was not addressed in the care plan or in the multiple communications with the member's mother.
Recommendations: ◆ Care plan goals need to be individualized based on the reported member concerns and needs. These goals need to address the member's care coordination needs.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ It was noted in the file review that the CM did follow up with the member's mother based on the acuity level assigned to the member.
Recommendations: ◆ None.

Case Identifier: Oversample Case 1
Diagnosis: Malignant neoplasm of upper outer quadrant of breast
Synopsis: Member self-referred for case management because of difficulty getting to her chemotherapy (chemo) treatments because of transportation issues.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member called into MEU on 5/22/2014 and reported that she was having issues with her transportation to chemo treatments. Member transferred to the manager, information concerning the CM program was given, and member agreed to CM.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Complex case management - acuity level 1

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 5/22/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy

Case Management Evaluation Guide

- Infant/toddler with risk for developmental delays

Observations:

- High-cost condition.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Assessment was completed telephonically with member on 5/28/2014.
- Member self-referred for case management services and was requesting support with transportation to her chemotherapy treatments.
- Member reported that she lives alone and has no issues getting food, shared that she has a master's degree in education and is retired.
- Member reported that she does not have a vehicle and she has been relying on the help of her friends.
- Member reported that she was diagnosed with malignant neoplasm of upper outer quadrant of breast,
- Member has PCP that she sees regularly.
- Member reported that she has an appointment with the oncologist on 7/1/2014.
- Member reported that other than the cancer she has no major medical issues.
- CAGE completed, no alcohol or drug use noted;
- PHQ9 completed, no issues with depression noted.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- No cultural or linguistic needs noted for this member.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- No over- or underutilization of services noted for this member.

Case Management Evaluation Guide

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- Member reported no family involvement in her care.

Recommendations:

- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- No discussion with member's provider identified in the assessment process.

Recommendations:

- Include the member's PCP and specialist in the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- Care plan completed 5/29/2014; problems identified were: Potential for decline in health status, interruption of health care services, deficit in cancer knowledge, risk of illness due to not adhering to CDC guidelines for age group, and at risk for inadequate medical care related to inability to secure transportation.
- Goals:
    1. Member will maintain health status or verbalized improvement after breast cancer treatment.
    2. Member will receive medically necessary services.
    3. Member will verbalize ways to manage side effects of treatment; i.e., proper diet, staying active, keeping up with appointments.
- During review of member's care plan, it was noted that one of the member's goals is to receive medically necessary services. The intervention and goal are based on the member's report that she wants to get a new PCP once her cancer treatment is done. Member verbalized to the CM that she is unhappy with PCP but continues to see him.
- During the review of the case file, it was identified that the care plan does not reflect the member's concern about transportation to her chemotherapy appointments. The care plan lacked member-centeredness and failed to reflect the member's concerns.

Recommendations:

- When member problems or areas of concern are identified through member/family/caregiver report or predictive modeling, ensure the care plan is member-centered and addresses the problem areas or concerns. Goals need to be individualized (based on reported member needs), measurable, realistic,

Case Management Evaluation Guide

and reachable by target dates.

- Goals and interventions need to reflect the member's need. If the member wants to obtain a new PCP, an example of a goal would be "Member will identify new PCP and schedule initial appointment."

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- During the review it was noted that there was no participation of the member's PCP or oncologist in the development of the care plan. Also, the care plan did not reflect the member's concerns or issues that she wished to address; e.g., transportation and getting a new PCP.

Recommendations:

- Goals and interventions need to reflect the member's goals for engaging in the member's medical care.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- No care gaps were noted for this member.

Recommendations:

- The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 5/28/2014: Initial assessment note—Member recently diagnosed with breast cancer, had first round of chemotherapy, reported one hospital admission in 2/2014 for mastectomy, no ER visits in the past year, no care gaps, currently receiving chemotherapy but reported no current medications, no ADL needs, reported that her church and close friends help when needed—this includes transportation. CM scheduled a follow-up on 6/18/2014.
- 6/18/2014: CM outreach to member who reported that she wants to change PCP but will wait until she is done with chemotherapy. CM scheduled follow-up on 7/2/2014.
- 7/2/2014: CM outreach to member, CM noted that member's Nystatin medication was picked up.
- 7/25/2014: CM contacted member who reported that she was prescribed Tramadol for pain but finished with the script, CM scheduled next follow-up on 8/1/2014.

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Recommendations:
- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:
- 7/25/2014: CM faxed care plan to oncologist.

Recommendations:
- Include specialists in the development of the care plan and provide the care plan to the member's PCP and specialist in a timely manner.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:
- No contact with member's support group due to member not giving consent to contact.

Recommendations:
- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- No referrals noted for this member.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Staff reported that member's case was not discussed during a multidisciplinary team meeting.

Recommendations:
- The CMO should use a multidisciplinary team in the management of members in case management.

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V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- No ER visits for member.
- One hospitalization for member in 2/2014 for her mastectomy.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:
- No discharge plan noted for this member due to no hospitalizations.

Recommendations:
- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:
- During the review it was noted that the care plan addressed the member's current medical needs related to her breast cancer. Transportation was an initial member concern but was resolved by church support group.

Recommendations:
- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:
- CM monitored the member based on her current acuity level.

Recommendations:
- None.

Appendix G. **Disease Management File Review Tool**

Following this page is the completed Disease Management File Review Tool HSAG used to evaluate WellCare's cases.

Disease Management File Review Tool—WellCare

Case Identifier: Case 1
Diagnosis: Hypertension
Synopsis: 60-year-old female with hypertension.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Hypertension (HTN).

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- The CMO indicates that the member was identified through the CMO's algorithm on 4/11/2014. Notes show that the provider, Dr. Chiam (PCP) referred the member for disease management on 3/27/2014.

Recommendations:
- The process by which a member is referred or identified for disease management is not clear. The CMO needs to make the identification and referral source for disease management clear within each case.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed 4/11/2014.
- Member has a PCP. Last seen April 2014. Next visit July 2014.
- No transportation issues identified.
- Member has diagnosis of HTN. Diagnosed in 2009.
- Member's PCP manages the HTN.

Disease Management

- Member has had no inpatient admissions in the last 12 months.
- Assessment captures height/weight and calculated the BMI. The member indicated she is not interested in weight loss. Member indicates she has a scale and exercises once a day.
- No DME noted.
- No allergies.
- Member has high cholesterol, identified in 2009. Member denies any history of strokes.
- Member is on medication and reports that she understands why she is taking the medications she is prescribed.
- Independent with ADLs, living arrangement – at home.
- Member on a special low-salt diet.
- Smoker – cigarettes, ½ pack a day.
- Takes a daily pulse. 135. Monitors BP daily – 103/79.

Assessment note – member indicates she wants to feel better and eat better. No barriers to change. Disease case manager will follow up with the member in 3–4 weeks to see if emergency plan is in place and if she has reduced fried foods to only two times per week.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan was developed on 4/11/2014.
- Goals:
  - Member will verbalize understanding of the disease process; knowledge deficit of HTN; long-term goal 9/30/2014 target date.
  - Understanding of signs and symptoms of impending exacerbation - 7/31/2014 goal.
- Interventions –
  - Communicate with PCP – will fax lab results.
  - Educate member/family on disease.
  - Educate on signs and symptoms of the disease.
  - Send educational materials – member will receive a workbook.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Disease Management

Observations:
- Assessment and care plan coincide with hypertension workbook. They are based on clinical practice guidelines and HEDIS measures.

Recommendations:
- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:
- No member educational materials noted in the chart.

Recommendations:
- The disease case manager should ensure that materials identified to be sent to the member are sent.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:
- The CMO had a workbook for hypertension, but this member did not receive the materials.

Recommendations:
- The disease case manager should ensure that disease management workbooks are sent.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- No additional contact with the member was made after initial contact.

Recommendations:
- The disease case manager should explore strategies to increase member engagement.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- No additional contact with the member was made after initial contact.

Recommendations:
- The disease case manager should explore strategies to increase member engagement.

Disease Management

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- 5/5/2014: Attempt to reach the member.
- 5/8/2014: Attempt to reach the member.
- 5/9/2014: Member reached and agreed to a reassessment in the afternoon. No answer.
- 5/9/2014: Due to multiple attempts to contact the member, member was moved to passive disease management.

Recommendations:

- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- 4/11/2014: PCP notified of member enrollment into disease management via fax.

Recommendations:

- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- No additional contact with the member was made after initial contact. The care plan did not include a measure(s) of member health outcomes.

Recommendations:

- The disease case manager should measure member health outcomes.

Case Identifier: Case 2
Diagnosis: Asthma
Synopsis: 15-year-old male with asthma.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Asthma.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Member referred for disease management on 6/26/2013, self-referral. The CMO's system is only able to identify the original date of referral to disease management versus spans of enrollment.

Recommendations:
- The CMO should consider system functionality that will allow the disease case manager to better identify each time a member is referred to disease management and capture each episode.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed with the member's parent on 6/26/2013.
- Member has a PCP.
- Member is Hispanic. Prefers English and has an eighth-grade education.
- Member diagnosed in 1999 with asthma.
- The PCP manages the member's asthma.
- Member is not on control medication.
- Parent does not know asthma triggers.
- Parent indicates that coughing wakes the member up at night.

Disease Management

- Member has a peak flow meter.
- Member was inpatient in 2010. Member has been to the ER two times since 2013.
- The member is on albuterol.
- BMI 24.96.
- Seasonal allergies.
- No issues with ADLs.
- No tobacco use.
- Takes pulse weekly – reading of 130.

Assessment note – indicates the parent stated, "we all have asthma and don't know how to take care of it."

Recommendations:

- A new assessment should be completed for each episode of disease management. The initial assessment was completed in 2013.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Goals – education on the disease process and signs and symptoms.
- Interventions –
  - 6/26/2013 – send educational materials.
  - Communicate with PCP.
  - Problems - knowledge deficits noted.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Guidelines are used within the assessment and in the creation of goals.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Documentation of educational materials sent in the notes, but the system screen used to show the materials that were sent was not documented.

Disease Management

Recommendations:

- The disease case manager should ensure that educational materials are sent to the member.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- Documentation of a booklet being sent to the member in June 2013; however, there is no indication that the member received this information.

Recommendations:

- The disease case manager should ensure that the member receives educational materials.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- It is unclear if the member received the hypoallergenic bedding. The assessment note indicates that there is a plan to see if the member can identify any triggers in 3–4 weeks, but there was no contact with the member at this interval.

Recommendations:

- The disease case manager should ensure contact with the member at the frequency established for the next planned follow-up.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- No. The disease case manager identified that the member did not have an action plan almost four months after enrollment into disease management.

Recommendations:

- The disease case manager may consider helping to ensure that identified needs are addressed, such as creation of the asthma action plan.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- The initial assessment note from 6/2013 indicated that the disease case manager ordered hypoallergenic bedding for the member with a plan to contact the member in 3–4 weeks. Sent out a booklet to the member, and the plan for the next contact is to identify triggers, asthma action plan, and education planned.
- 8/15/2013 Contact with member, reassessment to follow up on goals.
- 8/28/2013: Educational information mailed to the member on asthma.
- 9/23/2014: Contact to see if member went to pulmonologist. Checking if member will be on controlled medication due to overuse of rescue inhaler and nebulizer. Parent noted that the member underwent thyroidectomy.

Disease Management

- 10/13/2014: Goals noted as met and no need for further disease management; however, there was not notation or documentation of what happened with the member.
- Review of care plan –
  - 8/15/2013: Unable to assess triggers – identified educational needs. No action plan or rescue inhaler. Member understood that he should have rescue inhaler and plan for usage, especially at school. Mom to ask PCP for rescue inhaler.
  - 9/23/2013: No inhaler at school or action plan. Member had thyroidectomy. Member will see a pulmonologist.
  - 1/16/2014: Has nebulizer, no rescue inhaler. Education on use of nebulizer and asthma not in control. Needs to request rescue inhaler.

The progression of the case is difficult to follow using the case notes. It appears the member was moved out of disease management on 10/13/2014, but then additional notes are noted in January.

Recommendations:

- The disease case manager should ensure that progress toward each goal is documented. The disease case manager should ensure that there is clear rationale and documentation for "all goals met." The disease case manager should more actively help manage the member to help arrange for services and care identified as a gap.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- The disease case manager sent the PCP a notification on 6/26/2013. The letter also requested that the provider submit an asthma action plan, spirometry testing, and vaccine history.

Recommendations:

- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- There was no improvement in health outcome demonstrated for this member.

Recommendations:

- The disease case manager should work to establish goals, update progress toward the goals, and ensure there is a measure of member health outcomes.

Case Identifier: Case 3
Diagnosis: COPD
Synopsis: 31-year-old female with COPD.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- COPD in 2013, and then in the Obesity and Weight Watchers program in 2014.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Notes indicate that member self-referral for obesity and Weight Watchers program on 4/2/2014. The CMO indicates that the member was identified via the algorithm in 2012 for COPD.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- 7/3/2013: Assessment completed.
- Member is White. Eighth-grade education. Can read/write.
- Diagnosed in 2013 with COPD, which is managed by the PCP.
- Member's symptoms include air hunger or feeling a need for more air. Chronic cough, shortness of breath. Symptoms are daily.
- In April 2013, the member experienced exacerbations. Uses inhalers and nebulizers. Spirometry testing in 4/2013.
- BMI – 70.56 (obese).
- Diagnosed with sleep apnea in 2011. Uses a CPAP machine. At the time of assessment, member was not interested in weight management.
- High cholesterol.
- Diagnosis of hypertension – 1996, PCP manages.

Disease Management

- Medications – Lisinopril, synthroid, metoporol, Lasix, beta blocker.
- 7/3/2013: Referral for behavioral health, smoker Quitline, and a health coach provided. Obesity screening: 4/8/2014 and again on 7/14/2014.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- 7/3/2013: Goals – understanding of disease process, signs and symptoms.
- Interventions – PCP communication, education, and education on signs and symptoms.
- The care plan was not updated to reflect the more recent episode of the member wanting to lose weight. The CMO indicated that the obesity program is not a formalized disease management program and therefore care plans are not developed.

Recommendations:

- The CMO may consider establishing a care plan with members accessing its obesity program.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Disease management guidelines incorporated into assessment questions.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- PCP fax sent on 7/3/2013 and again on 8/1/2013. Member must obtain physician information before enrolling in Weight Watchers.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- A COPD booklet is available and was sent to the member in July 2013.

Recommendations:

- None.

Disease Management

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- 7/2013: Member indicated she was confused by her health and uncertain how to use COPD medications. The member was sent a workbook.
- 8/2013: Member indicated that she did not receive educational materials.

Recommendations:

- The disease case manager should ensure that educational materials are sent and that the member receives them.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- There was no documentation of a self-care plan.

Recommendations:

- The disease case manager should help the member develop a self-management plan.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- 7/3/2013: Member was referred to behavioral health.
- 7/8/2013: Attempt to contact the member.
- 8/2013: Member given support for smoking cessation. Notes indicated that the member had not been contacted by behavioral health for depression or by health coach for Weight Watchers.
- 7/8/2013: Attempted to contact.
- 9/6/2013: Multiple attempts to contact member without success. The CMO moved the member to passive disease management.
- There was no documentation of a self-care plan.
- 7/14/2014: Member reported that her BMI dropped from 72.6 to 70.5. Member indicated some barriers to eating healthy including financial. Member indicates she has had some past success with weight loss. Member indicated that she has made some changes, quit smoking. Member has been in Weight Watchers for six months and reported that she has not attended a meeting.

Recommendations:

- The disease case manager should provide more active management to ensure that identified care gaps are addressed.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- PCP fax sent on 7/3/2013 and again on 8/1/2013. Member must obtain physician information before enrolling in Weight Watchers.

Disease Management

Recommendations:

- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- The disease case manager was able to document a self-reported drop in BMI and to determine that the member has quit smoking.

Recommendations:

- None.

Case Identifier: Case 4
Diagnosis: Diabetes
Synopsis: 12-year-old female with diabetes.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Diabetes.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- The member was initially identified on 3/6/2012 and then re-identified 4/30/2014 from the algorithm. The member was enrolled into disease management on 5/4/2014.

Recommendations:
- The CMO should reduce the time between initial assessment and enrollment into disease management.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed 5/7/2014 with member's mother.
- Member has primary care provider (PCP). Last seen 2/24/2014 and next visit 5/19/2014.
- Black. Education level of mother – college.
- No transportation issues.
- Member was diagnosed with diabetes in 2011.
- Diabetes is managed by member's PCP, Dr. Baldwin.
- Member monitors blood glucose two times a day. At times the member has readings below 70 and feels funny, cold sweats. Member will take sugar reading at these times.
- Member has blood sugar readings 300 or greater approximately three times a week. Symptoms include increased urination, thirsty.

Disease Management

- Diabetes is treated with water, exercise, medication.
- Member gets feet checked. Last eye exam 1/2014. HbA1c – 9.0. Urine – within normal limits. Fasting glucose – 200.
- Member had an inpatient admission in March 2013. No ER visits.
- Member is on insulin. Exercises 2–3 times per week.
- No difficulty with completing ADLs.
- Member is on a low-sugar/carbohydrate diet.

Assessment note: Type I diabetes mellitus. No history of behavioral health issues.

- Mother indicated that she wants to learn as much about diabetes to support, teach, and give the member the tools to help her manage her disease.
- Member participates in a dance group at church.
- Wears glasses.
- No care gap – HEDIS screening.
- Working on food plan, promote self-independence. Set goals for blood sugar – reward. Some education.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- The care plan was created on 5/7/2014.
- Barriers – member with multiple blood sugar readings in the 300s related to noncompliance with diet.
- Goal – verbalize understanding of signs and symptoms of hyperglycemia.
- Priority level is noted as "high" by the disease case manager with follow-up planned on 6/7/2014.
- Interventions – customized by disease case manager.
- Promote independence – educated on meal planning.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- The assessment and care plan goals are based on clinical guidelines.

Recommendations:

- None.

Disease Management

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- 5/7/2014: Sent workbook – Living Well with Diabetes, Type 1 Diabetes and Your Child, and Growing Up with Type 1 Diabetes.
- 6/17/2014: Mother states has not received educational materials.

Recommendations:

- The disease case manager should ensure that educational materials are received by the member.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- The member was sent a workbook on diabetes.

Recommendations:

- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- There was only one contact with the member after the assessment and the member was at camp. The member's understanding of her conditions could not be assessed.

Recommendations:

- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- There was only one contact with the member's mother after the assessment, and the member was at a diabetes camp.
- A plan of self-care had not been developed.

Recommendations:

- None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Disease Management

Observations:

- 6/17/2014: Reassessment conducted with the member's mother who reported that the member was attending a diabetes camp. Mother reported that member is motivated. Plan scheduled to follow up in 3-4 weeks to discuss changes.
- 7/17/2014: Attempt to contact.

Recommendations:

- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- A notification of enrollment into disease management was faxed to the PCP on 5/7/2014.

Recommendations:

- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- The disease case manager established some relevant goals for the member and collected lab data and blood sugar information at the assessment and at times during the monitoring process. The system does not allow for entering of biometric data that can be entered, dated, and tracked over time.

Recommendations:

- The CMO may consider system enhancements that allow for member health outcomes to be tracked more objectively and over time. Currently, these are only available via free text.

Case Identifier: Case 5
Diagnosis: Hypertension
Synopsis: 43-year-old male with hypertension.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Hypertension.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- 2/28/2014: Referred through the algorithm.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed on 2/28/2014.
- Member has PCP, last seen 2/2014 and 3/17/2014.
- Member is able to read, write, and completed the eleventh grade.
- No transportation issues.
- Diagnosed with hypertension in 2005.
- No inpatient admissions.
- No ER visits.
- Diet – no added salt.
- ADL independent.
- History of smoking. Member indicates he quit in February 2014 and is now smoking again. Member has smoked for 11–15 years, about a pack a day.

Disease Management

Member indicates he is trying to quit today. Interested in materials to quit.
- Monitors blood pressure monthly, last reading was 160/80.
- PHQ-9 – completed. Score of 16. Member offered a behavioral health referral but declined.
- CAGE completed – no issues identified.

2/28/2014: Member wants to quit smoking, so blood pressure will come down. Plan for follow-up in 3–4 weeks and check on follow-through on self-checks, triggers for smoking, and emergency plan.

Recommendations:
- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:
- Care plan developed on 2/28/2014.
- Goals – understanding of disease process and signs and symptoms of impending exacerbation.
- Interventions – PCP education, self-monitoring, educational materials.

Recommendations:
- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:
- Guidelines are built into the assessment and care plan process.

Recommendations:
- No.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:
- No educational materials were documented as sent to the member.

Recommendations:
- The disease case manager should ensure that the member is mailed educational materials.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Disease Management

Observations:

- No materials were provided to the member.

Recommendations:

- The disease case manager should ensure the member is mailed educational materials.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- There was no contact made with the member after the initial assessment and enrollment into disease management.

Recommendations:

- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- 3/28/2014: Attempt to contact member. No additional follow-up.

Recommendations:

- The disease case manager should make additional effort to engage the member in the disease management program.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- There was no contact with the member after the initial assessment was completed.

Recommendations:

- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- 2/28/2014: Note that disease management notification was faxed to provider.

Recommendations:

- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Disease Management
Recommendations: ◆ None.
V. Measureable Outcomes
13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**
Observations: ◆ No health outcomes were measured. There was no contact with the member after the initial assessment.
Recommendations: ◆ The disease case manager should work to establish a mechanism to track member health outcomes.

Case Identifier: Case 6
Diagnosis: Asthma
Synopsis: 11-year-old female with asthma.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Asthma and enrolled 3/13/2014.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- The member was identified 12/3/2013 and enrolled 3/13/2014.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations
- The assessment was completed on 12/3/2013 by the member's parent.
- Member has PCP. Last visit 11/2013. No future visits scheduled.
- No transportation issues.
- Member diagnosed with asthma in 2012.
- PCP manages the asthma. Member uses inhaler.
- Triggers – exercise, weather, dust mites, pollen, grass.
- Symptoms of chest tightness and shortness of breath. Experiences symptoms 2–3 times per week.
- Had a pulmonary test – 11/2013, normal results.
- No inpatient admissions. No ER visits.
- Member is obese. Member exercises.

Disease Management

- ADL independent.

Assessment note: 12/3/2013 – disease case manager noted that she is sending scale and hypoallergenic bedding. Plan to follow up in four weeks, check on scale and bedding, will discuss page 14 of asthma in control booklet and send to the member.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan developed 12/3/2013. Understanding of disease process. Signs and symptoms of exacerbations.
- Interventions – communicate with PCP.
- Self-plan and urgent care plan.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Clinical guidelines are incorporated into the assessment and care plan goals.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Living Well with Asthma booklet sent.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- Booklet sent and action plan developed.

Recommendations:

- None.

Disease Management

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- Member met goals with understanding disease, signs and symptoms, etc.

Recommendations:
- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- Self-care developed.

Recommendations:
- None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:
- 12/20/2013: Bedding not received.
- 1/13/2014: Received bedding.
- 2/28/2014: Moved to new neighborhood.
- 3/23/2014: Asthma action plan. Member had rash and encouraged to discuss with doctor. Use of rescue inhaler two times per week.
- 3/28/2014: Follow-up.
- 4/21/14: Member noted as meeting goals, case closed, and member moved to passive disease management.

Recommendations:
- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:
- No documentation of coordination with PCP noted.

Recommendations:
- The disease case manager should coordinate with the member's PCP and other providers as appropriate.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:
- No.

Disease Management
Recommendations: ◆ None.
V. Measureable Outcomes
13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**
Observations: ◆ No measureable health outcomes were noted.
Recommendations: ◆ The disease case manager should establish a measure(s) of member health outcomes.

Case Identifier: Case 7
Diagnosis: Diabetes
Synopsis: 34-year-old female with diabetes.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Diabetes.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Member was identified on 10/1/2013 by the algorithm.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- The assessment was completed on 11/13/2013.
- Member has diabetes, hypertension, and asthma.
- Member self-reports as Black with a twelfth-grade education.
- Member has a PCP.
- No transportation issues.
- Member has had asthma since 1980. Has inhaler and has used it three times in the past year.
- Triggers – cold/flu, smoking.
- Symptoms - cough, wheezing, shortness of breath.
- Asthma action plan developed in May 2013.
- No inpatient admissions. No ER visits.
- Member diagnosed with diabetes in 2004.

Disease Management

- PCP monitors diabetes. Member does not monitor her blood glucose. When blood sugar is low, member experiences feeling shaky, dizzy. Experiences this monthly. Member indicates she has not had a reading greater than 300.
- Member gets her feet checked. Has not had an eye exam.
- HbA1c test – 5/2013 – result unknown.
- Member diagnosed with hypertension in 2013. It is managed by the PCP. Member is on a no-added-salt diet.
- BMI – 34 (obese).
- Member takes medications.
- ADL independent.
- Member smokes cigarettes.
- PHQ-9 completed with a score of 12.
- CAGE completed – score of 0.

11/13/2013 – Assessment note: The disease case manager offered the member a referral to a therapist and the patient agreed. Patient given Quit line information. Member given a health coach for Weight Watchers. Planned follow-up in 3–4 week to see if she is checking blood levels.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan developed on 11/13/2013.
- Goals – understanding disease process, signs and symptoms of exacerbation. Member able to evaluate lifestyle changes after Weight Watchers program. Goal to reduce BMI by 1.0 percent.
- Interventions – education/checking blood sugar.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Guidelines are integrated into the assessment questions and care plan goals.

Recommendations:

- None.

Disease Management

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Educational materials sent to the member on 11/13/2013.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- No toolkit or action plan was provided to the member.

Recommendations:

- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- There was no contact noted with the member beyond the initial assessment.

Recommendations:

- The disease case manager should explore strategies to increase member engagement.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- There was no contact noted with the member beyond the initial assessment.

Recommendations:

- The disease case manager should explore strategies to increase member engagement.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Disease Management

Observations:

- 11/22/2013: Member assigned to behavioral health.
- 12/23/2013: Member was closed for unable to contact.
- 2/27/2014: Assigned a health coach for Weight Watchers program.
- 2/27/2014: Baseline form for Weight Watchers not received – case closed.
- 4/2/2014: Baseline form received from provider.

Recommendations:

- The CMO should consider making entry into the Weight Watchers program easier for the member. In addition, the disease case manager should attempt linkage with the PCP to help with entry into the program.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- No contact with the PCP was noted.

Recommendations:

- The disease case manager should collaborate and coordinate with the member's providers.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- The disease case manager did establish a decrease in BMI of 1 percent as a goal. There was no contact with the member after the care plan goal; therefore, the disease case manager could not monitor the member's progress.

Recommendations:

- None.

Case Identifier: Case 8
Diagnosis: Depression
Synopsis: 36-year-old female with depression.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Depression.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Member was identified on 4/29/2014 from the algorithm.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- The assessment was completed on 5/1/2014.
- Member has depression. No other comorbidities identified.
- Member has PCP. Last seen on 1/2014. No future appointments scheduled.
- No transportation issues.
- Member self-reports as White, preferred language – English, and completed the eighth grade.
- BMI - 37 (obese). Interested in weight loss. Member has scale. Exercises daily.
- Member is not prescribed medications.
- Codeine allergy.
- ADL- independent.
- No tobacco.

Disease Management

- Flu shot 1/2014.
- Labs – unknown.
- PHQ-9 – 24. Member would not consent to case management.
- No CAGE completed.
- Member indicates she sees a behavioral health therapist currently.

Assessment Note: 5/1/2014 – plan for follow-up in 3–4 weeks. Discussed weight loss goal. Member given Weight Watchers referral.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan developed on 5/1/2014.
- Goals - will stabilize depression and identify depressive behavior.
- Interventions – Send educational material – body image, educated family on complications of disease – obesity, educated on eating alternatives and lifestyle, self-medication and self-care.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Clinical guidelines are incorporated into the assessment and care plan goals.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Depression Fact Guide.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Disease Management

Observations:
- No toolkit or action plan was provided.

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- There was no contact with the member after the initial assessment.

Recommendations:
- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- There was no contact with the member after the initial assessment.

Recommendations:
- None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:
- 5/21/2014, 5/23/2014, 5/27/2014 – attempted to contact the member without success. Member moved to passive disease management.

Recommendations:
- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:
- Communication faxed to the PCP on 5/1/2014.

Recommendations:
- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:
- No.

Disease Management
Recommendations: ◆ None.
V. Measureable Outcomes
13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**
Observations: ◆ No measureable outcomes were documented.
Recommendations: ◆ The disease case manager should establish measure health outcomes for the member.