IPA, Hospital & Ancillary Medicare Provider Manual

2024

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Section 1: Introduction and Overview

Wellcare Health Plans provides managed care services for Medicare and is a wholly-owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise. By 2023, Wellcare projects it will serve nearly 1 million Medicare members in 36 states. Wellcare's experience and exclusive commitment to these programs enable the company to serve its Members and Providers as well as manage its operations effectively and efficiently. For the purposes of this Manual, Wellcare and/or its constituent health plan(s) may be referred to herein as "Wellcare," or, as applicable, "Health Plan."

This manual covers plan code H5087.

Mission and Vision

Wellcare's vision is to be a leader in government-sponsored healthcare programs in partnership with the Members, Providers, governments, and communities it serves. Wellcare will:

- Enhance its Members' health and quality of life
- Partner with Providers and governments to provide quality, cost-effective healthcare solutions
- Create a rewarding and enriching environment for its associates

Wellcare's core values include:

- *Partnership* – Members are the reason Wellcare is in business; Providers are partners in serving Members; and regulators are the stewards of the public's resources and trust. Wellcare will deliver excellent service to its partners.
- *Integrity* – Wellcare's actions must consistently demonstrate a high level of integrity that earns the trust of those it serves.
- *Accountability* – All associates must be responsible for the commitments Wellcare makes and the results it delivers.
- *One Team* – With fellow associates, Wellcare can expect – and is expected to demonstrate – a collaborative approach in the way it works.

Purpose of This Manual

This Manual is intended for IPAs who have contracted to participate in Wellcare's provider networks through a capitated risk arrangement ("Provider Agreement") to deliver quality healthcare services to Members enrolled in Wellcare's Medicare Advantage (MA) Benefit Plan. Additionally, IPA may perform Delegated Activities set

forth in the Provider Agreement, which includes requirements and standards that IPA shall flow down to its Providers participating in Wellcare's contracted provider networks. If there is a conflict or inconsistency between the terms of this Provider Manual and the IPA's Provider Agreement, including, without limitation the performance of delegated functions, the terms and provisions contained in the IPA's Provider Agreement will supersede and control with respect to IPA, its subdelegates and its Providers. If there are any conflicting terms within this Provider Manual, the most stringent term/obligation/requirement shall be applied with regard to IPA's and its Providers' duties and obligations.

This Manual serves as a guide to IPA, Providers and their staff to comply with the policies and procedures governing the administration of Wellcare's Benefit Programs, and is an extension of, and supplements, the contract under which a Provider participates in Wellcare's contracted provider networks with Wellcare. **This Provider Manual replaces and supersedes any previous versions dated prior to July 29, 2024, and is available on Wellcare's website at www.wellcare.com/California/Providers/Medicare.**

A paper copy of this Manual is available at no charge to Providers upon request.
In accordance with the Agreement, Participating Providers must abide by all applicable provisions contained in this Manual.

Revisions to this Manual reflect changes made to Wellcare's policies and procedures. As policies and procedures change, updates will be issued by Wellcare in the form of Provider Bulletins and will be incorporated by reference into subsequent versions of this Manual. Unless otherwise provided in the Provider Agreement, Wellcare will communicate changes to the Manual through a Table of Revisions in the front of the Manual, Provider Bulletins posted to the provider portal on Wellcare's website, or in the quarterly Provider Newsletter. Additionally, Wellcare and IPA will abide by any additional requirements in the Provider Agreement regarding communication of changes to Providers, if required by the Provider Agreement.

Wellcare Service Area

The Member's Evidence of Coverage (EOC) defines a service area as the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) in which a person must live in order to become, or to remain, a Member of Wellcare. Members who temporarily move outside of the service area (as defined by CMS as six months or less) are eligible to continue to receive emergency and urgently needed services only, when outside of the service area.

At this time, Wellcare is approved to service the following counties: **Los Angeles, Orange, Riverside, Ventura, San Bernardino, and San Joaquin**.

Policy Update on Dual Special Needs Plans (D-SNP)

Starting in 2024, California Department of Health Care Services (DHCS) is requiring the state specific Dual Special Needs Plan (D-SNP) only contracts. As a result, all Wellcare of California D-SNP members in H contract H5087 are transitioning to the Wellcare By Health Net plan in H3561 and Network effective January 1, 2024.
If you are a contracted provider with Wellcare By Health Net for 2024, please refer to the Wellcare By Health Net Provider D-SNP Resource Page to access more detail provider resources.

Wellcare Compliance Program

Wellcare has a comprehensive values-based Compliance Program that reflects how fundamental components of Wellcare business operations are conducted. Wellcare recognizes that its employees and Provider affiliates are the keys to providing quality healthcare services and is committed to managing its business operations in an ethical manner, in accordance with contractual obligations, and consistent with all applicable statutes, regulations and rules.

An overview of the Wellcare Compliance Program can be found under Section 15: Attachments. It applies to all Wellcare personnel, its Board members, contractors, suppliers and participating Providers.

Fraud, Waste and Abuse Prevention

Wellcare is committed to the prevention, detection and reporting of healthcare fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. Wellcare has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of problematic healthcare service use, including overutilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and Wellcare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes

contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including, but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), Providers and their employees must complete FWA training program within 90-days of contract, and annually thereafter.

As a Provider in our Medicare network, Provider's are required to check the OIG/GSA Exclusion and CMS Preclusion List prior to hiring or contracting and monthly thereafter as outlined below for all staff, volunteers, temporary employees, consultants, Board of Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901. Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider or entity.

To report suspicions of fraud, waste and abuse, call the Fraud, Waste and Abuse Hotline at **866-685-8664**.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities such as health plans, healthcare clearinghouses and most healthcare Providers, including pharmacies, to safeguard the privacy of patient information. Covered entities are required to conduct HIPAA Privacy training on an annual basis and to ensure ongoing organizational compliance with the regulations.

A major goal of the Privacy Rule is to ensure that an individual's personal health information is properly protected while still allowing the flow of health information needed to provide and promote high-quality healthcare, as well as to protect the public's health and well-being. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent inappropriate uses and disclosures of Protected Health Information (PHI). The following are examples of appropriate safeguards that organizations/Providers should take to protect the security and privacy of PHI:

- Ensure that data files are not saved on public or private computers while accessing corporate email through the Internet
- Ensure that electronic systems for beneficiary mailings are properly programmed to prevent documents containing Personal Identifiable information (PII) from being sent to the wrong beneficiaries
- Ensure that PHI data on all portable devices are encrypted
- Implement security measures to restrict access to PHI based on an individual's need to access the data
- Perform an internal risk assessment or engage an industry-recognized security expert to conduct an external risk assessment of the organization to identify and address security vulnerabilities
- Shredding documents containing PHI before discarding them
- Securing medical records with lock and key or passcode
- Limiting access to keys and passcodes
- Locking computer screens when away from your desk/work station
- Refraining from discussing Member information outside the workplace, lunch rooms, elevators, lobby, etc.

Please refer to the Compliance Program for additional information.

Mandatory Data Sharing Agreement

The state of California established the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) to oversee the electronic exchange of health and social services information in California.

Entities listed below must sign a data sharing agreement (DSA). To sign the DSA, go to https://signdxf.powerappsportals.com.

Participating entities that must sign a DSA include:

- General acute care hospitals.

- Physician organizations and medical groups.
- Skilled nursing facilities.
- Clinical laboratories.
- Acute psychiatric hospitals.

Wellcare may apply a corrective action plan if the agreement is not signed.

Reproductive Privacy Act

The Reproductive Privacy Act guarantees individuals a fundamental right to privacy regarding their reproductive choices, preventing the state from denying or interfering with a person's right to choose or obtain an abortion before the fetus is viable or when the abortion is necessary to protect the person's life or health.[1]

Certain businesses handling medical information on sensitive services must develop security policies for data related to gender-affirming care, abortion, abortion-related services, and contraception. California law also prohibits health care providers, plans, contractors, or employers from sharing medical information for investigations or inquiries from other states or federal agencies regarding lawful abortions unless authorized by existing law.

Data for gender-affirming and abortion-related services must be omitted from data exchanged via health information exchanges (HIEs) and not be transmitted to California HIEs.

State law specifically states:[1]

- **A business that electronically stores or maintains medical information on the provision of sensitive services**, including, but not limited to, on an electronic health record system or electronic medical record system, on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer, must have capabilities, policies, and procedures that enable all of the following:

  (A) Limit user access privileges to information systems that contain medical information related to gender-affirming care, abortion and abortion-related services, and contraception only to those persons who are authorized to access specified medical information.

  (B) Prevent the disclosure, access, transfer, transmission, or processing of medical information related to gender-affirming care, abortion and abortion-related services, and contraception to persons and entities outside of the state of California.

  (C) Segregate medical information related to gender-affirming care, abortion and abortion-related services, and contraception from the rest of the patient's record.

  (D) Provide the ability to automatically disable access to segregated medical information related to gender-affirming care, abortion and abortion-related services, and contraception by individuals and entities in another state.

Additionally, regulations that apply primarily for Medi-Cal and Commercial lines of business prohibit the collection or disclosure of information outside California for operational claims payment purposes. State law includes requirements for provider licensing, enhanced protections for individuals and providers in sensitive services and "legally protected health care activity," including preventing the disclosure of medical information related to sensitive services outside the state, segregating such information from the patient's record, and enabling automatic disabling of access by entities outside the state.

Legally protected health care activity includes but is not limited to:

- Reproductive health care services,
- Gender-affirming health care services, and
- Gender-affirming mental health care services.

Sensitive services include but are not limited to:

- Services related to mental/behavioral health,
- Sexual and reproductive health,
- Sexually transmitted infections,
- Substance use disorder,
- Gender-affirming care, and
- Intimate partner violence.

How reproductive privacy affects providers and others[1]

Note these requirements:

- Specified businesses that store or maintain medical information regarding sensitive services must develop specific policies, procedures and capabilities that protect sensitive information.
- Health care service plans, providers and others may not cooperate with any inquiry or investigation from any individual, outside state, or federal agency that would identify an individual who is seeking, obtaining, or has obtained an abortion or related services that are lawful in California. Exceptions may be authorized if the individual has provided authorization for the disclosure.
- The exchange of health information related to abortion and abortion-related services is excluded from automatically being shared on the California Health and Human Services Data Exchange Framework.

Impacts of regulations on business, business partners, or members

- **Regulations prohibit healing arts boards** from denying an application for a license, or from imposing discipline on a licensee, on the basis of a civil judgment, criminal conviction or disciplinary action in another state if that judgment is

based solely on the application of another state's law that interferes with a person's right to receive sensitive services.

- **The practice of nurse-midwifery** includes care for common gynecologic conditions and (when certified by a physician or surgeon) to furnish or order Schedule II and III controlled substances as specified.
- **Regulations prohibit a person or business** from collecting, using, disclosing, or retaining the personal information of a person who is physically located at or within a precise geolocation of a family planning center.
- **Regulations repeal current state provisions that:**
  - Prohibit an abortion from being performed upon an unemancipated minor unless they have first given written consent to the abortion and also has obtained the written consent of one parent or legal guardian.
  - Provide specified judicial procedures when consent of a parent or guardian cannot be obtained by the pregnant unemancipated minor.

[1]Information taken or derived from Assembly Bill 352, Senate Bill 345, or information found at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB352 or https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB345.

DEFINITIONS:

Some definitions have been amended and some new definitions have been added as part of the California Medical Information Act (CMIA), a state of California regulation, these definitions would be apply across all lines of business.

1. "**Medical information"** means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual
2. **"Mental health application information"** means information related to a consumer's inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.
3. **"Mental health digital service"** means a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.
4. **"Reproductive or sexual health application information"** means information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
5. **"Reproductive or sexual health digital service"** means a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
6. **"Sensitive services"** means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the

Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Section 2: Wellcare Health Plan – Benefits

Wellcare benefit plans are open to all Medicare beneficiaries who meet all of the additional applicable eligibility requirements for membership (including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefit); have voluntarily elected to enroll; and, whose enrollment in Wellcare has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Wellcare provides comprehensive, coordinated medical services to Members on a prepaid basis through established Provider networks. Wellcare Medicare Advantage Plan Members must choose a Primary Care Physician (PCP) or Clinic and have all their care coordinated through this Provider.

Medicare Advantage plans are regulated by CMS, the same federal agency that administers Medicare, and by the California Department of Managed Health Care (DMHC).

Wellcare Benefit Summary

Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**.

Wellcare offers its Members benefits such as:

- Inpatient Acute Hospital, Skilled Nursing and Psychiatric Care
- Home Healthcare
- Doctor Office Visits
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Healthcare
- Outpatient Substance Abuse Care
- Outpatient Services/Surgery
- Ambulance Services
- Emergency Medical Services
- Outpatient Rehabilitation Services
- Durable Medical Equipment (DME)
- Prosthetic Devices

- Part D Prescription Drugs
- Hearing Aids
- Preventive Exams
- Acupuncture
- Out-of-Area Urgent and Emergent Medical Services
- Worldwide Emergency Travel Care
- Medical Nutrition Therapy
- Preventive and Comprehensive Dental Care
- Vision Services
- Transportation Services
- Telehealth services (outpatient medical & Behavioral Health)
- Fitness Membership
- Personal Emergency Response System (PERS)
- Post-Acute and Chronic Meals
- In-Home Support Services
- OTC Drugs
- Flex Card

Acupuncture

Members who have this coverage can obtain acupuncture services through the American Specialty Health Plans, Inc. (ASH Plans) network of participating acupuncturists without a referral from the member's PCP or Independent Practice Association (IPA). For any questions, refer the member to the Member Services Department at 866-999-3945, or contact ASH at 800-678-9133, Monday through Friday 5 a.m.-6 p.m. Pacific time (PT). For more information, visit ashcompanies.com.

Comprehensive Dental

Wellcare offers coverage for dental services, which is administered through Delta Dental. For 2024, all Members have access to dental services as part of their Wellcare Benefits. Please refer to Section 3: Coordination of Dental and Vision Services of the Provider Manual for additional information. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**.

Comprehensive Vision and Eyewear

Wellcare Members have coverage for routine vision exam and eyewear through Centene Vision Services for 2024. Please refer to Section 3: Coordination of Dental and Vision Services of the Provider Manual for additional information. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**.

Hearing Aids

Hearing aids are not a Medicare-covered benefit. However, Wellcare benefits offer a supplemental benefit through Hearing Care Solutions (HCS). HCS offer members affordable hearing care, including coverage for hearing aids. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**. Please direct any questions about hearing aids benefits to the Wellcare Customer Service Department at **866-999-3945**.

Contact HCS at **866-344-7756**, Monday through Friday, 5 a.m.-5 p.m. PT.
For more information, visit www.hearingcaresolutions.com.

Transportation to Medical Appointments

Wellcare has partnered with Access2Care to provide transportation for Medically Necessary services. The purpose of this service is to 1) assist Members in obtaining timely evaluation and treatment as recommended by their physicians; and 2) help ensure that a Member's healthcare is not compromised by a lack of transportation. This benefit has some restrictions and limitations, so please check the Member's *Summary of*

Benefits or *Evidence of Coverage* or call the Wellcare Customer Service Department at **866-999-3945**.

Additional Telehealth Services - Medicare Covered Services

Through Teladoc Health™, members can access telehealth services for virtual visits to discuss non-emergency health issues when their regular doctor is not available. Contact Teladoc Health at **800-835-2362**, 24 hours a day, 7 days a week. For more information, visit Teladoc.com/hn.

Benefit includes:

4b: Urgently Needed Services, 6: Home Health Services, 7a: Primary Care Physician Services, 7c: Occupational Therapy Services, 7d: Physician Specialist Services, 7e1: Individual Sessions for Mental Health Specialty Services, 7f: Podiatry Services, 7g: Other Health Care Professional, 7h1: Individual Sessions for Psychiatric Services, 7i: Physical Therapy and Speech-Language Pathology Services, 9c1: Individual Sessions for Outpatient Substance Abuse, 14e2: Diabetes Self-Management Training

Over The Counter (OTC)

Benefit includes:

Wellcare Spendables Program (multi-benefit card) – Depending on the plan, members will receive a fixed dollar monthly allowance amount preloaded into a Wellcare Spendables Card (debit card). The card can be used to help cover some out-of-pocket costs. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**.

OTC Items: Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home. Covered items are limited to those allowable per Chapter 4 of the Medicare Managed Care Manual. The value of the purchased item(s) is based on the retail price charged by the merchant, including sales tax and mail-order shipping, as applicable, and cannot be converted to cash.

Personal Emergency Response System (PERS)

Benefit includes:

Personal Emergency Response System (PERS): The Plan's contracted vendor, VRI, will send a device and a wearable pendant to the member's home. The device can connect the member's home phone line (traditional landline or digital service) or via cellular service. Once connected, the member can push the button on the pendant to activate assistance in the event of an emergency. When the button is pushed, the member will be connected to a representative at a 24/7-monitored call center who can then contact emergency services and/or a designated family member or friend on their behalf for assistance. Contact VRI at 800-860-4230, option 2, Monday through Friday, 5 a.m.-5 p.m. PT. For more information, visit wellcarepers.com.

Dental/Vision/Hearing Flex Card

If members have an allowance to cover out of pocket costs for Dental, Vision or Hearing, this would be available through the Wellcare Spendables Program (multi-benefit card) – Depending on the plan, members will receive a fixed dollar monthly allowance amount preloaded into a Wellcare Spendables Card (debit card). The card can be used to help cover some out-of-pocket costs. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California.**

Fitness Membership

Wellcare has partnered with FitOn Health, which gives members access to digital fitness and wellness content, fitness studios and gyms. Please direct any questions to the Wellcare Customer Service Department at **866-999-3945,** or contact FitOn Health at:

855-378-6683, select option 1
Email: move@fitonhealth.com
fitonhealth.com/help
fitonhealth.com/members

Meals

Wellcare has partnered with meals vendors to further promote health and wellness, and is offering home-delivered meals immediately following an inpatient hospital stay to aid in Members' recovery. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**. Please direct any questions to the Wellcare Customer Service Department at **866-999-3945**.

In-home Support Services

Wellcare has partnered with a vendor and offers Members who meet certain clinical criteria access to in-home support services, including light cleaning, household chores, and meal preparation. This benefit is in addition to the in-home support services provided by the county. Some plans also provide assistance with Activities of Daily Living such as, but not limited to, assistance with a safe bathing environment, dressing/clothing, and walking. The primary purpose of these services is to maintain the health and independence of Members, compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable ER utilization. Services must be recommended or requested by a licensed plan clinician or a licensed plan Provider. Members must have qualifying documented conditions. Please direct any questions to the Wellcare Customer Service Department at **866-999-3945**.

For Members who meet clinical criteria, includes: cleaning, household chores, and meal preparation to maintain the health and independence of Member, compensate for physical impairments, and/or reduce avoidable ER utilization and provide assistance with Activities of Daily Living such as, but not limited to, assistance with a safe bathing environment, dressing/clothing, and walking. Services must be requested by a licensed plan clinician or provider. Documentation of one of the following is required: Alzheimers or dementia diagnosis, joint replacement surgery, fall recovery, limb amputation, cataract/retinal/other eye surgery, advanced cardio pulmonary disease, stroke, ambulation w assistive device, impaired vision, frequent hospitalizations or ER visits, post-surgery with chronic diseases, including one of the following: diabetes, COPD, CHF, UTI, renal disease, cancer, or Behavioral Health diagnosis.

Culturally and Linguistically Appropriate Services

Wellcare recognizes that providing culturally and linguistically appropriate services is a crucial component to ensuring Member access to quality healthcare services. As such, Wellcare has a policy that when our enrolled membership reaches 10% of the benefit plan population, Member documents are translated into the spoken language. Currently, Wellcare offers Member information in Chinese, English, Spanish, Vietnamese and Korean. Wellcare also offers no-cost language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats.

To help ensure culturally and linguistically appropriate services, Wellcare:

- Recruits and employs qualified bilingual and bicultural staff who have the knowledge and experience of working within the culture.
- Provides cultural diversity and sensitivity training to its staff and Provider office staff to promote understanding of cultural differences among ethnic communities.
- Provides access to interpreter services at key points of contact for all Members, including those who may be deaf or hard of hearing. Program information is available and understandable to any non-English speaking Member. This is accomplished through the use of a 24-hour interpretation service for phone calls and a contract for face-to-face interpreter services to provide interpretation on a scheduled basis.
- Provides written materials in languages most familiar to Wellcare Members when any given population segment is equal to or greater than Medicare's 5% threshold for language or Department of Health Care Services' (DHCS) threshold language. Member educational materials are developed at appropriate Member literacy level and quantity for the given language.
- Conducts regular informational presentations and targeted outreach for different ethnic communities at community-based organizations to ensure that information on Wellcare programs and benefits are dispersed to a wide range of Members.
- Works closely with community and faith-based organizations across the county to ensure our Members have a wide range of culturally and linguistically appropriate services available to them.
- Requires that Wellcare Members have direct access to contracted specialist services whenever the Member's PCP in collaboration with the appropriate specialist and network medical director determine that the medical or service complexity warrants ongoing care by a specialist over a prolonged period. Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)

and complex cancer Members are examples of conditions or Members who require specialized medical care over a prolonged period.

- Assigns a Care Manager to Members who are identified as high risk through the initial risk assessment or subsequently through a variety of avenues, such as inpatient, emergency room or outpatient access, so as to assist in ensuring that care is provided in a timely, efficient and cost-effective manner.

For More Information

For information about any of Wellcare's Benefits, or Cultural and Linguistic Services, please call Wellcare at **866-999-3945**. If Wellcare Members have questions about these services, please have them call our Customer Service Department at **866-999-3945**.

Section 3: Coordination of Dental & Vision Services

Wellcare Members automatically receive preventive and comprehensive dental coverage when enrolling in a benefit plan. Wellcare Members have coverage for routine vision exams and eyewear through Centene Vision Services. Because benefits may change each year, please refer Members to their annual *Summary of Benefits* and *Evidence of Coverage* documents, which are available on the Wellcare website at **www.wellcare.com/California**.

Dental Service Requests

Dental benefits are administered through Delta Dental. A Primary Care dentist will be auto-assigned based on the Members' home address. Changes can be performed online or via Delta Dental's customer service call center. Changes made by the 15th of the month are effective on the 1st of the upcoming month. Changes made after the 15th of the month take effect on the 1st of the following month. There is no limit to the number of times a Member can change his/her dentist. Members will receive ID cards upon enrollment. ID cards are not required to receive treatment. Simply provide name, DOB, and ID Number (Wellcare or Delta). Any questions pertaining to dental services should be directed to Delta Dental Member Services Department:

DeltaCare USA
P.O. Box 1810
Alpharetta, GA 30023
Customer Service: **855-643-8515**

Vision Service Requests

Wellcare has partnered with Centene Vision Services to administer vision benefits. Covered Members may schedule an appointment with any participating Provider with Centene Vision Services to access their vision benefits.

Rosters are provided to Members for both dental and vision services upon enrollment with Wellcare, on an annual basis, and also upon request. For further information, please call our Customer Service Department at **866-999-3945,** or contact Centene Vision Services at **866-392-6058**.

Providers can access the Transitions of Care Management (TRC) Worksheet to:

- Help support transitions of care to ensure appropriate documentation and timely report of the notification of a Medicare patient's inpatient admission, receipt of discharge information, and patient engagement after inpatient discharge.

- Reconcile discharge medications with the most recent medication lists to optimize HEDIS® and Star Rating scores and improve care coordination.

Section 4: Member Enrollment & Eligibility

Member Enrollment Overview

Wellcare uses the following criteria to determine eligibility for enrollment in its Medicare Advantage Benefit Plans:

- A person must be entitled to Medicare Part A and enrolled in Medicare Part B as of the effective date of coverage under Wellcare, which also includes those under age 65 and qualified by Social Security as disabled.
- A person must reside within the Center for Medicare & Medicaid Services (CMS) approved service area for Wellcare (currently Los Angeles, Orange, Riverside, Ventura, San Bernardino, and San Joaquin counties), and must not reside outside of the service area for periods of six or more consecutive months.
- A person must make a valid enrollment request and submit to Wellcare during an election period.

A person with End Stage Renal Disease (ESRD) has the option to enroll in a Medicare Advantage Plan. The 21st Century Cures Act gives patients with ESRD access to more affordable Medicare coverage choices and extra benefits such as transportation or home-delivered meals.

Individuals become enrolled with Wellcare effective on the first day of the month after completing an enrollment application. When approaching the age of 65 and becoming entitled to Medicare Parts A and B on a prospective basis, Wellcare may enroll these beneficiaries for future effective dates, in accordance with the date of their conversion to Medicare. These individuals are referred to as “Age-Ins”.

If a PCP and IPA is not selected on the enrollment form, Wellcare will help the Member select a PCP and IPA near his or her residence. Wellcare encourages selection of a PCP within 30 minutes or 15 miles of a Member’s residence.

Member Eligibility Overview

Each Provider is responsible for verifying the Member’s eligibility before rendering services, unless it is an emergency. All Members should have a health plan ID card, which should be presented each time services are requested. Please refer to Section 15: Attachments of this manual for sample.

The Health Plan Identification Card identifies the following information:

- Health Plan: **Wellcare (plus specific Benefit Plan name such as "Wellcare Giveback (HMO)"**
- Member Name/Subscriber Name
- Member Health Plan Identification Number
- Primary Care Physician – name and phone number
- Affiliated IPA
- Pharmacy Information, including RX BIN, RX Group, and RX PCN numbers.
- Customer Service – toll-free number

Although the ID card is a primary method of identification, it does not guarantee coverage or benefits. Please see eligibility verification process below. Members are allowed to change health plans several times during election periods, thus his/her eligibility can change from month to month.

Eligibility List

In order to ensure the proper management of care for Members enrolled with Wellcare, our contracted IPAs will have access to the Wellcare FTP site to obtain current eligibility files by IPA.

The electronic eligibility data will be updated on the 1st and the 15th day of every month. If these days fall on a weekend or holiday, the eligibility files will be available on the next business day.

The following file will be posted on the FTP site using the bi-monthly schedule outlined above:

- System Import Eligibility File – in comma delimited text file format.
    - This will be used to import all electronic Wellcare Member eligibility into your internal Member systems. (File Layout as found under Section 15: Attachments).

Wellcare provides an electronic Eligibility List to all contracted IPAs twice per month. These lists contain information about the Member's status with the health plan for that particular month. It is the responsibility of the IPA to share this information with its PCPs and other contracted Providers. Please refer to Section 15: Attachments for information on how to download eligibility files. For other Provider inquiries, please contact our Customer Service Department at **866-999-3945**.

Eligibility Verification Process

If a Member does not have his/her ID card, or the Member is not listed on the current eligibility list at the time of service, please verify eligibility by calling Wellcare at **866-999-3945**. When contacting Wellcare, please be prepared to give the following information:

- Member's name
- Member's date of birth
- Member's Medicare ID number and/or Wellcare ID number

Wellcare also offers online eligibility verification. To check Member eligibility online, you will need to register for provider portal access:

- Go to **provider.wellcare.com/provider/accounts/registration**
- Complete the registration form. All fields with an asterisk are required. You must select three different security questions and answers, and agree to the terms and conditions.
- After completing steps 1 and 2, you will receive a verification email. You must click the link in this email to activate your account and set your password.
- After setting and submitting your password, you will be routed to the request affiliation screen. This is where you can ask for affiliation to an account at the contract or sub group level. Once you find the desired contract or sub group and submit the request, it is sent to the administrator of that account to approve or deny. Please note that you will not be able to access the tools in the portal until the admin has approved your request.
- You will see a confirmation message for the submitted affiliation request. You can then submit additional requests or log out. Please remember, you will not have access to the tools in the portal until the Admin of that account has granted your access. Once your Admin grants or denies your request, you will receive an email confirmation.
- Once you have completed registration, you can go to the My Patients area in the portal to check Member eligibility.
- If you are not able to find the Member on the Wellcare provider portal, please check the provider portal of our affiliate, Health Net - CA by going to **https://provider.healthnetcalifornia.com** and follow the outlined steps

Please call Customer Service at **866-999-3945** for questions about Member benefit information.

Eligibility Discrepancy

If an eligible Member does not appear correctly on the monthly eligibility report, please call Wellcare Customer Service at **866-999-3945**. For example:

- The Member is eligible with the health plan but is not listed on the eligibility list.
- The Member is not eligible with the health plan but is listed on the eligibility list.
- The PCP or IPA assignment is not accurate.
- The identification information on the eligibility list is not accurate.

Member Disenrollment

Voluntary Disenrollment

A Member may choose to disenroll from Wellcare during a valid election period and can obtain more information on the disenrollment process by calling Customer Service at **866-999-3945**. The disenrollment is effective the first of the month following the month in which the request was received.

There should be no discontinuation or disruption of any healthcare services and treatments for Members despite disenrollment with Wellcare.

Involuntary Disenrollment

Per CMS guidelines, Wellcare may initiate Member disenrollment for the following reasons:

- Member loses or no longer has Medicare Part A & B coverage.
- Member permanently moves or resides outside of Wellcare's service area for six or more consecutive months.
- Member supplies fraudulent information or misrepresents himself/herself on the membership application to enroll with Wellcare.
- Member commits fraud or allows another person to use his/her Wellcare ID card to obtain services.
- The Member is disruptive, abusive, unruly or uncooperative to the extent that Wellcare's ability to provide services is impaired. Please note that CMS must review this type of request.

Provider-Initiated Member Disenrollment

Wellcare Customer Service has developed a Policy and Procedure for documenting the process of disenrolling Members from a physician practice. Providers may not end a relationship with a Member because of the Member's medical condition or the cost and type of care required for treatment. Wellcare procedures for involuntary transfer or disenrollment of Members are based on the Centers for Medicare & Medicaid Services (CMS) requirements. A Member **may not** be disenrolled without the consent of CMS.

A PCP may submit a request to initiate disenrollment for a Member under any of the following circumstances:

- Repeated (documented) abusive behavior by the patient
- Physical assault to the Provider, office staff or another Member
- Serious threats by the Member or family member(s)
- Disruption to medical group operations
- Inappropriate use of Out-of-Network services
- Inappropriate use of medical services
- Inappropriate use of Medicare services
- Non-compliance with prescribed treatment plan
- The Member moves out of the Wellcare service area
- The Member is temporarily absent from the Wellcare service area for more than six consecutive months

In instances where the Member is disruptive, abusive, unruly or uncooperative, CMS must review any request for disenrollment from Wellcare. In most situations, the CMS review looks for evidence that the individual continued to behave inappropriately after being counseled/warned about his/her behavior, and that an opportunity was given to correct the behavior. Informal counseling is done by Providers and an initial warning related to the Member's behavior must be sent by Wellcare. Wellcare requires documentation/records from the IPA before sending the Member an official warning. If the inappropriate behavior was due to a medical condition, Wellcare must demonstrate that the underlying medical condition was controlled and was not the cause of the inappropriate behavior.

Please note that documentation in the patient's medical record is pertinent evidence, along with police reports, if applicable. All requests to initiate disenrollment of a Member along with supporting documentation should be sent via facsimile to the Manager of Membership Operations at **877-999-3945**. The information submitted will

be reviewed and, if appropriate, forwarded to the CMS for consideration. Both the Provider and the Member will be notified via mail of the decision of Wellcare and CMS.

Please also refer to Requests to Disenroll a Member under Section 10: Quality Improvement of this Provider Manual for additional information.

Member Retro Transfers

A Member can request a retro transfer to a new IPA if they contact Customer Service prior to the 15th of the month and answer "No" to all the questions listed below:

- Are you currently seeing a specialist?
- Do you have any scheduled specialist appointments?
- Do you have any scheduled procedures?
- Are you currently using medical equipment?
- Did you have any hospital admissions?
- Did you go to any urgent care facilities?

If the Member answers no to all questions, a retro transfer is granted for the 1st of the current month. If Member answers "Yes" to one or more questions, a retro transfer will not be granted and the request to transfer is made effective the 1st of the following month.

Section 5: Customer Service

Toll-Free Numbers

Wellcare's Customer Service Department is designed to assist Members and Providers with all of Wellcare's health plan benefit coordination.

Wellcare can be reached as follows:

Phone: 866-999-3945

Fax: 877-999-3945

TTY: 711

Customer Service has friendly, knowledgeable and bilingual representatives who are available 8 a.m. to 8 p.m. every day of the week from Oct. 1–March 31, and 8 a.m. to 8 p.m. Monday through Friday from April 1–Sept. 30. Our Customer Service Representatives help Wellcare Members by answering questions about, but not limited to: Eligibility, General Benefits, Assigned Physician, Hospital Information and Pharmacy Locations.

The Customer Service Department can also provide your patients with information about:

- Status of Referrals and Authorizations
- Billing Questions
- Hospital Services
- Health Plan Options
- Community Resources and Support Groups
- Pharmacy Benefits and Coverage
- Grievances and Appeals Process
- ID Card Replacements

Interpreter Services

To provide care to all eligible Members in the language that the beneficiary is most comfortable with, Wellcare has representatives fluent in Spanish, Korean, Vietnamese, Chinese and English and has contracted with interpreter services vendors for other languages.

When a Member needs to interact with Customer Service and there is a language discordance, an interpreter service vendoris to be used.

When a Member interacts with their Provider (PCP or Specialist) there is a language discordance, it is the responsibility of the IPA to provide an interpreter in accordance with the IPA's Provider Agreement. An attending adult is only to be used as an interpreter if specifically requested by the Member, that adult agrees to assist and the reliace on that adult is fitting. If the Member asks to an attending adult as an interpreter, the Provider must document the Member's reason and the refusal to use the services of a qualified interpreter. A parent cannot give permission for a minor child to interpreter in any circumstances. Please reference your participating Provider Agreement with Wellcare for clarification on the Interpreter Service requirements.

Member Complaints and Grievances

The Customer Service Department helps Members obtain health services according to their needs. If a Member has a **complaint** about Wellcare or any of its Providers, they may contact Customer Service toll-free at **866-999-3945**.

For example, a Member could file a grievance if they had a problem with the following:

- Quality of medical care
- Difficulty in scheduling appointments
- Long wait times in a Provider's office or at the pharmacy

Member complaints are documented, forwarded to the appropriate department for resolution, and kept on file.

If the Member's complaint cannot be resolved informally to the Member's satisfaction, he or she may file a **formal grievance** directly with Wellcare Customer Service at **866-999-3945**. Once the Member files a formal grievance, Wellcare will work to resolve the grievance within 30 calendar days of receipt.

Wellcare retains the responsibility for resolving its Members' grievances. All Wellcare Providers agree to cooperate and use best efforts to help resolve Member grievances when brought to their attention.

Member Rights and Responsibilities

Wellcare communicates to Members what their rights and responsibilities are when trying to access care or are in the act of obtaining healthcare services. These rights and responsibilities are for all Members, regardless of race, sex, culture, economic, educational or religious backgrounds.

When a Member exercises their right to get more information about their "Rights and Responsibilities," their first point of reference should be the Wellcare *Evidence of Coverage* Booklet. A second point of contact for the Member is the Customer Service Department at **866-999-3945**. Wellcare requires that the Member's Rights and Responsibilities be posted in all Provider offices.

All Members will receive a Member handbook upon enrollment along with the Evidence of Coverage information, which details their right and responsibilities. Please refer to Section 15: Attachments of this manual to view a copy of the Member Rights and Responsibilities from the *Evidence of Coverage* booklet. In summary:

Members have the following rights:

- You have the right to be treated with respect and dignity.
- We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in audio, in braille, in large print, or other alternate formats, etc.).
- You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.
- You have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- We must ensure that you get timely access to your covered services and drugs.
- We must protect the privacy of your personal health information.
- You have the right to look at your medical records held by the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

- You have the right to know how your health information has been shared with others for any purposes that are not routine.
- We must give you information about the plan, its network of providers, your rights and responsibilities, and your covered services.
- We must support your right to make decisions about your care.
- You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:
    - To know about all of your choices. You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
    - To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
    - The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
- You have the right to make recommendations about our member rights and responsibilities policy.

Members have the following responsibilities:

- Get familiar with your covered services and the rules you must follow to get these covered services.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask and get an answer you can understand. You have the responsibility to understand your health problems and help set treatment goals that you and your doctor agree upon.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
- You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
- If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- If you move within our plan service area, we need to know so we can keep your membership record up to date and know how to contact you.
- If you move outside of our plan service area, you cannot remain a member of our plan. If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Transportation Scheduling

Wellcare has partnered with Access2Care to coordinate the transportation benefit for seniors enrolled in all Wellcare Medicare Advantage Benefit Plans. Transportation may be scheduled by the Member or by the Provider's office staff by calling Access2Care at:

Routine requests	Call at least 72 hours in advance, Monday through Friday, 8 a.m. to 8 p.m. Pacific time	844-515-6876 Website: access2care.net/services/managed-transportation/members-riders

Urgent care or immediate transportation	Available 24 hours a day, 7 days a week	844-515-6876
Customer service	October 1-March 31, call seven days a week from 8 a.m. to 8 p.m. April 1-September 30, call Monday-Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, on weekends and on federal holidays.	866-999-3945

This does not apply to Medically Necessary transportation services, such as ambulance service.

Access2Care requests a minimum of 72 hours advance notice for scheduling appointments. This benefit has some restrictions and limitations, so please check the Member's *Evidence of Coverage* or call the Wellcare Customer Service Department at **866-999-3945**.

For further information regarding the Transportation benefit, refer to Section 2: Wellcare Health Plan - Benefits of this Manual.

Call Center Standards and Requirements

Call centers must comply with the operating standards set forth in the participating Provider Agreement, including, without limitation:

- Follow an explicitly defined process for handling customer complaints.
- Provide interpreter service to all non-English speaking, limited English proficient and hard-of-hearing beneficiaries.
- Inform callers that interpreter services are at no cost to them.

- Limit average hold time to two minutes. The average hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.
- Answer 80% of incoming calls within 30 seconds.
- Limit the disconnect rate of all incoming calls to 5%.

Call Center Reporting Requirements

The MSO/IPA will be required to submit monthly call center reports to the FTP site in a folder identified as "Delegation Reports". Reports are due no later than the 15th of each month to capture the previous month's data.

Reports are required (at minimum) to consist of the following data elements below:

- Service Level (by month and year to date) demonstrating compliance with the requirement to answer 80% of all calls within 30 seconds.
- Abandonment Rate (by month and year to date) demonstrating compliance with the requirement to have an abandonment rate below 5%.
- Hold Times (by month and year to date) demonstrating compliance with the requirement to not exceed 2-minute hold times.

Wellcare Self-Service Tools for Providers

Wellcare offers technology options to save Providers time using the secure web portal, Chat and IVR (Interactive Voice Response System) self-service tools. These self-service tools help Providers do business with Wellcare. We want your interactions with us to be as easy, convenient and efficient as possible. Giving Providers and their staff self-service tools and access is a way for us to accomplish this goal. Providers can access this information below or at **www.wellcare.com/California**, then click on Overview from the Provider's drop-down menu

Secure Provider Portal: Key Features and Benefits of Registering

Wellcare's secure online provider portal offers immediate access to what Providers need most. All participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

- **Member Eligibility, CoPay Information and More –** Verify Member eligibility, and view copays, benefit information, demographic information, care gaps, health conditions, visit history and more;
- **Pharmacy Services and Utilization –** View and download a copy of Wellcare's preferred drug list (PDL), access pharmacy utilization reports, and obtain information about Wellcare pharmacy services;
- **Visit Checklist/Appointment Agenda –** Download and print a checklist for Member appointments, then submit online to get credit for Partnership for Quality (P4Q);
- **Secure Inbox –** View the latest announcements for Providers and receive important messages from Wellcare.

Provider Registration Advantage

The secure provider portal allows Providers to have one username and password for use with multiple practitioners/offices. Administrators can easily manage users and permissions. Once registered for Wellcare's portal, Providers should retain username and password information for future reference.

How to Register

To create an account, please refer to the *Provider Resource Guide* on Wellcare's website at **www.wellcare.com/California/Providers/Medicare**. For more information about Wellcare's web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service training.

Additional Resources

The following resources are on Wellcare's website at **www.wellcare.com/California/Providers/Medicare**:

- The *Provider Resource Guide* contains information about Wellcare's secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals, and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the *Provider Resource Guide*.
- The *Quick Reference Guide* contains important addresses, phone/fax numbers and authorization requirements.

Website Resources

Wellcare's website, **www.wellcare.com/California**, offers a variety of tools to help Providers and staff. Available resources include:

- Provider Manuals
- *Quick Reference Guides*
- Clinical Practice Guidelines
- Clinical Policies [Clinical Coverage Guidelines (CCGs)]
- Wellcare Companion Guide
- Forms and documents
- Pharmacy and Provider lookup (directories)
- Authorization look-up tool
- Training materials and job aids
- Newsletters
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

Using Chat: Get to Know the Benefits of Chat

Faster than email and easier than phone calls, Chat is an easy way to ask simple questions and receive real-time support. Providers may use our Chat application instead of calling and speaking with agents. Here are some ways our Chat support can help you and your staff: multi-session functionality; web support assistance; and real-time claim adjustments. Explore the benefits of using live Chat!

- **Convenience –** Live Chat offers the convenience of getting help and answers without having to have a phone call.
- **Documentation of Interaction –** Chat logs provide transparency and proof of contact. When customers engage with customer support via phone, they don't typically receive a recording of the verbal conversation. Live Chat software lets you receive a transcription of the conversation afterward.
- **You can access Chat through the portal –** The *Chat Support* Icon is on our secure provider portal. From there, you can:
    - Log on to the provider portal at: **https://provider.wellcare.com/**
    - Access the "Help" section
    - Select the desired Chat topic
    - If the Chat agent is unable to resolve the issue, the issue will be routed to the right team for further assistance.

Interactive Voice Response (IVR) System

IVR system

- New technology to expedite Provider verification and authentication within the IVR
- Provider/Member account information is sent directly to the Customer Service Representative's desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability, allowing Providers to speak their information or use the touch-tone keypad

Self-Service Features

- Ability to receive Member copay information
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials
- Automatic routing to the provider claims support (PCS) claims adjustment team to dispute a denied claim
- Rejected claims information

Tips for using our IVR

Providers should have the following information available with each call:

- Wellcare Provider ID number
- NPI or Tax ID for validation, if Providers do not have their Wellcare ID
- For claims inquiries – provide the Member's ID number, date of birth, date of service and dollar amount
- For authorization and eligibility inquiries – provide the Member's ID number and date of birth

Benefits of using Self-Service

- 24/7 data availability
- No hold times
- Providers may work at their own pace
- Access information in real time
- Unlimited number of Member claim status inquiries
- Direct access to PCS – no transfers

The *Phone Access Guide* is at **www.wellcare.com/California/Providers/Medicare** under *Overview & Resources*.

Providers may contact the appropriate departments at Wellcare by referring to the *Quick Reference Guides* on Wellcare's website at **www.wellcare.com/California/Providers/Medicare**.

Also, Wellcare Provider Relations representatives are available to help Providers. Please contact the local market office for assistance.

Provider Services Phone Numbers and Other Key Contacts

Provider Services toll-free number	**866-999-3945**
Secure Provider Portal	**https://provider.wellcare.com**
Fraud, Waste and Abuse Hotline	**866-685-8664**
Ethics and Compliance Hotline	**800-345-1642**
Specialty Pharmacy AcariaHealth Specialty Pharmacy #26, Inc.	8715 Henderson Rd. Tampa, FL 33634 Phone: **866-458-9246** (TTY **855-516-5636**) Fax: **866-458-9245** **www.acariahealth.com**
Authorization Look-Up Tool	**www.wellcare.com/California/Providers/Authorization-Lookup**
For more information on contacting Provider Services, refer to the *Quick Reference Guide* at **www.wellcare.com/California/Providers/Medicare**.	

Non-Wellcare Provider Resources

Wellcare understands that Members may elect to visit providers that are not part of Wellcare's Provider Network. If a provider is not in-network, the Provider will still need

to know how to file claims, and will need to understand any policies and procedures that may affect them and Wellcare-Member patients. Resources to help non-participating providers interact with Wellcare are found at **www.wellcare.com/California/Providers/Non-WellCare-Providers**.

Section 6: IPA Administration

The success of the relationship between the IPA and Wellcare is contingent upon the cooperative efforts put forth by each party. The IPA must identify a Medical Director who will coordinate all matters related to patient care, quality assessment and utilization. The IPA must also identify a Health Plan Liaison who will assume the day-to-day responsibilities with regard to the IPA's contractual obligations to Wellcare. Wellcare's Network Management Department works directly with the IPA and acts as the liaison for all administrative matters.

Management Services Organizations (MSO)

An IPA's use of a Management Service Organization (MSO) to perform administrative delegated functions for Wellcare is subject to the IPA's Participating Provider Agreement ("Provider Agreement") with Wellcare. IPA shall notify Wellcare of its intent to use an MSO, obtain Wellcare's prior written approval, pass a pre-delegation audit (when applicable), and provide Wellcare a copy of the contractual agreement between the IPA and MSO for review.

MSOs not currently affiliated with Wellcare must pass a Pre-Delegation Oversight Audit before the MSO can perform delegated activities on behalf of the IPA. If IPA has been approved to use an MSO for the delegated functions, IPA must provide written notice to Wellcare 90 days prior to any change or termination of the subdelegated MSO.

Provision of Professional Services

Pursuant to the terms of the IPA's Provider Agreement with Wellcare, IPA must:

- Provide or arrange for the provision of all professional Covered Services and maintain 24-hour practice coverage. Primary care services must be provided by physician members of the IPA. If the IPA subcontracts for any non-primary care services, all subcontracts must meet the requirements stated in the Provider Agreement.
- Have written contracts that bind the Provider to the applicable terms of the Wellcare Provider Agreement and provide front and signature pages to Wellcare from all IPA agreements with contracted Providers.
- Provide sample boilerplate templates of all IPA's contracts with Providers rendering Covered Services to Members

- Provide and maintain access to, in accordance with CMS Time and Distance Standards, the following medical services:

  - Primary Care Physicians
    - Family Practice
    - General Practice
    - Internal Medicine
    - Geriatrics
    - Primary Care – Physician Assistants
    - Primary Care – Nurse Practitioners
  - Allergy and Immunology
  - Cardiology
  - Cardiothoracic Surgery
  - Chiropractor
  - Dermatology
  - Endocrinology
  - ENT/Otolaryngology
  - Gastroenterology
  - General Surgery
  - Gynecology, OB/GYN
  - Infectious Diseases
  - Nephrology
  - Neurology
  - Neurosurgery
  - Oncology – Medical, Surgical
  - Oncology – Radiation/Radiation Oncology
  - Ophthalmology
  - Orthopedic Surgery
  - Physiatry, Rehabilitative Medicine
  - Plastic Surgery
  - Podiatry
  - Psychiatry
  - Pulmonology
  - Rheumatology
  - Urology
  - Vascular Surgery
  - Urgent Care

- Provide readily accessible lab and other diagnostic services.
- Ensure adequate practice coverage for contracted Providers when specific Providers are not available.
- Provide the following information for each IPA Provider participating in the Wellcare Provider Network:
  - Credentialing profile to include the following:
    - Complete Name
    - Primary Office Location(s)
    - Telephone Numbers
    - Office Hours
    - Specialty
    - Board Status (Board Name, Certification Specialty, Issue Date, Expiration Date)
    - Completed Malpractice History Questionnaire
    - California License Number
    - Hospital Staff Privileges (List Hospitals and Types of Privilege)

- IRS Number
- Proof of Professional Liability Coverage
- DEA Certificate
- NPI Number
- Languages Spoken
- New Patient Acceptance Status

Primary Care Services

PCPs are responsible for providing certain basic healthcare services to Wellcare Members. The PCP has primary responsibility for coordinating the Member's overall healthcare, which may include care planning during the Member's transition of care from one care setting to the next, as well as ensuring the appropriate use of pharmaceutical medications. All Wellcare Members must choose a PCP or clinic at the time of enrollment, or one will be chosen for them.

Provider Data Maintenance

IPA shall maintain and provide current information to Wellcare on all physician Providers. IPA shall notify Wellcare of all changes to IPA's physician network in writing via email to **ECProviderServices@Wellcare.com**. A current revised copy of the Provider's W-9 form must be submitted with all Provider additions, demographic changes or changes to a Provider's Tax ID number.

Provider change request will be processed within 30 days from receiving the request in the mail box.

IPA will allow Wellcare to use Provider performance data for quality improvement activities.

PCP Terminations and Address Updates

IPA shall notify Wellcare, in writing, of all PCP terminations and address updates in accordance with the terms of the Wellcare Provider Agreement. Wellcare will process terminations to be effective on the last day of the month.

If a notice of a PCP termination is received, the membership will be retained within the original IPA unless the PCP's termination notice is accompanied with their termination letter to/from the originating IPA. Upon receipt of a written termination notice from the PCP with a request to transfer his or her membership from one IPA to another, the membership will follow the PCP to the designated IPA.

IPA Specialists and Ancillary Provider Updates/Terminations

IPA shall notify Wellcare, in writing, of all Specialist and Ancillary Provider terminations and address updates in accordance with the terms of the Wellcare Provider Agreement. Wellcare will process terminations to be effective on the last day of the month.

Notification to Wellcare and Members of Contract Termination

Wellcare must notify members at least 45 days prior to the termination date for contract terminations that involve a primary care physician (PCP) or a behavioral health provider. **For PCP terminations,** IPAs must provide Wellcare with the name of the new PCP as well as **two alternative PCPs**.

Wellcare must:

- Identify all members who are currently a patient of that PCP or behavioral health provider or who were a patient of that PCP or behavioral health provider within the past three years;
- Provide written notice to the identified members that includes the newly assigned PCP and two alternative PCPs; and
- Make at least one attempt at telephonic notice to the identified members (unless the member has opted out of calls regarding Plan business).

Wellcare must provide written notice to members at least 30 days prior to the termination date for all other contracted providers and facilities.

IPA notification of members for specialist terminations: For Medicare HMO plans, capitated and shared-risk IPAs must notify members in writing at least 30 days in advance of a specialist, behavioral health specialist or ancillary provider termination effective date, and the template sent to members must be approved by CMS. The Plan's CMS-approved Medicare termination notification template (PDF) must be completed by the IPA and mailed to the member.

Provider Directory Accuracy

Provider Directory Guidelines

To ensure directories accurately reflect Providers who are available to provide adequate access to Covered Services, Provider participation must adhere to the following guidelines:

- Directories may only list Providers who enrollees can go to for appointments

- Providers may only be listed in the directory when accepting appointments for enrollees
- Providers with multiple addresses should only reflect locations where the Provider is regularly available to see enrollees
- Ensure that Providers with more than one specialty or those that are designated as both a PCP and Specialist reflect the correct specialty and designation type for which the Provider is practicing and submit updates when a Provider's status changes
- Non-physician Providers (nurse practitioners, physician assistants) listed in the directory must be accurately notated as such

Each year the delegated entity is responsible for submitting a comprehensive list of:

- Contracted Urgent Care Facilities
- Available Extended Hours
- Contracted Labs/Radiology Facilities
- Ancillary Services
- Behavioral Health (BH) Providers
    - Comprehensive list of BH Providers to include psychology, psychiatrists, therapists, clinical social workers, and/or sub-delegated Managed BH Organizations (MBHO)

Providers with Full Risk or Global Risk arrangements are required to submit a full roster of the contracted network to Wellcare annually by 1/15 to **ECProviderservices@wellcare.com**.

Capitation Payment

Payment

If IPA receives capitation payments under its Wellcare Provider Agreement, such payments shall be made in accordance with the terms of that contract. If that contract is silent on the date that Wellcare will issue the payment, Wellcare will make the capitation payment to IPA by the 15th business day of each month. The Capitation Payment will include both current Member-eligible and retroactive Member-eligible capitation.

Report

If the Wellcare Provider Agreement includes a Capitation Report, such Capitation Report will be available to the IPA using an FTP Site. The report will be uploaded by the 15th day

of each month. If the 15th falls on a non-business day, the Capitation Report will be available on the next business day.

A file layout of the report can be found under Section 15: Attachments.

It is the responsibility of the IPA to forward a copy of the report to its PCPs and other contracted Providers. To ask for access to our FTP Site, please refer to Connectivity and Communication under Section 15: Attachments of this Provider Manual or contact the Wellcare Network Management Department at **714-226-2800.**

Non-Standard Deductions/Payments

Details for any non-standard deductions or payments included in the IPA's capitation will be provided in the form of a supplemental report that will also be made available on the FTP site.

Risk Pool Reporting

Wellcare may establish annual risk pool arrangements to provide an incentive for the efficient and effective utilization management of certain Covered Services. Risk pools shall be calculated, reconciled, reported and settled in accordance with established contractual terms included in the applicable IPA Provider Agreement and corporate policies and procedures.

If the Wellcare Provider Agreement provides for risk pool reporting, all questions or concerns pertaining to the information provided in the risk pool reports may be discussed with the Wellcare Network Management Department at **1-714-226-2800.**

Notwithstanding the above, all Risk Pool Surplus payouts are final in nature and shall only be re-opened at Wellcare's discretion for such purposes as deemed necessary by Wellcare, including but not limited to instances of Fraud, Waste, and Abuse.

Advance Directives

At the time of initial enrollment, Wellcare will inform Members of their rights to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. (Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Section 160.2).

A Provider office shall have available written information regarding the Member's right to establish an advance directive, pursuant to the Patients Self-Determination Act

(PSDA). Members shall be asked whether they are aware of the PSDA and their right to execute an advance directive. If the Member is unaware of the PSDA and their right, the Provider shall give the Member an informational pamphlet and inform the Member of where he/she may obtain further information.

Providers are required to document advance directive education in the Member's medical record. If an advance directive is executed, a copy must be filed in the Member's chart.

Advance care planning is part of the Care for Older Adults Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measurement which is reviewed annually by CMS. In order to be compliant with this measure, a Member's medical record must contain a copy of an advance directive or documentation, including dates, showing that discussions with the Member regarding advance directives have taken place on an annual basis.

Disabled Member Services

The Americans with Disabilities Act (ADA) requires public accommodations, including the professional office of a healthcare Provider, to provide goods and services to people with disabilities on an equal basis as people without disabilities. If a Provider cannot accommodate a disabled patient, the IPA should arrange for the patient to be seen by a Provider who can accommodate the Member. For any inquiries or assistance, please contact Wellcare Customer Service at **866-999-3945**.

On-Call Coverage (24 Hours/Day, 7 Days/Week)

IPAs are responsible for arranging for Provider on-call coverage.

Individual Providers arranging for on-call coverage should contact contracted IPAs with any questions relative to on-call services.

Emergency Room Utilization

Emergency Medical Conditions are defined as the sudden, unexpected onset of a medical condition or injury manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention may result in:

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

- Placing the health of the Member (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services mean the covered inpatient and outpatient services that are (i) provided by a Provider qualified to furnish emergency services, and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

The IPA shall take into consideration the presenting and discharge diagnosis when reviewing Emergency Service claims for a potential retrospective denial. Retrospective denial of services for what appears to the "prudent layperson" to be an emergency is prohibited.

Confidentiality and Disclosure of Medical Information

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires all physicians and healthcare professionals to make reasonable efforts to limit disclosure of Protected Health Information (PHI), or individually identifiable health information that is transmitted or maintained, in any form or medium. The HIPAA Privacy Rule has established that written Member authorization is required for any use or disclosure of PHI that is not related to treatment, payment or healthcare operations. The person or entity that is seeking to obtain medical information must obtain authorization from the Member and is to use that information only for the purpose it was requested and retained only for the duration needed.

Release of Confidential Information to the Patient

Information may be released to a Member who is the subject of the information without a written request.

Release of Confidential Information to Personal Representatives

- A person authorized (under state or other applicable law, e.g., tribal or military law) to act on behalf of the Member in making healthcare related decisions is the individual's "personal representative."
- Personal Representatives are appointed for Members who are legally or otherwise incapable of exercising their rights, or simply choose to designate

another to act on their behalf (this also includes minors that lack the statutory ability to consent to treatment).

- Covered entities shall treat a Member's personal representative as the Member with respect to uses and disclosures of the Member's PHI, as well as the Member's rights under the Privacy Rule.
- Members with intellectual disability and/or who lack capacity have the control over dissemination of their PHI to the extent that state law provides such Members with the ability to act on their own behalf.
- A covered entity can choose not to disclose information pursuant to a consent or authorization, in cases where state law has determined that a Member has intellectual disability who lacks capacity and is not competent to act, but however expresses his or her desire that such information not be disclosed.

45 CFR 164 §164.502(g)

Note: Covered entities must verify the authority of a personal representative, in accordance with applicable state law by, acceptable documentation (Healthcare Power of Attorney; General Power of Attorney; Dual Power of Attorney or Letters of Conservatorship).

Release of Confidential Information to Employers

- A covered entity must obtain the Member's written authorization for any use or disclosure of PHI that is not for treatment, payment or healthcare operations.
- An authorization must be written in specific terms. It may allow use and disclosure of PHI by the covered entity seeking the authorization, or by a third party.
- Uses or disclosure of information that is inconsistent with the statements in the authorization constitute a violation of the Privacy Rule.

45 CFR 164 §164.508(a)

Release of Confidential Information to Providers

Provider requests may be honored if the request pertains to that Provider's services.

All other requests require the Member's or Member representative's signed release.

Electronic, facsimile, or written clinical information sent must be secured with limited access to those persons who are facilitating appropriate patient care and reimbursement for such care.

Release of Confidential Information – Outpatient Psychotherapy Records

A written request must be received from the person or entity requesting Member outpatient psychotherapy records. The only situation where a written request is not required is when the Member has signed a waiver or form waiving notification to the patient and treating Provider. The request must be sent to the patient within 30 days of the receipt of the records except when the patient has signed a written letter or form waiving notification.

Guidelines for the Written Request

The Written Request must be signed by the requestor identifying the following:

- What information is requested
- Purpose of the request
- Length of time the information will be kept

The timeframe may be extended provided that the person or entity notifies the practitioner of the extension. Any notification of the extension must include the following:

- Specific reason for extension
- Intended use of the information during the extended time
- Expected date of destruction of the information

The Written Request must specifically include the following:

- A statement that the information will not be used for any purpose other than its intended use
- A statement that the person or entity requesting the information will destroy the information when it is no longer needed
- Specifics on how the information will be destroyed, or specify that the person or entity will return the information and all copies of it before or immediately after the length of time indicated in the request
- Specific criteria and process for confidentially faxing and copying outpatient psychotherapy records

Release of Confidential Information – Pursuant to a Subpoena

Member information is to be released in compliance with a subpoena duces tecum by an authorized designee in Administration.

- The subpoena must be accepted, dated and timed.
- The subpoena must allow at least 20 days from the date of the subpoena to allow a reasonable time for the Member to object to the subpoena and/or preparation and travel to the designated, stated location.
- All subpoenas must be accompanied by either a written authorization for the release of medical records or a "proof of service" demonstrating the Member has been "served" with a copy of the subpoena.
- Alcohol or substance abuse records are protected by both federal and state law (42 USC Section 290dd-2;42C, CR 2.1 et.seq,; and Health and Safety Code Sections 1182 and 11977), and may not be released unless there is also a court order for release that complies with the specific requirements.
- Only the requested information is to be submitted, (HIV and AIDS information is excluded). HIV and AIDS or AIDS related information require a specific subpoena (Health & Safety Code Section 120980).
- If a notice contesting the subpoena is received before the required date, records will not be released without a court order requiring so.
- If no notice is received, records may be released at the end of the 20-day period.
- Records should be sent through the U.S. Postal Service by registered receipt or certified mail.

Medical Record Standards

Medical records should reflect:

- All services provided directly by a practitioner who provides primary care services.
- All ancillary services and diagnostic tests ordered by a practitioner.
- All diagnostic and therapeutic services for which a Member was referred by a practitioner, such as:
    - Home health nursing reports
    - Specialty physician reports
    - Hospital discharge reports
    - Physical therapy reports
- Each medical record must include:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical finding and evaluation of each visit
- Preventive services/high-risk screening

Confidentiality and Availability of Medical Records

All medical records are required to be organized and stored in a manner that allows easy retrieval. Medical records should be kept in a secure location that allows access by authorized personnel only. Providers and employees are required to receive periodic training in Member information confidentiality and must sign confidentiality statements. Providers must also have policies and procedures in place to protect and ensure confidentiality of Member information at all times. In addition, Providers must have a written policy regarding the release of medical records. Wellcare reserves the right to review medical records. Providers must produce medical records to Wellcare within 30 days of request for treatment, payment and healthcare operations.

Retention of Medical Records

Medical records and patient related data are to be retained in a locked storage area according to the following time periods:

Data	Retention Period
Adult Patient Charts	10 years from the CMS Contract Period or the date of completion of any audit, whichever is later
Minor Patient Charts	(< 18 years of age) 1 year after the 18th birthday but not less than 10 years
X-rays	10 years from the CMS Contract Period or the date of completion of any audit, whichever is later
Sign-in Sheets	10 years from the CMS Contract Period or the date of completion of any audit, whichever is later

Section 7: Claims & Encounter Data Submission

Note: Claims payment is determined according to the Division of Financial Responsibility (DOFR) in the Provider participation agreement between Wellcare and the IPA or Hospital, when applicable.

If you are a Provider currently contracted with Wellcare through a contracted and delegated IPA, please submit all claims to your contracted IPA.

For all other Wellcare contracted Providers, please see Wellcare's Medicare Advantage Provider Manual for Fee For Service Providers.

Misdirected Claims

If an IPA or Hospital receives a claim that is the financial responsibility of Wellcare, the claim should be denied as a misdirected claim and forwarded to Wellcare within 10 calendar days from receipt of the claim. Each IPA or Hospital is responsible for maintaining a log of all misdirected claims that were forwarded to Wellcare. The log is to be used as a record of claims that were sent to Wellcare for future audit purposes and does not need to be submitted until requested.

At minimum, the misdirected claims log must display the following: line of business, Member name, Member ID number, Provider name, received date, date of service, billed amount and date forwarded.

If Wellcare receives a claim that is the financial responsibility of a contracted IPA or Hospital, the claim will be denied as a misdirected claim and forwarded to the appropriate payer within 10 calendar days from receipt of the claim.

Wellcare Report Reminders:

- Scorecards
    - Send via Wellcare FTP in folder "Delegation Reports"
        - Send the Multifunctional Scorecard by the 10th day each month
        - Send the Credentialing Scorecard by the 10th day of the 2nd month following the end of each quarter
- ODAGs
    - Send Quarterly via the Wellcare FTP in folder "Delegation Reports"

        - Send the UM ODAG Universe by the 10th day of the month after each quarter
        - Send the Claims ODAG Universe by the 10th day of the month after each quarter
- Part C – ODR Reporting
    - Send ODR-Detail and ODR-Reopen UM and Claims reports Quarterly via Wellcare FTP in folder “Part C Preservice”, “Part C Claims”, or “Part C Reports”
        - Send the UM ODR reports by the 10th day of the month after each quarter
        - Send the Claims ODR reports by the 10th day of the month after each quarter

Monthly Timeliness Reports

Monthly Timeliness Reports (MTR) should be submitted to Wellcare by no later than the 10th of each month. These reports will be accepted via email and should be sent via FTP in folder “Delegation Reports”.

Quarterly Reports

CMS Provider Dispute Request Quarterly Report and Medicare Advantage Part C Reporting Payment (claims) Organization Determinations/Considerations Report should be submitted to Wellcare by no later than the following:

Medicare Advantage Part C Reporting Payment (Claims) Organization Determinations/Considerations Report submit via FTP in folder “Part C Claims”:

1st Quarter	10 th of April
2nd Quarter	10 th of July
3rd Quarter	10 th of October
4th Quarter	10 th of January

CMS PDR Quarterly Reporting submit via FTP in folder “Delegation Reports”:

1st Quarter	10 th of May
2nd Quarter	10 th of August
3rd Quarter	10th of November
4th Quarter	10th of February

Coordination of Benefits

Occasionally, an Wellcare Member may have secondary healthcare insurance. For those Members who are over 65 years of age and retired, Wellcare will generally be the primary payer. However, a Provider should always verify eligibility and ask the Member whether he or she has healthcare insurance other than with Wellcare.

When Wellcare is the Primary Payer

When Wellcare is the primary payer, the IPA may bill the secondary carrier for usual and customary fees and receive compensation in addition to that received from Wellcare.

Under no circumstances may a Member be billed for any balance due amount.

When Wellcare is the Secondary Payer

Wellcare will be the secondary payer in the following situations:

- The Member is age 65 or older and has coverage under an employer group health plan through an employer with 20 or more employees, either through the Member's own employment or the enrollee's spouse's employment.
- The Member is under age 65 and is entitled to Medicare due to disability other than ESRD, and the Member has coverage under a large employer (100 or more employees) group health plan, either through the enrollee's own employment or the enrollee's spouse's employment.
- The Member is being treated for an accident or illness that is work-related or otherwise covered under Workers' Compensation.

- The Member has ESRD and an employer group health plan. Wellcare will be secondary for up to 30 months; Medicare will be the primary payer after 30 months.
- The Member is being treated for an injury, ailment, or disease caused by a third party, and automobile or other liability insurance is available.
- The Member has elected Hospice while enrolled with Wellcare. During the hospice election period Original Medicare is financially responsible for part A and B that are related or unrelated to the terminal illness.

Questions regarding Coordination of Benefits can be directed to the Wellcare Customer Services Department at **866-999-3945**.

Definitions

Capitalized terms in this manual that are not defined herein, shall have the meaning set forth in the IPA's Provider Agreement with Wellcare. Additionally, the following terms as used in this Manual shall be construed and interpreted as follows, unless otherwise defined in the Agreement.

Contracted Provider Appeals

A **written** notice to Wellcare, submitted to the designated Provider Appeal address, challenging, appealing or requesting reconsideration of a denied claim, such as no prior authorization, exceeds benefit, or not a covered benefit. To request an appeal, send **written** notice to Wellcare, submitted to the designated Provider Appeal address, disputing administrative policies and procedures, administrative terminations, retroactive contracting, or any other contract issue. Please refer to specific language in your contract.

Claims Payment Disputes

- **Provider Dispute Request (PDR) –** A **telephone** or **written** dispute between non-contracted and Private Fee-for-Service Plans to include disputes between non-contracted Providers and all: Medicare Advantage Organizations (HMO, PPO, RPPO, and PFFS), 1876 Cost Plans, Medi-Medi Plans and Program of All-Inclusive Care for the Elderly (PACE) organizations. Includes decisions where a non-contracted Provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare or instances where there is a disagreement between a non-contracted Provider and the payer about the plan's decision to make payment on a more appropriate code (downcoding).
- **Provider Inquiry –** A **telephone** or **written** request for information, or question, regarding claim status, submission of corrected claims, Member eligibility, payment methodology rules (bundling/unbundling logic, multiple surgery rules), Medical Policy, coordination of benefits, or third-party liability/workers' compensation issues submitted by a Provider to Wellcare, or a **telephone** discussion or **written** statement questioning the way Wellcare processed a claim

(i.e., wrong units of service, wrong date of service, clarification of payment calculation).

This section applies to Provider issues concerning the Provider's dissatisfaction with denial of payment, where a denial has been issued for reasons such as: no prior authorization, benefits exhausted, service exceeds authorization, days billed exceed authorization, nursery days exceed mother's stay, payment error/not authorized, authorization denied, authorization expired, requires authorization or lack of medical information.

A Provider may appeal a claim or utilization review denial on his or her own behalf by mailing or faxing Wellcare a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are located on Wellcare's website at **www.wellcare.com/California/Providers/Medicare/Forms**.

Providers have 90 calendar days from Wellcare's original utilization management review decision or claim denial to file a Provider appeal. Appeals after that time will be denied for untimely filing. If the Provider feels that the appeal was filed within the appropriate timeframe, the Provider may submit documentation showing proof of timely filing. Examples of acceptable proof include registered postal receipt signed by a representative of Wellcare, or a similar receipt from other commercial delivery services or fax submission confirmation.

Upon receipt of all required documentation, Wellcare has up to 60 calendar days to review the appeal for Medical Necessity and/or conformity to Wellcare guidelines and to render a decision to reverse or affirm. Required documentation includes the Member's name and/or identification number, date of services and reason why the Provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the Provider is requesting a Medical Necessity review, medical records should be submitted. If the Provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the Provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

To Submit a Contracted Provider Appeals & Claims Payment Disputes

Must contain:

- The Provider's name
- The Provider's identification number – the Wellcare Provider identification number (PIN) and/or the Provider's tax or Social Security number
- Contact information – mailing address and phone number
- Wellcare's Internal Control Number (ICN), when applicable
- The patient's name, when applicable
- The patient's Wellcare subscriber number, when applicable
- The date of service, when applicable
- A clear explanation of issue the Provider believes to be incorrect, including supporting medical records when applicable
- Completed claim form based on the Claims Submission Guidelines stated above

Appeals must be submitted to the following address for both Contracted and Non Contracted Provider Appeals:

Contracted Provider Appeals:

Wellcare Health Plans
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631

Submission of appeals for contracted Providers must be filed within the timeframe stated on the contract.

Note: Appeals must be submitted with substantiating information like a summary of the appeal, relevant medical records and Member-specific information. If the Provider is non-contracted, a waiver of liability must also be executed before an appeal review.

Claims Inquiries or Disputes must be submitted to the following address:

Claims Department
P.O. Box 31370
Tampa, FL 33631-3370

Claims Disputes related to Coding Edits must be submitted to the following address:

Payment Policy
Dispute Department

P.O. Box 31426
Tampa, FL 33631-3426

Submission of a Contracted Provider Dispute must be filed based on the timeframe outlined in your agreement.

Readmission Appeal/Dispute must be submitted in writing to the following address:

Attn: Wellcare Clinical Chart Validation
COTIVITI
555 E. North Lane, Suite 6120
Conshohocken, PA 19428
Phone: **203-202-6107**
Fax: **203-202-6607**

Refund checks are to be sent to:

Refund Checks:
Wellcare Health Plans
Attn: CCU Recovery
P.O. Box 31584
Tampa, FL 33631-3584

It is important to send a copy of the letter so the refund is correctly applied to your account.

Correspondence Mailing Address Regarding Offset Amounts:
Wellcare Health Plans
Attn: CCU Recovery
P.O. Box 31658
Tampa, FL 33631-3658

Wellcare will respond within 30 working days of your Claims Provider Dispute.

NOTE: THE CMS PROVIDER DISPUTE MUST BE RESOLVED WITHIN 30 CALENDAR DAYS FROM RECEIPT.

Claims processing errors should be brought to the attention of the Claims Department as soon as possible so they may be corrected. These types of errors may be addressed by calling **866-999-3945**.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial

If it is determined during the review that the Provider has complied with Wellcare protocols and that the appealed services were Medically Necessary, the initial denial will be reversed. The Provider will be notified of this decision in writing.

The Provider may file a claim for payment related to the appeal, if one has not already been submitted. After the decision to reverse the denial has been made, any claims previously denied as a result of the now-reversed denial will be adjusted for payment.

Affirmation of Initial Denial

If it is determined during the review that the Provider did not comply with Wellcare protocols and/or Medical Necessity was not established, the initial denial will be upheld. The Provider will be notified of this decision in writing.

For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Member Reconsideration Process

Overview

A Member reconsideration, also known as an appeal, is a formal request from a Member for a review of an action taken by Wellcare. With the Member's written consent, a reconsideration may also be filed on the Member's behalf by an authorized representative, or by a physician who has or is currently treating the Member. All appeal rights described in this Manual that apply to Members will also apply to the Member's authorized representative or a Provider acting on behalf of the Member with the Member's consent when appropriate.

To request an appeal of a decision made by Wellcare, a Member may file a reconsideration request orally or in writing within 60 days from the date of the Notice of Action.

Examples of actions that can be appealed include but are not limited to:

- Denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by CMS

Wellcare gives Members reasonable assistance in completing forms and other procedural steps for a reconsideration, including providing interpreter services and toll-free telephone numbers with TTY and interpreter capability.

Wellcare will assign decision-makers who were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of Medical Necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or will seek advice from professionals with expertise in the field of medicine related to the request.

Wellcare will not retaliate against any Provider acting on behalf of or in support of a Member requesting a reconsideration or an expedited reconsideration.

Appointment of Representative

If the Member wishes to use a representative, he or she must complete a *Medicare Appointment of Representative* (AOR) form. The Member and the person who represents the Member must sign and submit the AOR form to the Plan. The form is on at **www.wellcare.com/California/Providers/Medicare/Forms.**

Types of Appeals

A Member may request a standard pre-service, retrospective or expedited appeal.

Standard pre-service appeals are requests for coverage of services that Wellcare has determined are not Covered Services, are not Medically Necessary or are otherwise outside of the Member's Benefit Plan. A pre-service appeal must be filed before the Member has received the service.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the Member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review.

Only pre-service appeals are eligible to be processed as expedited appeals.

Appeal Decision Timeframes

Wellcare will issue a decision to the Member or the Member's representative within the following timeframes:

- Standard Pre-Service Request: **30 calendar days (7 calendar days for Pharmacy Appeals)**
- Retrospective Request: **60 calendar days (7 calendar days for Pharmacy Appeals)**
- Expedited Request: **72 hours**

Standard Pre-Service and Retrospective Reconsiderations

A Member may file a reconsideration request either verbally or in writing within 60 calendar days of the date of the adverse determination by contacting the Customer Service Department.

A Member may also present his or her appeal in person (as used here, "in person" also includes appeals conducted via telephone). To do so, the Member must call Wellcare Customer Service to advise that the Member would like to present the reconsideration in person. If the Member would like to present her or his appeal in person, Wellcare will arrange a time and date that works best for the Member and Wellcare. A Member of the management team and a Wellcare Medical Director will participate in the in-person appeal.

After the Member presents the information, Wellcare will mail the decision to the Member within the timeframe specified above, based on the type of appeal.

If the Member's request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for Wellcare to accept the late request. Examples of good cause include:

- The Member did not personally receive the adverse organization determination notice or received it late.
- The Member was seriously ill, which prevented a timely appeal.
- There was a death or serious illness in the Member's immediate family.
- An accident caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- The Member had incorrect or incomplete information concerning the reconsideration process.

Expedited Reconsiderations

To ask for an expedited reconsideration, a Member or a Provider (regardless of whether the provider participates in Wellcare's network) must submit a verbal or written request directly to Wellcare. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member's life, health or ability to regain maximum function, including cases in which Wellcare makes a less than fully favorable decision to the Member.

A request for payment of a service already provided to a Member is not eligible to be reviewed as an expedited reconsideration.

If a reconsideration is expedited, Wellcare will complete the expedited reconsideration and give the Member (and the provider involved, as appropriate) notice of the decision as expeditiously as the Member's health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If Wellcare denies the request to expedite a reconsideration, Wellcare will provide the Member with verbal notification within 24 hours. Within three calendar days of the verbal notification, Wellcare will mail a letter to the Member explaining:

- That Wellcare will automatically process the request using the 30-calendar-day timeframe for standard reconsiderations;

- The Member's right to file an expedited grievance if he or she disagrees with Wellcare's decision not to expedite the reconsideration, and providing instructions about the expedited grievance process and its timeframes; and
- The Member's right to resubmit a request for an expedited reconsideration, and that if the Member gets any provider's support indicating that applying the standard timeframe for making a determination could seriously jeopardize the Member's life, health or ability to regain maximum function, the request will be expedited automatically.

Member Reconsideration Decisions

Reconsideration Levels

There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by Wellcare
2. Reconsideration of adverse organization determination by the independent review entity (IRE)
3. Hearing by an administrative law judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met
4. Medicare appeals council (MAC) review
5. Judicial review, if the appropriate threshold requirements have been met

Please note that these reconsideration levels do not apply to Participating Provider Retrospective Claims Disputes.

Standard Pre-Service or Retrospective Reconsideration Decisions

If Wellcare reverses its initial decision, Wellcare will either issue an authorization for the pre-service request or send payment if the service has already been provided.

If Wellcare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals), in whole or in part, it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. For standard appeals, the IRE has 30 days from receipt of the standard pre-service appeal to issue a

final determination. The IRE has 60 days from receipt of the retrospective appeal to issue a final determination.

Once a final determination has been made, the IRE will notify the Member and Wellcare. If the IRE agrees with Wellcare, the IRE will provide the Member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the Member or representative in writing of the decision. Wellcare will also notify the Member or Member's representative in writing that the services are approved, along with an authorization number, or that the claim has been paid.

Expedited Reconsideration Decisions

If Wellcare reverses its initial action and/or the denial, it will notify the Member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If Wellcare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination.
- Notify the Member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the Member and Wellcare. If the IRE agrees with Wellcare, the IRE will provide the Member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the Member or representative in writing of the decision.

Encounter Data Submission Guidelines

Encounter data and professional claims data for Wellcare Members are required. This information is needed by Wellcare to comply with regulatory requirements, various reporting requirements and for Utilization Management oversight. Also, reimbursement to Medicare Advantage plans by CMS is based on health status, or Hierarchical Condition Category (HCC), of each Member, which is driven by the diagnoses codes

submitted on claims and encounter data received by Wellcare from IPAs, facilities and other healthcare professionals.

At minimum, capitated IPAs, or other submitting entities, must submit encounter data to Wellcare by the 15th of the month for the previous month (preferred on a weekly basis), based on the processed or finalized date of claim(s), for all Wellcare Members, or such other timeframe required in the IPA's Provider Agreement. All encounter data submissions are monitored for quality as well as quantity. Wellcare has established a threshold of 100% for encounter data submissions. If submissions fall below this level, capitated IPAs, or other submitting entities will be non-compliant, which may result in corrective action plans, penalties and other remedies set forth in the Wellcare Provider Agreement.

All encounter data must be accurate, complete and truthful based upon the Provider's best knowledge, information and belief. Because CMS may audit the data Wellcare submits at any time, it is important that encounter data be reflective of the original CMS1500 or UB04 submitted by the Provider of service.

For encounters/claims data to be included and used in the calculation of CMS reimbursement to Wellcare for each Member, they must pass through audits that CMS applies. Any data that does not successfully pass the CMS audits will be returned to Wellcare. Given that only the Provider can make changes to or submit new claims data, Wellcare will request correct or missing information from capitated IPAs or other submitting entities to resubmit the data to CMS and such information shall be corrected and resubmitted to Wellcare within 30 days.

Wellcare requires that encounters/claims data is submitted on a CMS 1500 or UB04 Form for all capitated services, including in the HIPAA mandated version EDI format ANSI 837P for Professional and 837I for Institutional. Please refer to the Connectivity and Communication under Section 15: Attachments for more information regarding File Transfer Protocol (FTP) transmissions. For any questions pertaining to EDI or to obtain a companion guide, please contact: **ec_edi@wellcare.com.**

Should encounter data need to be submitted on paper form, it should include the following:

- Member Name
- Wellcare Member ID
- Date of Birth

- Gender
- Date of Service
- Diagnosis Codes (ICD-9 Code(s) – ICD-10 Codes)
- Admitting Diagnosis Code, if applicable (Inpatient)
- CPT Code(s)
- Modifier(s), if applicable
- Revenue Code(s)
- IPA Name
- Billing Provider Name/NPI
- Attending Provider Name/NPI, if applicable

Please send hard copy or paper encounter data to:

Wellcare Health Plan
Attn.: Encounter Data
P.O. Box 260519
Plano, TX 75026-0519

Wellcare shall have the right to perform routine medical record chart audits on an IPA's participating Providers to determine accuracy and completeness of encounter data coding.

Wellcare may invoke a penalty if the IPA, or other submitting entity, fails to submit or meet the encounter data element requirements pursuant to terms of its participation agreement with Wellcare.

Section 8: Pharmacy Services

Benefit Management Company – Express Scripts®

The Pharmacy Benefit Manager (PBM) is **Express Scripts**.

Click or tap here to enter text.

Pharmacy Help Desk Phone: **833-750-0408**
Website: **Express-Scripts.com/rx**

Pharmacy Network

Participating pharmacies are part of the Wellcare Pharmacy Network. A list of participating pharmacies is in the Wellcare Provider Directory or online at **www.wellcare.com/California**. If a Member obtains a prescription from a non-participating pharmacy, any charges incurred will not be eligible for reimbursement, except if the prescription was not available at a participating pharmacy site (i.e., after hours, out of area, urgent/emergent prescriptions).

In addition to having the ability to fill a prescription at one of the many Wellcare participating pharmacy locations/sites, Members also may use a prescription mail order service.

Mail Order Pharmacy Provider (Home Delivery)

Express Scripts Pharmacy will offer Pharmacy Mail Order Services or Home Delivery to members. Members have a $0 copay for select medications for a 90-day supply of Tier 1 and Tier 2 drugs if filled at Express Scripts Pharmacy. For Tier 3 and Tier 4 drugs, members will pay only two full months copay for a 90-day supply at Express Scripts Pharmacy (i.e., one month free).

The prescribing physician can send requests for new prescriptions via fax to Express Scripts Pharmacy at 800-837-0959 or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx. The mail order form can be found at express-scripts.com/rx.

Specialty Pharmacy Provider

AcariaHealth™ (a division of Centene Pharmacy Services)
AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician's offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday–Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. (ET).

AcariaHealth Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: **866-458-9246** (TTY **855-516-5636**)
Fax: **866-458-9245**
Website: **www.acariahealth.com**

Formulary

The Wellcare formulary contains information regarding pharmaceutical management procedures including:

- A list of covered pharmaceuticals, including restrictions and preferences, and copayment information, if applicable.
- How to use the pharmaceutical management procedures, including the prior authorization process and an explanation of limits or quotas on refills, doses & prescriptions.
- How to submit an exception request.
- The process for generic substitution, therapeutic interchange and step-therapy protocols

Wellcare's formulary is a list of generic and brand name drugs reviewed and approved by our PBM's Pharmacy and Therapeutics Committee and CMS to be covered as a pharmacy plan benefit. The formulary is updated monthly throughout the year. Please check the Wellcare website on a regular basis to obtain current formulary information at **www.wellcare.com/California/Providers/Medicare/Pharmacy**. Practitioners may call

866-999-3945 to receive a copy of the pharmaceutical management procedures and updates by mail, fax or email.

Formulary Exceptions Process

For any Members participating in a treatment plan that requires a medication that was on the formulary at the beginning of the year, but was later removed, or Members requesting coverage of a non-formulary medication, please call Wellcare's Coverage Determination line at **866-999-3945** to ask for information about the exceptions process, or fax the *Medicare Prescription Drug Coverage Determination Form* at **877-277-1809**. You may also download the *Medicare Prescription Drug Coverage Determination Form* at **www.wellcare.com/California/Providers/Medicare/Forms**. The exceptions process lets Providers submit a request for consideration for a Member to continue on a specific medication for the remainder of the benefit year or to have a non-formulary medication covered by Wellcare.

Requests for Formulary Changes

To request consideration for inclusion of a drug to Wellcare's formulary, Providers may write Wellcare, explaining the medical justification. For contact information, refer to the Quick Reference Guide on Wellcare's website at **www.wellcare.com/California/Providers/Medicare**.

For more information on requesting exceptions, refer to the Coverage Determination Request Process subsection below.

Coverage Determination Request Process

The goal of Wellcare's Coverage Determination Request program is to promote the appropriate use of medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices, in accordance with FDA-approved indications.

The Coverage Determination Request process is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary as requiring a prior authorization
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits, or prescriptions exceeding the permitted QL noted on the formulary

- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office
- Drugs that have a step edit and the first-line therapy is inappropriate.

Obtaining a Coverage Determination Request

Complete a Coverage Determination Request Form online, or call, fax or mail the form to the Pharmacy Department. The form is located at **www.wellcare.com/California/Providers/Medicare/Pharmacy/Coverage-Determination-Request**.

For the appropriate fax number, refer to the Quick Reference Guide at **www.wellcare.com/California/Providers/Medicare**.

Notification of FDA Recalls

Wellcare will notify Providers and any affected Members of FDA recalls. For any questions or additional information, please contact the Wellcare Customer Services Department at **866-999-3945**.

It is the policy of Wellcare for its Pharmacy Department to notify Members who have received a medication affected by a Class 1 and/or a Class 2 retail level recall as well as its authorized prescribers. Wellcare's Pharmacy Department shall also notify affected Members and authorized prescribers of market withdrawals.

- Formulary Services shall receive an alert from one of the following regarding a drug recall or planned market withdrawal:
    - The FDA via email (**fda@service.govdelivery.com**)
    - Facts and Comparisons news items (**online.factsandcomparisons.com**)
    - Pharmaceutical company communications to healthcare professionals
- Formulary Services shall review the alert to determine if the recall is relevant to Wellcare's membership. Wholesale-only drug recalls and withdrawals do not require notification of Providers or Members.
- Formulary Services shall identify and notify Members who have received the recalled or withdrawn medication in the 90 days prior to the date the notifications were discovered.

- Formulary Services shall notify authorized prescribers of product recalls and market withdrawals, which include voluntary withdrawals by the manufacturer and those under an FDA requirement.
- For Class 1 Recalls, Members and authorized prescribers shall be notified within 10 calendar days of the date which Wellcare discovers the recall.
- For Class 2 Recalls, Members and authorized prescribers shall be notified within 30 calendar days of the date which Wellcare discovers the recall when affected Members can be identified from batch and lot numbers.
- For Market Withdrawals, Members and authorized prescribers shall be notified within 30 calendar days of the FDA alert when affected Members can be identified from batch and lot numbers.

Medication Therapy Management Program (MTMP)

The Medication Therapy Management (MTM) program (MTM Program) is required by the Centers for Medicaid & Medicare Services (CMS) for all Part D Prescription Drug Plans (PDP) and Medicare Advantage Plans (MA). The program is not considered a benefit, but rather a free service offered to those who are eligible and qualify for the program. There is no change to a Member's insurance benefits, copays, prescription coverage, or available doctors or pharmacies.

The MTM Program helps Members get the greatest health benefit from their medications by:

- Preventing or reducing drug-related risks
- Increasing Member awareness
- Supporting good habits

Please visit **https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM** for the MTM eligibility criteria. Note that the eligibility criteria are subject to change yearly as set forth by CMS.

Section 9: Utilization Management

Utilization Management Program

IPAs are delegated for all Utilization Management (UM) activities. The IPA must develop a UM program that includes:

- A written program description
- Annual Work Plan
- Evaluation of Prior Year Work Plan
- A senior physician who actively participates in the UM Committee, signature is reflective on UM policies and procedures and has extensive involvement in the execution of and oversight of the UM program
- A designated behavioral healthcare practitioner to provide key behavioral healthcare aspects of the UM program
- Adoption and/or development of UM decision-making criteria that are objective and based on medical evidence
- Annual review of interrater reliability to ensure consistent decision-making of physician reviewers and non-physician clinical reviewers
- Annual satisfaction assessment with UM processes
- Monitor and conduct at least annual audits of system controls of modified UM denial receipt and notification dates to protect data from unauthorized modification
- A mechanism to assist Members with transition to other care, if necessary, when benefits end

IPAs must have a policy and process for the availability of UM staff to Members and Providers at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues and provision for receipt of calls after normal business hours.

IPAs must have a policy and process that staff and Providers receive Annual Notification of non-incentive statement for UM decision-making. UM Policy also provides decisions timely to accommodate clinical urgency of the situation, to minimize any disruption in provision of care, and consistent with decision timeliness requirement.

Access to Staff

Wellcare provides access to staff for Members and Providers seeking information about the UM process and the authorization of care.

Wellcare provides the following communication services for Members and Providers:

- Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- TTY services for Members who need them.
- Language assistance for Members to discuss UM issues

Referral Processing Responsibilities

Each IPA has its own policies and procedures relative to the authorization process. The IPA is delegated to authorize all types of services to including:

- Professional Services including referrals for Specialty Care
- Outpatient Diagnostic and Surgical Procedures
- Rehabilitation therapy including Acute Rehabilitation Unit (ARU)
- Inpatient Acute Care
- Long Term Acute Care (LTAC)
- Skilled Nursing Facility Admissions
- Home Health Services
- Durable Medical Equipment

Qualified licensed health professionals are required to supervise all Medical Necessity decisions.

For services in which Wellcare is responsible for payment to the IPA, the IPA is required to timely review the healthcare services requested from a Provider for authorization and respond to such request in accordance with the IPA's UM Program's policies and procedures that have been approved by Wellcare.

The Wellcare Contracting Department will distribute an Ancillary Roster to all IPAs on a quarterly basis.

Wellcare may authorize and/or provide a tracking number for the following types of services:

- Urgent or emergent out-of-area professional and facility services (refer to your IPA Division of Financial Responsibility for services in which Wellcare holds the responsibility)
- Power Operated Vehicles (POV) – IPA remains responsible for making the UM determination using Medicare coverage guidelines and evidence-based criteria
- Organ transplantation (the IPA remains responsible for all work-up services before listing)
- Investigational or experimental services

Non-Discrimination in the Delivery of Healthcare Services

Wellcare and its IPAs are to ensure Members are not discriminated against in the delivery of healthcare services consistent with benefits based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, or evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment as outlined in the Medicare Managed Care Manual Chapter 4, 10.6 Anti-Discrimination Requirements.

The following websites contain useful information about discrimination:

www.eeoc.gov/policy/adea.html
www.ada.gov

Affirmative Statement

All UM decision-making is to be based only on appropriateness of care and service and existence of coverage. Neither IPA nor Wellcare shall specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers shall not encourage decisions that result in underutilization. Practitioners are ensured independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion or any other similar matters.

Out-of-Network Services

IPAs must make every attempt to authorize services that are the financial responsibility of Wellcare to a Provider within Wellcare's contracted network. If a Member requires out-of-network services because Wellcare is not contracted with a Provider of like specialty, the IPA must notify Wellcare's Utilization Management Department before issuing an authorization. The Utilization Management Department will discuss the case with the Wellcare Contracting Department and notify the IPA accordingly whether an authorization may be issued.

For services that are the financial responsibility of the IPA, the IPA must follow its organization's policy in reference to authorization of out-of-network Providers.

Authorization Response and Decision Notification Timeframes

At a minimum, IPAs are required to adhere to the CMS Timeliness Standards.

- Standard Preservice Medical - notification within 14 days of receipt.
- Standard Preservice Part B Drug – notification within 72 hours of receipt.
- Expedited Preservice Medical – notification within 72 hours of receipt.
- Expedited Preservice Part B Drug – notification within 24 hours of receipt.
- Concurrent Inpatient – within 24 nours of notification, no more than 72 hours with request for additional information.
- Post-service – within 30 days of receipt.

Offer of Peer to Peer/Denial Notices

An offer of peer-to-peer review to the requesting Provider is required before rendering a medical necessity denial decision. Documentation in the file must demonstrate evidence of offer of peer-to-peer, including that the reviewing practitioner is available to discuss any potential UM denial and notice to the requesting practitioner about how to contact a physician reviewer.

The denial letter rationale for a clinical denial reason must include member-specific clinical information in layman's terms that explains why member does not meet clinical criterion. Denial rationale must also include the reference to the clinical criterion and section used as basis for the denial decision or if a benefits denial reference to EOC (Evidence of Coverage).

Peer-to-Peer Review Requests

Wellcare aims to promote treatment that is specific to the member's condition and consistent with medical necessity, clinical practice, and appropriate level of care. An authorization request will be denied if the information provided does not meet the coverage requirements for the requested medical treatment. Wellcare will notify the provider and the member of the reason for the adverse determination.

Providers may contact Wellcare to discuss the adverse determination with a medical director (known as peer-to-peer review or P2P) using the instructions below.

Peer-to-peer reviews may not be used in certain situations
The peer-to-peer review does not apply to:

Appeals. Once you or a member submits an appeal, you cannot request a peer-to-peer review. If the member submits the appeal for an adverse determination you have issued, we will reach out to you for any additional information you may have.

Post-discharge. For adverse concurrent review determinations, you must request a peer-to-peer review prior to the member's discharge. Once the member has been discharged from a facility, you cannot request a peer-to-peer review. If a member is discharged on the weekend, please call prior to discharge and leave a message for your peer-to-peer request to be considered timely. Beyond this time, an appeal may be filed.

Initial adverse determinations beyond five business days. You have five business days to request a peer-to-peer review following issuance of an adverse prior authorization determination. Beyond this time, an appeal may be filed.

How to request a peer-to-peer review
Call 818-676-7371 with the required information available to request a peer-to-peer review.

If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Required information:
- Member name
- Member date of birth

- Case number
- Medical director name
- Name of the nurse who worked the case
- Member identification number

Utilization Management Criteria

The IPA must adopt or develop UM decision-making criteria that are objective and based on medical evidence. Criteria must be reviewed annually and updated as appropriate. Wellcare criteria are available to practitioners on the Wellcare website under "Clinical Coverage Guidelines," and the criteria must be made available to Members upon request.

Wellcare has adopted utilization review criteria developed by InterQual® products to determine Medical Necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the participant's condition or disease, reviews all potential adverse determinations and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Practitioners may obtain the full criteria used to make a specific adverse determination by contacting the Utilization Management Department at **888-546-5252**. Examples of criteria that may be utilized are Centene/Wellcare Clinical Policies and InterQual criteria appropriate to the applicable clinical condition and Member's particular needs (e.g. Adult, Geriatric, Child, Adolescent, and Behavioral Health/Psychiatry). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification of an adverse determination. The Medical Director may be contacted through Provider Services by calling Wellcare at **866-999-3945** and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or, with the Member's consent, healthcare professionals may request an appeal related to a Medical Necessity decision made during the authorization or concurrent review process orally or in writing to:

Wellcare Health Plans
Complaint and Grievance Coordinator
P.O. Box 31384
Tampa, FL 31384
Phone: **877-902-6784**
Fax: **866-388-1769**
Email: **Operationalgrievance@wellcare.com or pdpgrievance@wellcare.com**

Inpatient Acute Care, SNF, Psychiatric and Rehabilitation Admissions

- The IPA is also responsible for authorizing and performing concurrent review on all acute care, SNF, psychiatric and rehabilitation admissions.
- The IPA or hospital is to notify Wellcare's Health Services Department of all admissions within one business day of the admission. Notification should take place as follows:

    - Phone: **866-999-3945**
    - Fax: **855-547-9764**

- Wellcare may assign a case manager to co-manage the inpatient stay. Note: It is the responsibility of the IPA's concurrent review nurse to obtain medical information and update Wellcare as frequently as mutually agreed upon.

Out-of-Area Inpatient Acute Care SNF, Psychiatric and Rehabilitation Admissions

- Urgent or emergent out-of-area admissions are the responsibility of the Wellcare Health Services Department.
- If notified of an urgent or emergent out-of-area-admission, the IPA shall notify the Wellcare Health Services Department within one business day of the notification as follows:

    - Phone: **866-999-3945**
    - Fax: **855-547-9764**

- Unless specifically delegated to the IPA, Wellcare Health Plan's Utilization Management Department will be responsible for issuing an authorization, performing concurrent review, and working with the IPA to coordinate transfer of the Member to an in-network facility once the Member has been stabilized. Upon notification of an Out-of-Area admission, it is the responsibility of the assigned IPA/MSO to secure a receiving hospital and a receiving physician.

Rules for Coverage that Begins or Ends During an Inpatient Stay

This section applies to inpatient services in a hospital, psychiatric hospital, rehabilitation hospital, rehabilitation distinct part unit or a long-term acute care hospital. Should a Member's coverage with Wellcare begin during an inpatient stay in an acute-care hospital, psychiatric hospital, rehabilitation hospital, a rehabilitation distinct part unit or a long-term acute care hospital, Wellcare is not financially responsible for services until the Member is discharged from the facility.

Payment for Part B (Physician) services is determined by the Division of Financial Responsibility in participating Provider Agreement with IPA, and begins on the Member's effective date with Wellcare.

If a Member's coverage with Wellcare ends during an inpatient stay in an acute care hospital, psychiatric hospital, rehabilitation hospital, a distinct part rehabilitation unit or a long-term acute care hospital, Wellcare shall remain responsible for inpatient services until the date of discharge.

Wellcare or contracted IPA's liability for Part B (Physician) services ends the date a Member is effectively disenrolled with Wellcare.

(42 CFR – Public Health, Part 422 – Medicare Advantage Program §422.318)

The above rules are not applicable to inpatient services in a Skilled Nursing Facility or to those hospitals that are not part of the Medicare Prospective Payment System (PPS).

Required Notification to Members for Observation Services

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) effective Aug. 6, 2015, contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Member who receives observation services as an outpatient for more than 24

hours. The MOON is a standardized notice telling the Member that the Member is an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status. The MOON must be delivered no later than 36 hours after observation services are initiated or sooner upon release.

The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions is at **www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html**.

Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) Public Law 114-42, amending Section 1866(a)(1) of the Social Security Act (the Act) (42 U.S.C. 1395cc(a)(1))

42 CFR 489.20 and 405.926

Inpatient Acute Discharge/Important Message Notice Letter

As a delegated entity, the IPA must be aware of CMS Notification of Hospital Discharge Appeal Rights. Hospitals must deliver a revised version of the Important Message (IM) from Medicare to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Notice is required both for Original Medicare beneficiaries and for those enrolled in Medicare health plans. Beneficiaries who choose to appeal a discharge decision will receive a more detailed notice.

All Members hospitalized in an acute-care setting have the right to appeal to the Quality Improvement Organization (QIO) for an immediate review when a practitioner determines inpatient care is no longer necessary. If the Member decides to appeal the discharge, the Member must notify the QIO no later than midnight of the day of discharge and before the Member leaves the hospital.

If the Member files an appeal with the QIO, Wellcare will be notified by the QIO. The Wellcare Health Services Department will call the IPA and ask the IPA to deliver the Detailed Notice of Discharge. This letter explains to the Member why the hospital and IPA agree with the practitioner's determination that the Member should be discharged. The Detailed Notice of Discharge must be delivered as soon as possible, but no later than noon of the day after the QIO's notification.

Wellcare will gather all supporting documents to include, but not limited to: a copy of the IM, a copy of the Detailed Notice of Discharge and hospital medical records. These

documents will be sent to the QIO as soon as possible but no later than noon of the day after the QIO notifies Wellcare. If all of the above is submitted in a timely manner, the QIO will determine within one calendar day of receiving all of the pertinent information and will notify Wellcare of the outcome.

Providers can access the Transitions of Care Management (TRC) Worksheet to:

- Help support transitions of care to ensure appropriate documentation and timely report of the notification of a Medicare patient's inpatient admission, receipt of discharge information, and patient engagement after inpatient discharge.

- Reconcile discharge medications with the most recent medication lists to optimize HEDIS® and Star Rating scores and improve care coordination.

Skilled Nursing Facility, Home Health, CORF Discharge/Notice of Medicare Non-Coverage/Detailed Explanation of Non-Coverage

The Notice of Medicare Non-Coverage (NOMNC) is a written notice designed to inform Members that their covered skilled nursing facility (SNF), home healthcare or comprehensive outpatient rehabilitation facility (CORF) care is ending.

All Members receiving any of the above services are required to receive a NOMNC upon termination of services. This notice must be delivered no later than two days before the proposed termination of services. As a delegated entity, the IPA must adhere to the CMS requirements surrounding notification requirements.

If a Member files an appeal with the QIO, Wellcare will be notified. Wellcare, in turn, will notify the IPA and direct the IPA to issue a Detailed Explanation of Non-Coverage (DENC). The DENC is a standardized written notice providing specific and detailed information on why the Member's services are ending. The IPA must issue the DENC immediately following notification and provide Wellcare with a copy of the NOMNC, DENC, and medical records immediately because all documents must be forwarded to the QIO by no later than close of business (typically 4:30 p.m.) the day of the QIO's notification that the Member requested an appeal, or the day before coverage ends, whichever is later. Members have the right to file an appeal 24 hours a day, seven days a week, including holidays. The IPA must also comply with all QIO requests 24 hours a day, seven days week, including holidays.

IPA Reporting Requirements

Utilization Management activities specific to Wellcare Members are required to be reported on a daily, monthly, quarterly, semiannual and annual basis. Please see the Changes in Delegated Reports in Section 15: Attachments.

Section 10: Quality Improvement

Wellcare Quality Improvement Program

Quality Improvement (QI) is not a delegated function to the IPA. However, the IPA must adhere to the QI Program as administered by WellCare, under Centene Corporation. As a health plan, Wellcare is responsible for the quality of care provided to our Members. Throughout the year, the Quality Improvement Department, under the direction of the Quality Improvement and Utilization Management Committee, performs audits of Member/Provider satisfaction, services provided, and monitors IPA activities to help ensure that potential quality of care issues are identified and addressed in a timely manner.

All practitioners must cooperate with Wellcare's QI activities, allow Centene/Wellcare personnel access to practitioner medical records, to the extent permitted by state and federal law, and all practitioners must maintain the confidentiality of Member information and records.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve quality of care and services and the Member experience. This includes the collection and evaluation of performance data and participation in Wellcare's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Wellcare the use of their performance data for quality improvement activities.

Practitioners may freely communicate with Members about the Member's treatment, regardless of benefit coverage limitations.

Program Summary

The purpose of the WellCare's QI Program is to:

- Provide an infrastructure for objectively and systematically monitoring organizational data, analysis and reporting of data to evidence the quality, appropriateness, accessibility, and availability of safe, timely, effective, efficient, equitable and patient-centered medical and behavioral healthcare and services.
- Serve to reduce healthcare disparities in all settings using analyses that ensure cultural, ethnic sensitivity in materials, case management, network adequacy, etc.

- Confirm interventions recommended by quality leadership are planned, implemented, and tested, demonstrate improvement, or a need for an alternate interventionis identified using the Plan, Do, Study, Act methodology (PDSA).
- Ensure the application of the principles and tools of performance improvement including root cause analyses as indicated.
- Provide consultation/guidance to corporate and market teams to affect strategies to improve the quality, appropriateness, and accessibility of healthcare provided to members.
- Facilitate organization-wide integration of quality management principles.
- Implement processes for formal evaluation of the impact and effectiveness of the quality program. The Quality Improvement Program Description (QI Program Description) indicates:
    - The essential structure, resources, divisions served, and processes through which the QI Program is constructed and implemented.
    - The QI Program scope as well as associated accountabilities and responsibilities.

QI Program objectives are to:

- Facilitate integration, support of, and commitment to continuous quality improvement throughout Wellcare for sustained improvements.
- Educate, encourage, and evaluate compliance to policies and procedures that standardize approaches to the completion of activities that reflect key program components.
- Develop and maintain a process through which clinical and operational performance is continuously measured; opportunities for improvement identified; meaningful interventions identified as appropriate; and the results of actions taken to improve outcomes are tested and studied before they are implemented and evaluated.
- Select and conduct meaningful and relevant (high-volume, high-risk, and/or problem-prone) population-specific quality improvement initiatives that achieve, through ongoing measurementand definition of barriers and interventions, sustained and significant improvement in aspects of clinical care and non-clinical services.
- Report data to medical and behavioral health leadership in identifying availability of and access to qualified providers and adherence to established standards for credentialing and re-credentialing of network practitioners and providers.
- Describe metrics that ensure the adoption and dissemination of evidence-based guidelines that promote the delivery of safe clinical practices.

- Facilitate integration of services to promote continuity and coordination of care, resulting from a change in setting or a transition of care, inclusive of both medical and behavioral healthcare delivery.
- Promote a supportive environment that assists associates and providers in rendering culturally competent medical and behavioral healthcare services, thereby promoting compliance with the Centene Corporate Cultural Competency Plan and ensuring all aspects of the QI Program activities comply with contractual, state, federal, and accreditation standards.
- Encourage plan areas to expand member participation in programs and services through the dissemination of information with consideration for language and readability levels.
- Support engagement of members in managing, maintaining, and/or improving their current health status through preventive/wellness activities, disease management, case management, and other chronic care initiatives.
- Ensure the maintenance of established safeguards for member privacy, including confidentiality of member health information in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations adopted there under (collectively, HIPAA).
- Support a process for members, providers, associates, various healthcare associations, and community agencies to receive updates and offer suggestions, concerns, and recommendations regarding the QI Program and activities.
- Collaborate with various internal stakeholders to ensure the information systems support the collection, tracking, analysis, reporting, and historical record keeping of relevant QI Program related data.
- Sustain standards and objectives and conduct continuous, comprehensive oversight of all delegated entities serving members with complex health needs.
- Analyze HEDIS, Health Outcomes Survey (HOS), and CAHPS results that provide evidence of improvements in initiatives to improve member experience, satisfaction, health, and wellness.
- Identify specific objectives to promote realization of select goals on an annual basis and record in the Medicare QI Work Plan document.
- Ensure members, members' family members and/or representatives, providers, vendors, and associates have a non-threatening, non-punitive forum for reporting grievances and/or quality-of-care safety issues.

The QI Program is comprehensive, systematic, and continuous. It applies to all member demographic groups, care settings, and types of services afforded to Medicare Advantage members, including the SNP membership. The QI Program addresses the quality of medical and behavioral health care and non-clinical aspects of service.

Objective and systematic key areas of focus include, but are not limited to, the following:

- Appeals/grievances/complaints.
- Member experienceand retention.
- Provider experience.
- Behavioral health services.
- Utilization management
- Population health management (including disease and case management, chronic care improvement program, preventive and clinical health, and model of care).
- Patient safety and quality of care.
- Continuity and coordination of care.
- Clinical indicators and initiatives (including HEDIS®, HOS, and STAR ratings).
- Preventive and clinical health outcomes.
- Credentialing and peer review
- Cultural competency.
- Delegation.
- Pharmacy and therapeutics.
- Network adequacy and accessibility.
- Components of operational service (including customer service/claims, etc.)
- Confidentiality and ethics.
- Regulatory and/or accreditation reporting requirements.

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. The National Medicare QI Program Description, the Medicare QI Work Plan, and the Annual Medicare and SNP Quality Improvement Program Evaluation describe the CQI processes. These processes are approved and evaluated by the applicable committees. The Organization uses the CQI methodology to improve and accomplish identified goals and processes. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources. The Organization uses the Plan-Do-Study-Act (PDSA) method of CQI throughout the organization where multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care, evidence-based medicine, and service delivery. When variations are noted, root cause analysis, action plans, and re-measurement occur to ensure progress toward established goals.

The strategy of PDSA incorporates the continuous tracking and trending of quality indicators to ensure that outcomes are measured,and goals are attained. Quality of care interventions and outcomes are monitored through nationally recognized quality standards such as HEDIS performance measures and CAHPS surveys, while also utilizing current knowledge and clinical experience to monitor external quality review studies,

periodic medical record reviews, clinical management, and quality initiatives. Corrective Action Plans/Previously Identified Issues Action Plans are issued annually based on market and corporate performance within the Work Plan.

The Medicare QI Work Plan identifies specific activities and initiatives carried out by the Plan and the performance measures for analysis throughout the year. Work Plan activities align with contractual, accreditation, and regulatory requirements and identify measurements to accomplish goals. The Annual Medicare QI Program Evaluations describe the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and trending as appropriate. The Program Evaluation describes the overall effectiveness of the QI Program by including:

- A description of ongoing and completed QI activities and initiatives. Trended clinical care and service performance measures, as well as the desired outcomes and progress toward achieving goals.
- An analysis and evaluation of the effectiveness of the QI Program and its progress toward influencing the quality of clinical care and service.
- A description of any barriers to accomplishing quality clinical care or achieving desired outcomes.
- Current opportunities for improvement with recommendations for interventions.
- Regular follow-up on action items identified in the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) meeting forum.

The Organization achieves QI Program objectives through collaboration and coordination of resources at both the corporate and plan levels. The following activities are performed by Wellcare:

1. QI Program policy and procedure development.
2. QI Program data collection and preliminary analysis.
3. HEDIS data collection and reporting.
4. Member and provider experience data collection and reporting.
5. Utilization, case, and disease management.
6. Pharmacy program data collection and preliminary analysis.
7. Medical and behavioral health care necessity review criteria development and application.
8. New technology evaluation including development and implementation of new medical management platforms.
9. Appeals/complaints/grievances processes.
10. Delegation oversight.
11. Credentialing.
12. Appointment availability/accessibility surveys.

13. Member and provider call center operations.
14. Marketing operations.

Work products resulting from the above Wellcare processes require organizational approval. They are presented to the appropriate Corporate/Plan Sub-Committees/Work Groups, including the National Medicare QIUMC, then integrated into daily QI Department functions.

Once the data is analyzed and reported, assessed for strategy, as well as other communication to improve the level of care provided to members. Some of the areas addressed by various programs and initiatives include, but are not limited to, the following:

- Appeals/grievances/complaints.
- Member experience.
- Provider experience.
- Behavioral health services.
- Utilization management.
- Population health management (including disease and case management, chronic care improvement program, preventive and clinical health, and model of care).
- Patient safety and quality of care.
- Continuity and coordination of care.
- Clinical indicators and initiatives (HEDIS, HOS, and STAR ratings).
- Preventive and clinical health outcomes.
- Credentialing and peer review.
- Cultural competency
- Delegation
- Pharmacy and therapeutics.
- Network availability and accessibility.
- Components of operational services(customer service/claims, etc.).
- Confidentiality, ethics,regulatory and/or accreditation reporting requirements.

Access-to-Care Standards

Wellcare monitors geographic access through the production of GeoAccess reports and maps. Reports are generated utilizing the specific access standards per regulatory agencies and accrediting bodies to ensure compliance and the needs of all members are met, which includes both ethnic/cultural/medical/behavioral health requirements.

Wellcare monitors the timeliness of access to care within its provider networks via appointment accessibility and after-hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements, and accrediting bodies.

Wellcare requires that all network providers, both first tier and downstream providers, offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service patients. GeoAccess maps and accessibility reports are developed and reviewed for targeted lines of business that adhere to regulatory agencies, accrediting bodies, and company requirements. On at least a semi-annual basis, WellCare completes GeoAccess maps and analysis to evaluate compliance to geographic access standards, take action as appropriate, and report to the appropriate committees. On at least a semi-annual basis, audits are conducted for network adequacy to ensure members can access providers within specific appointment availability timeframes. A review and validation of the survey results are conducted to ensure completeness and accuracy to resolve any outstanding questions/issues, and to identify opportunities for improvement.

In addition, average speed of answer, hold times and call abandonment rates are monitored on an ongoing basis to assure adequate access to Plan personnel for Members and Providers. Access and availability is also monitored on an annual basis via the Member satisfaction survey. Network availability data is reported to the QIUMC on a semiannual basis.

Primary Care Accessibility	
Service	**Standard**
Urgent but non-emergency	Within 24 hours
Non-Urgent but in need of attention	Within 7 days
Regular and routine care	Within 30 days
After-hours care	24 hours per day, 7 days per week
Mental Healthcare Accessibility	
Service	**Standard**
Care of non-life threatening emergency	Within 6 hours
Urgent care	Within 48 hours
Initial visit for routine care	Within 10 business days
Routine care follow-up	≤ 30 days
Routine office visits – after inpatient stay	Within 7 days
Specialty Care Accessibility	
Service	**Standard**
High-volume specialty care	≤ 30 days
High-impact specialty care	≤ 30 days

Standards for Telephone Access

During Normal Business Hours	
Answer by a non-recorded voice	Within 30 seconds
Abandonment rate	Less than 5%
After Normal Business Hours	
Response rate to after-hours calls	Within 30 seconds

Standards for Office Wait Times

The maximum wait time for the following services should be:

Office Wait Time	
All scheduled appointments	Within 15 minutes

Access Audit

On a biannual basis, Wellcare will conduct an access audit to confirm all PCPs, Specialists and Behavioral Health (BH) practitioners are compliant with the access to care standards as mandated by CMS and NCQA.

The audit will include access during normal business hours and after hours. Areas to be audited will include:

- Access to routine care appointments (medical and BH)
- Urgent care appointments (medical and BH)
- After-hours care and emergency direction
- Call answer timeliness
- After hours Provider availability

Results will be tabulated and may be shared with the PCP, BH practitioner and/or IPA. Scores resulting in ≤ 80% will require a Corrective Action Plan (CAP). Providers and/or the IPA will have 30 calendar days to respond to CAP requests. Providers/practitioners who score ≤ 80% in subsequent audits after implementation of a CAP may be excluded from participation in the Wellcare Provider Network.

Audit results will be presented to the Wellcare Quality Improvement and Utilization Management Committee.

Appeals, Concerns, Complaints, and Grievances

Wellcare provides an appeal process that includes both standard and expedited reviews that provides objective resolution for members and providers who submit a request for review of an adverse determination. The mission of the Appeals Department is to support the organization's reconsideration process and compliance through the review of all requests for additional review of service and claim denials, as well as provide a mechanism for approval and/or payment for overturned decisions. The Appeals Department establishes and maintains procedures for reviewing all appeals made by enrollees, providers on behalf of enrollees, or appointed representatives.In accordance with federal and state laws, an external appeal mechanism may also be available when the Plan makes an adverse decision. Appeals activities are reported to at least one of the following: the Customer Service Quality Improvement Workgroup (CSQIW), and/or QIUMC. If a trend of medical necessity or benefit coverage overturn is identified, an in-depth review of the decision process is initiated, and an intervention plan is implemented as appropriate. In addition, monthly metrics related to the reasons for the appeal and the overturn are presented to stakeholders with appeals volume and overturn rates by top providers (by volume). Appeals trends are monitored and reviewed through ad-hoc workgroups relating to utilization management, claims, processing errors, and configuration.

Within the Appeals Department, objectives are to:

- Resolve 95% of appeals within compliance and/or accreditation time frames.
- Improve quality of data to facilitate reporting, tracking, trending, and analysis.
- Achieve acceptable scores on accreditation, internal, and external audits.
- Reduce the volume of appeals.
- Improve compliance and efficiency through automation whenever possible.

Members and providers are encouraged to contact Wellcare to report issues. Concerns may be reported via telephone, the company website, or in writing. A thorough review is conducted on all expressions of dissatisfaction received from our members or authorized representatives on behalf of the members. Concerns are carefully analyzed and completely resolved; the best interests of the member are always considered in accordance with Wellcare's coverage and service requirements.

Issues are documented in a common database to enable appropriate classification, timely investigation, and accurate reporting of issues to the appropriate quality committee. Trended data is reviewed on a periodic basis to determine if a need for further action exists, be it Wellcare, practitioner, or provider focused. This data, any

identified trends or problem areas, and mitigation strategies to eliminate top reasons for dissatisfaction are reported through the QIUMC on a quarterly basis.

Wellcare uses information regarding member experiences as a way to measure member satisfaction with their health care. Sources of data used to evaluate experience include the annual CAHPS survey, the annual Experience of Care and Behavioral Health Outcomes (ECHO®), grievances, and appeals.

Member Experience: CAHPS

Wellcare collects data regarding member experience through multiple avenues including but not limited to Medicare CAHPS® (MCAHPS®), BH ECHO, appeals and grievances. The member experience data collected through the CAHPS survey measures members' satisfaction in multiple domains including:

- Getting needed care.
- Getting appointments and care quickly.
- Customer service.
- Care coordination.
- Rating of drug plan.
- Getting needed prescription drugs.
- Flu vaccination.
- Pneumonia vaccination.
- Medical assistance with smoking and tobacco use cessation.
- Rating of health care quality.
- Rating of health plan.

The member experience data collected through the BH ECHO® survey measures:

- Getting teratment quickly.
- How well clinicians communicate information about treatment options.
- Access to treatment and information from health plan.
- Office wait times.
- Informed about medication side effects.
- Received information about managing condition.
- Informed about patient rights.
- Ability to refuse medication and treatment.
- Rating of counseling or treatment.

The Organization identifies opportunities for improvement based on results from MCAHPSsurvey, the ECHO survey, appeals, and grievances. Wellcare contracts with a CMS-certified survey vendor to conduct the MCAHPS survey on an annual basis, utilizing

CMS-required survey techniques and specifications. MCAHPS results are presented to the QIUMC to share deficiencies and/or areas of opportunity identified.

The Organization's Member Retention team strives to deliver star scores that exceed expectations of the industry standard and to understand the drivers of disenrollment. These ends are achieved through strong analytics, meaningful partnerships across all departments and execution of targeted campaigns. Member Retention analysis and reporting is also a part of the member experience evaluation process. The Member Loyalty and Retention Department strives for excellent member satisfaction and uses voluntary disenrollment performance as the basis for monitoring success and performing root cause analyses for continuous improvement of member satisfaction.

Refer to Section 11: Medicare Star Rating for additional information regarding CAHPS.

Provider Experience

An ongoing analysis of provider complaints is conducted to evaluate provider satisfaction. In addition, on an annual basis, the provider network is formally surveyed by a certified vendor to assess provider satisfaction with Wellcare. The survey includes questions to evaluate the provider experience with our services such as claims, communications, utilization management, and provider services. Participants are randomly selected by the vendor, meeting specific requirements. Results of the survey are analyzed and used as a basis for forming provider-related quality improvement initiatives. The annual National Medicare and SNP Quality Improvement Program Evaluation addresses the areas identified as needing improvement. The results and action plan are presented to the QIUMC for approval and recommendations.

Behavioral Health Services

Behavioral health is integrated in the overall care model with guidance from Behavioral Health Medical Directors. The goals and objectives of the behavioral health activities are congruent with the Population Health Solutions health model, and are incorporated into the overall care management model program description, which involve efforts to monitor and improve behavioral healthcare Special populations such as serious and persistent mentally ill (SPMI) adults may require additional services and attention, which may lead to the development of special arrangements and procedures with our provider network to arrange for and provide certain services including:

- Coordination of services for members after discharge from state and private facilities to integrate them back into community. This includes coordination to implement or access services with network behavioral health providers or Community Mental Health Centers (CMHCs).
- Targeted case management by community mental health providers for adults in the community with a severe and persistent mental illness.

The goals of the Behavioral Health Program mirror that of the Utilization and Care Management Programs. The program is intended to decrease fragmentation of health care service delivery; facilitate appropriate utilization of available resources; and optimize member outcomes through education, care coordination, and advocacy services for the population served. It is a collaborative process that utilizes a multi-disciplinary, member-centered model that integrates the delivery of care and services across the care continuum. It supports the Institute for Healthcare Improvement's Triple Aim objectives, which include:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations.
- Reducing the per capita cost of healthcare.

The Continuity and Coordination of Care Work Group is a sub-committee of the QIUMC and serves to look at Behavioral Health metrics and how Centene can improve upon the care of members with Behavioral Health needs. This includes the focus on communication between Behavioral Health and medical professionals in the care of Wellcare's members. A behavioral health Medical Director serves as chair of that work group and is the designated physician to assist in implementation of interventions addressed by the work group.

Population Health Management

Population Health Management (PHM) allows for the assessment of the characteristics and needs of the entire membership with the goal of determining actionable categories for appropriate intervention. The results of the assessment and stratification of Members allow Wellcare to develop its strategy guide to improve the quality of life of its Members. The population assessment is conducted annually by collecting, stratifying, and integrating various data sets and programs to assess its Member's needs across the entire membership. The population assessment is used to:

- Assess the characteristics and needs of its Member population including social determinants of health
- Identify and assess sub-populations
- Assess the needs of child and adolescent Members
- Assess the needs of Members with disabilities
- Assess the needs of Members with serious and persistent mental illness (SPMI)
- Stratify the Members into one of the following focus areas:
    - Keeping Members Healthy

    - Managing Members with Emerging Risk
    - Patient Safety or Outcomes Across Settings
    - Managing Multiple Chronic Illnesses
- Review and update PHM activities to address Member needs in each of the focus areas
- Review and update PHM resources to address Member needs in each of the focus areas
- Review community resources for integration into program offerings to address Member needs for each of the focus areas
- Identify and address Members' social determinants of health in each of the focus areas

Annually, Wellcare:

- Updates the Population Health Strategy Guide
- Measures the effectiveness of its PHM programs for each focus area
- Improves current programs and/or develop new programs based on the assessment findings
- Update the Population Health Program Catalog with new/changed programs
- The population assessments for each NCQA Accredited plan are presented to the QIUMC at least annually. Leadership from the Population Health Solutions department helps to set the strategy for managing population health and carry out actions that address findings from the population assessments are voting members on the QIUMC.

Utilization Management

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within Population Health and Clinical Operations, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial, and consistent utilization management decisions and coordination of care for the health plan members. UM is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of physical, behavioral health and substance use services to identify improvements and opportunities for improvement over time. The UM Program takes a multidisciplinary, comprehensive approach and process to manage resource allocation. The UM process influences systematic monitoring of medical necessity and quality and maximizes the cost effectiveness of the care and service provided to members. Integral factors in the UM process include:

- Consideration of individual member clinical and psychosocial needs, including those identified with special healthcare needs, cultural, characteristics, and individual preferences.
- Consideration of benefit coverage for services (including but not limited to medical, behavioral health, substance use, pharmacy, or ancillary services) which have been prescribed and are based on generally accepted medical practices and behavioral health clinical practice guidelines in light of conditions at the time of treatment. Information sources utilized in determining benefit coverage for members include Medicare National and Local Coverage Determinations, nationally established guidelines, InterQual or MCG Criteria, or other evidenced based medical literature andestablished corporate-written clinical policies.
- An available and accessible care delivery system.
- A diverse network of qualified medical and behavioral health practitioners and providers/facilities.
- Clinically sound, evidence-based medical/behavioral health necessity decision-making tools to facilitate the consistent application of criteria for appropriate utilization of available resources in an efficient and effective manner.
- Available and applicable plan benefits.

The scope of the UM Program includes an overview of policies, procedures, and operational processes related to the delivery of medical care, behavioral health and substance use care, dental care, and pharmaceutical management, including services and physicians who have an impact on the provision of healthcare.This includes the evaluation of medical necessity and the efficient use of medical, behavioral health and substance useservices, procedures, facilities, specialty care, inpatient and outpatient care, home care, skilled nursing services, ancillary services, and pharmaceutical services.

The UM Program incorporates psychiatric evaluation, pharmacotherapy, psychotherapy, group therapy, psychological testing, community-based interventions, and any other therapies or social or environmental manipulations that may be utilized by behavioral health practitioners and providers. The services include behavioral, and substance use disorder services.

The UM Program processes include components of prior authorization as well as prospective, concurrent, and retrospective review activities, each of which are designed to provide for an evaluation of healthcare and services based on the member's coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to providers of care. Neither Centene, nor the Wellcare health plans reward its practitioners, providers, or associates who perform utilization reviews, including those of the delegated entities, for denials. No entity or associate is

compensated or otherwise given incentives to encourage denials. Utilization denials (adverse determinations) are based on lack of medical necessity or lack of covered benefits. As part of the UM Program performance measurement data regarding frequency of selected procedures, and Behavioral Health readmissions and admissions are all monitored and reported to QIUMC or the appropriate sub-committee.

Each Wellcare Subsidiary Group has its own Board of Directors (the board) that is the governing body of the Plan and has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The board oversees development, implementation, and evaluation of the quality improvement program, which includes the UM Program. The board delegates the daily oversight and operating authority of the utilization management activities to the National Medicare QIUMC. This oversight includes the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The QIUMC Committee is responsible for reviewing all utilization management issues and related information and making recommendations to the QIUMC which reports up through the board. The UM Program is reviewed and approved by Centene's National Medicare QIUMC on an annual basis.

The Senior Vice President and Deputy Chief Medical Director at Centene Corporation, of which Wellcare is a part of, serves as the Chairperson of the QIUMC and is the designated physician for the QIUMC. In partnership, the Chief Medical Director and Senior Medical Director have authority and oversight of the UM Program and serve as the co-chairpersons for the QIUMC and are also designated physicians for the QI Program and UM Programs.

Wellcare actively involves participating network practitioners in utilization review activities, as available, and to the extent that there is not a conflict of interest. Participation in Centene's QIUMC is one of the primary ways that network practitioners participate in health plan utilization review activities. The multidisciplinary staff and practitioners employed by Centene Corporation conduct UM activities within their legal scope of practice as identified by licensure standards.

CM/Chronic Care Improvement Program/Disease Management/MOC

The mission of the Care Management department is to educate Members and coordinate timely, cost-effective, evidence based, integrated services for the individual health needs of Members to promote positive clinical outcomes. Integrated program components include complex Care Management, disease management, Behavioral Health management and transitional Care Management. Care Management uses multiple data sets to identify and treat high-risk Members. This department employs a

multidisciplinary population health model to approach members needs from a variety of perspectives.

Care Management monitors the member engagement, Members' satisfaction with Care Management, Members' utilization of services, readmission rates, admission rates, and high-volume service utilization. Care Management also reviews continuity of care between Member's behavioral health care services and their medical care services for those Members who are receiving both. Care Management data is reported to QIUMC.

Medicare Advantage organizations (MAOs) must have an ongoing Chronic Care Improvement Program (CCIP) for each contract. CCIPs promote effective management of chronic disease, improve care and health outcomes for enrollees with chronic conditions, and are conducted overa three-year period. CCIPs foster treatment adherence, disease education, and advocacy designed to improve outcomes. The organization focuses on patient-centered care for members' complex medical, behavioral health and socioeconomic needs that often require more frequent monitoring and/or costly treatment. Effective management of chronic disease is important to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays, improve quality of life, and save costs for the MAO and for the member.

Members are engaged through several methods, including, but not limited to, initial and subsequent health risks assessments and referrals from providers, discharges planners, and case and utilization managers.The Plan ensures that:

- Quantifiable, measurable data is reviewed, analyzed, and reported to the QIUMC annually.
- Target goals, barriers, and specific interventions are developed based on data analysis to increase care management and preventive services utilization and improve health outcomes.
- Best practices are identified and implemented.
- The program is applicable to MAOs and interrelates with aspects of Population Health Services, model of care, and care management.

Members may be identified internally through claims/encounter data and/or referred by the IPA using the Care Management Referral form in Section 15: Attachments.

Wellcare identifies, supports and engages our most vulnerable Members to assist them in achieving an improved health status. Wellcare provides services in a Member-centric

fashion. Wellcare's objectives for serving Members with complex and special needs include:

- Completing an annual population assessment to identify the needs of the population and sub-populations so Care Management processes and resources can be updated to address Member needs
- Promoting preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in Members
- Conducting comprehensive assessments that identify Member needs and barriers to care
- Coordinating transitions of care for Members with complex and special needs to assist in navigating the complex healthcare system and accessing Provider, public, and private community-based resources
- Improving access to primary and specialty care to ensure that Members with complex health conditions receive appropriate services
- Consulting with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers, Behavioral Health professionals, etc.
- Ensuring that Members' socio-economic barriers are addressed

Wellcare identifies, supports, and engages our most vulnerable members at any point in their health care continuum to assist them in achieving an improved health status, while providing services in a member-centric fashion. Wellcare's objectives for serving members with complex and special needs include, but are not limited to:

- Completion of an annual population assessment to identify the needs of the population and sub-populations so that Care Management processes and resources can be updated to address member needs.
- Promotion of preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in members.
- Conducting comprehensive assessments that identify member needs and barriers to care (cultural, ethical, behavioral health, etc.).
- Coordination of transitions of care for members with complex and special needs to assist in navigating the complex healthcare system and accessing provider, public, and private community-based resources.
- Improvement of access to primary and specialty care to ensure that members with complex health conditions receive appropriate services.

- Consultation with appropriate specialized health care personnel when needed such as medical directors, pharmacists, social workers, behavioral health professionals, etc.
- Ensuring that members' socio-economic barriers are addressed.

Effectiveness of the Model of Care Program is evaluated through the identification of objective, measurable and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis; outcomes are analyzed; interventions are implemented for goal attainment; and reports are generated. Data collection follows protocols established in approved policies and/or program designs. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection.

Standardized tools are developed for utilization with any manual data collection, such as extraction of data from medical records. Statistically valid sampling techniques are utilized as appropriate. Wellcare has established performance outcomes for the SNP plans to evaluate and measure the quality of care, quality outcomes, service, and access for members. For each metric, benchmarks have been established based on evidenced-based medicine found in current literature, standards, and guidelines. Root cause analysis is conducted, and interventions identified for each indicator that falls below the desired value. The analysis, process improvement plan, implementation of interventions, and improvements are reported to the National QIUMC for review, feedback, and approval.

Complex Care Management Programs

As a part of Wellcare's services, Complex Care Management Programs (CCMP) are also offered to Members. Complex Care Management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition, through integrative care.

Complex Care Management supports the physician or Practitioner/Member relationship and plan of care, emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Not all participants identified with specific targeted diagnoses will be enrolled in the CCMP. Participants are stratified into risk levels that determine the level of intervention.

High-risk participants with co-morbid or complex conditions will be referred for Care Management assessment. Complex Care Management is considered an opt-out program such that all eligible Members have the right to decline to participate.

To refer a Member for Complex Care Management:

- Call: **866-999-3945**
- Online: **www.wellcare.com/California**

Patient Safety

Wellcare's QI Program places emphasis on patient safety as an integral part of the Organization's purpose. The structure of the Patient Safety QI Program Structure involves potential quality of care (PQOC) issues investigated and resolved at the state and plan level with data analysis, root cause analysis and further resolution (if required) completed and reported at the state and national level. Organizational Medicare reporting oversight and direction is performed at the Corporate Level. Quarterly state/market data is consolidated, summarized andreported to the QIUMC. The objectives for incorporation of patient safety practices into Wellcare's QI Program are to:

- Perform surveillance to identify harm, or the potential of harm, to members in health care delivery.
- Develop organization-wide standards, definitions, processes, analysis and reporting to ensure cohesiveness and consistency within the markets in order to identify trends.
- Promote evidence-based policies and practices.
- Disseminate training and re-training of case management, utilization management, customer service, appeals and grievances (both medical and behavioral health) in identifying and reporting potential quality of care issues.
- Encourage all associates, providers, and practitioners to report potential quality of care issues.
- Collaborate with practitioners and providers in improving breakdowns in processes when a PQOC is identified.
- Utilize market level patient safety in root cause analyses for recognizing and intervening of common and special cause variation.

In focusing on patient safety, Wellcare's approach is to:

- Inform members and providers of Wellcare's patient safety initiatives and how to report a grievance.

- Encourage practitioners and providers to adopt processes to improve safe clinical practices when quality of care issues are identified.
- Motivate members to be participants in the delivery of their own safe health care.
- Communicate patient safety best practice to associates, practitioners and providers/facilities when recognized.
- Develop clear policies, sound organizational leadership, and meaningful data to drive safety improvements.
- Utilize both corporate and market Medical and Behavioral Health Medical Directors in the peer review process and refer to external review agencies as necessary.
- Ensure consideration is paramount for cultural and linguistic requirements in the safety of the care provided to members.

The scope of the Patient Safety/Quality of Care (QOC) plan encompasses recognition of medical, behavioral health, pharmaceutical care, and administrative issues in practitioner, provider/facilities,and member interactions. All member demographic groups, care settings, and types of services are included in patient safety activities. The sources of data used to monitor aspects of patient safety include, but are not limited to:

- Practitioner-to-practitioner communication.
- Office site visit review of results when indicated.
- System care management, utilization management, documentation, etc.
- Medical record review of findings.
- Clinical practice guideline compliance.
- Potential quality of care (PQOC) tracking/trending.
- Concurrent review during the utilization management or care management process/interaction.
- Identification of potential trends in under- and over-utilization.
- Case and disease management program participation.
- Pharmaceutical management practices.
- Member and/or member representative communications during customer service/member services contacts.

The Patient Safety Work Group was established to serve as a proactive, interactive team consisting of market and corporate medical and behavioral health Medical Directors, Quality Improvement Specialists/Nurses/QI Reviewers from all markets facilitated by a

Medical Director Champion and Work Group Chair, who also provide guidance. The group's objective is to build cohesiveness in the health plan QOC Reviewer community and ensure consistency in the PQOC process from identification of a potential quality of care issue and investigation to resolution and reporting. Another work group goal is to identify best practices and recognize trends should they occur. The work group meets eight times per year. The monthly agenda and action plans are generated and reviewed/approved by the Medical Director physician champion prior to the work group meeting. Minutes of the meetings are detailed, approved by the work group, signed by the physician champion, and are reported to the QIUMC for oversight and approval.

Continuity and Coordination of Care

Wellcare , in accordance with federal and state regulations, ensures that its members' care is directed and coordinated by a PCP. The company also complies with CMS requirements, applicable federal and state regulations, and state-specific Medicaid contracts regarding partnership with Wellcare's providers in coordinating appropriate services for members requiring continuity and coordination of care. NCQA requires that accredited organizations monitor and take action, as necessary, to improve continuity and coordination of care across the health care network. Wellcare refers to these standards as Medicare Continuity and Coordination of Care standards. These standards guide the organization in utilizing information at its disposal to facilitate coordination of care and collaboration between medical and behavioral health care providers across its care delivery system.

The Plan's activities encourage the PCP relationship to serve as the member's provider "home." This strategy promotes one provider having comprehensive knowledge of the member's health care needs, whether it is disease or preventive care in nature. Through contractual language and program components, PCPs are educated regarding their responsibilities.

With increased coordination of care, health care interventions can be more consistent with an individual's overall physical and/or behavioral health, and there become fewer opportunities for negative medication interactions, side effects, complications, and polypharmacy. Attention to continuity and coordination of care promotes patient-centered care, improves a member's overall physical and mental well-being, decreases hospitalizations, and ensures appropriate and smooth transitions of care.

Effective coordination of care is dependent upon clear and timely communication among PCPs, specialists, behavioral health practitioners, and facilities. Effective communication allows for better decision-making regarding treatment interventions, decreases the potential for fragmentation of treatment, and improves member health outcomes. Coordination of care is a continual quality process that requires ongoing

monitoring and evaluation of the delivery of high-quality, high-value, patient-centered care to members. Wellcare uses a variety of mechanisms to monitor continuity and coordination of care. In addition, Wellcare works collaboratively with medical and behavioral health practitioners to monitor and improve coordination between medical and behavioral health care. The metrics chosen to identify areas that contribute to continuity and coordination of care are listed on the table below.

These areas include:

Specific Area Monitored	Description of Monitor	Frequency
Movement between practitioners	HEDIS – Comprehensive Diabetes Care – Retinal Eye Exam (EED)	Annual
Movement between practitioners	HEDIS- UOP- Use of Opioids Multiple Prescribers, Multiple Pharmacies	Annual
Movement between settings	HEDIS FMC- Follow Up after Emergency department Visit for People with High Risk Multiple Chronic Conditions.	Annual
Movement between settings	HEDIS – Transitions of Care Medication Reconciliation Post-Discharge (TRC)	Annual
Exchange of Information	-Timeliness of feedback/reports from specialists. -Frequency of feedback/reports from specialists. -Timeliness of feedback/reports from Behavioral Health Clinicians. -Frequency of feedback/reports from Behavioral Health Clinicians.	Annual
Appropriate Diagnosis, Treatment, and Referral of Behavioral Disorders Commonly Seen in Primary Care	HEDIS – Antidepressant Medication Management – Acute phase (AMM)	Annual
Appropriate Use of Psychotropic Medications	HEDIS – Potentially Harmful Drug-Disease Interactions in the Elderly – Dementia and Prescription of Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine	Annual

Specific Area Monitored	Description of Monitor	Frequency
	Hypnotics, or Anticholinergic Agents (DDE)	
Management of Treatment Access and Follow-Up for Enrollees with Coexisting Disorders	HEDIS – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Annual
Primary or Secondary Preventive Behavioral Healthcare Program Implementation	Depression Screening for Members with a Chronic Health Condition	Annual
Special Needs of Members with Severe and Persistent Mental Illness	HEDIS – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	Annual

The National Continuity and Coordination of Care Steering Committee is comprised of Medical Directors from medical and behavioral health arenas and corporate leadership from Quality, Utilization Management, Care Management, and Population Health Solutions. The Steering Committee reviews and analyzes data and guides the National Continuity and Coordination of Care Work Group in identifying barriers to adequate continuity and coordination of care and markets that have successfully implemented interventions to overcome such barriers.

The mission of the National Continuity and Coordination of Care Steering Committee and Work Group is to ensure that Wellcare continues to serve our members by establishing high quality programs and processes that enable proper coordination of care between medical and behavioral health providers. The work group ensures that NCQA accreditation standards for Continuity and Coordination of Care are met and maintained in order to remain in good standing with regulatory responsibilities. The vision of the group is to establish and maintain a position as a leader in government-sponsored health care programs through organizational collaboration with primary care and behavioral health practitioners to improve coordination of integrated health care. The work group encourages the monitoring of member experience to ensure desired health outcomes for our members.

The completion of covered services must be provided by a terminated provider to a member who at the time of the contract termination, was receiving services from that provider for one of the conditions described below.

Additionally, the completion of covered services must be provided by a non-participating provider to a newly covered member who, at the time their coverage

became effective, was receiving services from that provider for one of the conditions below.

Conditions

- A serious chronic condition.
- A pregnancy.
- A terminal illness.
- The care of a newborn child between birth and age 36 months.
- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

For more detailed information refer to California Code, Health and Safety Code - HSC § 1373.96

Refer to the Member Services Department at 866-999-3945 for assistance.

Medicare members: COC services not covered:

- Durable medical equipment (DME) providers or other ancillary services, such as transportation or carve-out services.
- Out-of-network providers who do not agree to abide by Wellcare utilization management policies.

Credentialing and Peer Review

WellCare has established standards for conducting the functions of network provider selection and retention. The Credentialing Program standards include practices for individual and organizational/facility credentialing, re-credentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Centene Corporation requirements.

For consideration to participate in the network, all individual practitioners who have an independent relationship with Centene Corporation or Wellcare must complete an application, submit copies of applicable supporting documentation, meet minimum administrative requirements, and meet credentialing qualifications. Re-credentialing is performed at least every 36 months, and the re-credentialing cycle begins with the date of the initial credentialing decision. Credentialing team verifies application using primary and secondary sources, which are reviewed, date stamped and placed in the applicant's file prior to the credentialing decision.

Wellcare has designated a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. The Credentialing Committee is comprised of network practitioners and Health Plan staff to provide advice and expertise for credentialing decisions, reviews credentials for practitioners and providers who do not meet established thresholds and ensures files that meet established criteria are reviewed and approved by a medical director or designated physician, the Medical Director and network physician attendees are considered voting members. The Medical Director directs and coordinates the credentialing functions and facilitates and chairs the Credentialing Committee. Proactive steps are taken to prevent and monitor for discriminatory credentialing/re-credentialing. Policies are in place to ensure that participating practitioners are treated equitably and that any actions taken against a practitioner for quality reasons are reported to the appropriate authorities and the practitioner is offered a formal appeal process.

The QIUMC oversees the Credentialing Committee and is the vehicle through which credentialing monitoring and reporting mechanisms is communicated to The Board.

Credentialing reviews and verifies sanction, exclusion and/or complaint activity that might impact ability to provide safe, appropriate care to members on an ongoing basis during the intervals between formal re-verification of credentials. Exclusion from federal

procurement activities is noncompliant with minimum administrative requirements and results in exclusion from payment and for participating practitioners and providers, immediate termination of network participation. Incidences of poor quality of care are referred to the Quality Improvement Department so that important quality or safety issues may be identified and, when appropriate, acted on in a timely manner.

Wellcare may delegate responsibilities for credentialing activities, an evaluation of the delegate's capacity to perform the delegated activities is completed prior to implementation of the delegation. A delegation agreement signed by both parties clearly defines performance expectations, and the Health Plan retains accountability for the delegated services and monitors the performance of the delegate entity. Wellcare retains the right to reclaim the responsibility for performance of this function should standards not be maintained.

Pharmacy and Therapeutics

Wellcare provides access to quality, cost effective medications for eligible beneficiaries by maintaining a network of conveniently located pharmacies. An electronic adjudication system efficiently processes prescription drug claims at the point of dispensing to confirm eligibility, make drug and benefit coverage determinations,evaluate for patient safety, and adjudicate the claim with the appropriate pharmacy provider payment.

Network contracting and the adjudication of pharmacy claims are managed by Express Scripts Pharmacy, the pharmacy benefit manager (PBM). Pharmacy has oversight of the PBM for these functions. Pharmacy provides a Medicare prescription drug formulary. Pharmacy reviews and responds to all drug exception requests or coverage determinations (DERs) and medication appeals (redeterminations) through a formalized process that utilizes the drug formulary, prior authorization protocols, and prescriber supplied documentation. Emphasis is placed on the quality of care of members through Medication Therapy Management (MTM) services as well as quality initiatives, which include, but are not limited to, member and prescriber outreaches.

Pharmacy data, analysis, and interventions are reported to the Clinical Services Quality Committee (CSQC), Pharmacy and Therapeutics Committee, the QIUMC, and the Enterprise Quality Committee (EQC).

Preventive Health and Clinical Practice Guidelines

Wellcare, whenever possible, adopts preventive and clinical practice guidelines (CPGs) from recognized sources for the provision of acute, chronic, and behavioral health services relevant to the populations served. WellCare CPG process is governed by the Centene Corporate Clinical Policy Committee who also presents guidelines to the QIUMC for appropriate physician review and adoption. Guidelines are updated at least annually or upon significant new scientific evidence or changes in national standards.

Wellcare adopts clinical practice guidelines which are relevant to their population. Guidelines are based on the population's health needs and/or opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program. Wellcare also adopts applicable preventive health guidelines for perinatal care, care for children up to 24 months old, care for children 2–19 years old, care for adults 20–64 years old, and care for adults 65 years and older.

The Centene Corporate Clinical Policy Committee (CPC), is responsible for researching evidence-based guidelines. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based. Board-certified practitioners who will utilize the guidelines have the opportunity to review and give advice on the guidelines through the Corporate CPC and the National QIUMC. If guidelines from a recognized source cannot be found, Centene's CPC is consulted for assistance in guideline sourcing or development. Centene's QI/QM designee or clinical policy staff, update guidelines upon significant new scientific evidence or change in national standards and guidelines are reviewed by the Corporate CPC and the QIUMC at least annually.

All CPGs were reviewed and updated March 2022. New or updated guidelines are disseminated to providers via Wellcare's website, as well as the provider manual which includes a listing of adopted clinical practice and preventive health guidelines. Additional mechanisms to notify and distribute guidelines may include but are not limited to new practitioner orientation materials, provider and member/enrollee newsletters, member/enrollee handbook, and special mailings.

The CPG Grid is posted **www.wellcare.com/en/California/Providers/Clinical-Guidelines**. Mechanisms to notify and distribute guidelines may also include:

- New Provider orientation materials
- Provider and Member newsletters
- Member handbook

- Special mailings

Medical Record Review

Providers should maintain medical records that are comprehensive and reflect all aspects of care for each Member. These records are to be stored in a secure location for the period of time required under the Provider's network participation Agreement. Documentation in the Member's medical record is to be completed in a timely, legible, current, detailed and organized manner which conforms to good professional medical practice and in accordance with all applicable laws. Records should be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

Complete medical records include:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other health care professionals' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of service provided

Medical records must be signed and dated.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Wellcare or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to Wellcare upon request.

The Member's medical record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his or her medical record. Additional copies shall be made available to Members upon request and Providers may assess a reasonable cost.

Wellcare follows state and federal laws regarding the retention of records remaining under the care, custody and control of the physician or healthcare Provider. Information

from the medical records review may be used in the recredentialing process as well as quality activities.

Delegation Oversight

Delegation occurs when Wellcare engages another entity to perform administrative and/or clinical functions on behalf of the Plan. Functions that may be delegated include, without limitations: inpatient and outpatient authorizations, denials, concurrent reviews, care management, disease management, provider appeals, claims payment, credentialing, network development, customer service, billing, sales and marketing, enrollment, QI, and any portion of the overall functions listed. All entities are responsible for a compliance program and adequate information security.

While a function may be delegated to another entity, Wellcare retains overall accountability. Wellcare is responsible for ensuring the delegated entity's compliance with internal Plan standards and requirements, as well as federal, state and accreditation standards. Oversight activities include but are not limited to:

- Completing an annual formalized performance review and re-approving all applicable programs, including the entity's QIP.
- Evaluating the entity's ability to fulfill delegation obligations through review of the entity's programs, policies, procedures, and service delivery, including use and handling of protected health information and other applicable HIPAA privacy and security concerns prior to delegation.
- Ensure written agreements with each delegated entity that specify the activities to be delegated and those to be retained by the Plan, including data reporting standards.
- Imposing sanctions or revoking delegation if the entity's performance is inadequate
- Performing ongoing performance monitoring via review of submitted data reports and ensuring that corrective action is taken, in a timely manner, to address any opportunities for improvement identified.

The Delegation Oversight Committee (DOC) consists of corporate and Plan representation from quality, field health services, network management, analytics, operations, finance, and compliance.The committee meets regularly, and the minutes are approved by the QIUMC. Minutes are approved by the DOC chair andprovided to the applicable States or Medicare QIUMC for approval.

Independent Practice Associations (IPA) Performance Scorecard

As the health care industry in California continues to demand increased performance and value, Wellcare has improved our delegation program tools to include an enhanced IPA Performance Scorecard to evaluate IPAs in seven performance areas. Delegated IPAs are reviewed for performance measures including grievances, contractual financial requirements, delegated medical management, service and quality. The IPA scorecard brings these together in a 360-degree view of performance through an executive dashboard format, with the goal of helping ensure that delegated IPAs are meeting or exceeding standards. The resulting performance management system is governed by the Plan's delegation oversight process.

The IPA Performance Scorecard is used to:

- Ensure transparency in performance.
- Jointly identify opportunities to improve performance and commit to developing performance improvement plans that are regularly reviewed at joint operation meetings (JOMs) and regular meetings.
- Ensure performance exceeds minimum performance standards.
- Serve as a catalyst for corrective action and improvement plans.
- Align performance to performance standards, penalties and rewards outlined in IPA contracts.

Dissemination of scorecard results

IPAs will receive individualized scorecard results electronically on a quarterly basis via JOMs. Results, opportunities and actions are reviewed in JOMs and workgroups for IPAs with minimum membership thresholds.

Performance scoring

IPA performance is measured in seven key performance areas including quality, delegation oversight utilization management (UM), delegation oversight claims, risk adjustment, financial solvency, network and encounters. Multiple measures are compiled and calculated by performance area. Findings are weighted by membership to form the performance score, defined through the following scale:

- 80% or greater: Performing – meeting/exceeding performance targets.

- 50-79%: Monitoring – inconsistently meeting performance targets.
- Less than 50%: Below standard – consistently below performance targets.

Performance management

Continued low performance may result in a corrective action plan (CAP), with expectation of improvement within a specified time-period. If performance does not improve as expected and/or as agreed, an escalation process may be activated. If necessary, formal action may be taken, which may include, but is not limited to, the following:

- Request for formal corrective action.
- A reduction in capitation.
- A freeze on enrollment.
- Revocation of delegation.
- Contract termination.

All actions taken are subject to the terms of the IPA contract.

Performance areas

Performance Area	Metric	Definition	LOB	Cadence
Quality	Quality Score Avg Rate	Quality HEDIS® priority measures as compared to the existing, most available QC benchmarks by PPG. A score is attributed to each measure's performance against the benchmark, then an average of all scores is provided as the "Quality Score". To determine ranking of scores that can fall into each of the 5 performance categories; the Quality scores were ranked across all eligible PPGs by population of interest.	Commercial (Comm)/ Medi-Cal (MCL)/ Medicare (MCR)	Monthly
	CAHPS	CAHPS stands for Consumer Assessment of Healthcare Providers and Systems. It is a measure of member experience for Medicare providers.	MCR	Annual
Delegation Oversight - UM	Overall Compliance Rate	The utilization management PPG scorecard embodies an overall measurement of the PPG compliance rate based on their annual audit score and their turn around timeliness scores for authorization during the previous quarter.	Comm/MCL/MCR	Quarterly

Performance Area	Metric	Definition	LOB	Cadence
Delegation Oversight - Claims	% Claims paid within 30 Calendar days	Total count of all claims paid within reporting quarter and number of those claims processed timely.	MCL/MCR	Quarterly
	% Provider Dispute Resolution (PDR) Resolved within 45 Working days	Total count of all provider disputes processed within reporting quarter and number of those provider disputes processed timely.	Comm/MCL	Quarterly
	% Claims paid within 45 Working days	Total count of all claims paid within reporting quarter and number of those claims processed timely.	Comm	Quarterly
	% PDR Resolved within 30 Calendar days	Total count of all provider disputes processed within reporting quarter and number of those provider disputes processed timely.	MCR	Quarterly
Risk Adjustment	Build-up Risk Adjustment Factor (RAF)	Raw Risk Adjustment score based on all Encounters and Alternative Submission Method (ASM) received as of the data refresh date.	Comm/MCR	Monthly
	MWOV	Represents members without visits as of the data refresh date.	Comm/MCR	Monthly
	Recapture Rate	Represents the percent of suspected conditions captured by the data refresh date.	Comm/MCR	Monthly
Financial	Financial Solvency (blue book rating)	A solvency ratio is a key metric used to measure an PPG's ability to meet its debt and other obligations.	Comm/MCL/MCR	Monthly
Network	Access – Provider Appointment Availability Survey (PAAS)	Survey data collected to indicate the % availability of timely access to provider appointments.	Comm/MCL/MCR	Annual
	PTMPY Grievances	PTMPY (Per Thousand Members Per Year) rates are calculated using the total number of grievances, divided by total member months and multiplied by 12,000 (1,000 x 12 months).	Comm/MCL/MCR	Quarterly
	Annual Network Adequacy	Annual Subnetwork Certification for Medi-Cal. The Plan certifies delegated at-risk subnetworks to provide adequate access to members assigned to them based on a set of criteria required by DHCS for services they are at-risk for. Pass/Fail metric.	MCL	Annual
Encounters	Total PMPY	This is a measurement of the Per Member Per Year Visits received in Encounters.	Comm/MCL/MCR	Annual
	Timeliness 0-60 Days	Shows the percent of Encounters received up to 60 Days from the date of service.	Comm/MCL/MCR	Quarterly

Cultural Competency

Wellcare recognizes that culture is formed through the combined pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated with racial, ethnic, or linguistic groups. In addition, Wellcare understands that religious, spiritual, biological, geographical, and sociological characteristics all serve as part of one's culture. Individuals may identify wholly or partially with one or more groups and may change over time. Wellcare acknowledges the diversity and specific cultural needs of its members and supports a culturally competent healthcare system that can improve health outcomes and quality of care as well as contribute to the elimination of racial, ethnic, and cultural disparities associated with low-income status, disabilities, ethnic/racial/cultural minority groups, non-English speaking members, and low literacy, among other things.

Wellcare is committed to performance according to the collective set of Culturally and Linguistically Appropriate Services (CLAS) issued by the U.S. Department of Health and Human Services Office of Minority Health. Centene associates are the first line of culturally competent care. A diverse workforce and network of providers are key to best serving members. Wellcare encourages associates to be involved and volunteer in their communities.Internally, Wellcare celebrates and supports employees from diverse backgrounds through Employee Inclusion Groups. Other objectives that have been implemented to facilitate cultural and linguistic needs include:

- Acknowledgement and recognition of the effect of culture on perception and needs.
- Delivering culturally appropriate communications and services for members and their caregivers in their primary languages through a language translation line at no cost to those members with limited English proficiency.
- Using text telephone/telecommunication device (TTY/TDD) for members with hearing loss.
- Utilizing the Community Connections Help Line that performs social needs assessments and provides members with referrals to a robust social services network.
- Ensuring the network includes a diverse array of providers and support services that value diversity and are committed to serving minorities.
- Partnering with providers to strengthen their sensitivity to cultural diversity.

- Addressing healthcare disparities by leveraging Wellcare's community connections to help remove social barriers to the members served.
- Providing mandatory, annual cultural competency training for every associate, contractor, and vendor.
- Creating an inclusive environment for associates where differences are valued, and everyone can contribute to their fullest potential.
- Offering every associate paid community impact time so they can earn a deeper appreciation of the diverse needs of members.
- Using language that is relatable and easy to understand in communications to members and their caregivers so they can make the best decisions concerning their health and health care.
- Making assistive tools and technologies for disabled associates and members available.
- Ensuring prejudice is removed from policies and practices.
- Hiring and retaining bilingual staff.
- Providing member-related materials, including conflict and grievance resolution instructions, in languages of commonly encountered membership groups.
- Continually assessing the cultural, ethnic, racial, and linguistic needs of members and identifying opportunities to pursue and improve provider network composition.
- Implementing strategies to recruit and retain a diverse provider network that meets the cultural needs of the membership.
- Reviewing and analyzing complaints, grievances, and appeals for issues identified by members or other community stakeholders related to the design of activities and initiatives to meet the cultural needs of the population.
- Complying with Section 504 of the Rehabilitation Act of 1973, the Office for Civil Rights at Healthand Human Services, and Title II of the Americans with Disabilities Act.

The organization continually assesses its ability to meet the diverse needs of its members, providers, and staff. Cultural competency training is made available via Centene University for all staff members. The training program identifies methods utilized to ensure members' preferences, needs, and values are addressed in a manner that is free from discrimination. The Organization analyzes data on populations served in each market for the purpose of learning their cultural and/or linguistic needs, as well as any health disparities they may be challenged with. Data sources and analysis methods include but are not limited to:

- State-supplied data for Medicaid and State Children's Health Insurance program (SCHIP) populations.
- Demographic data available from enrollment files and the U.S. Census and studies conducted locally.
- Claims and encounter data.
- Member requests for assistance, complaints, and grievances.

Requests to Disenroll a Member

The IPA must provide specific documentation and information to support its request, pursuant to what is outlined in the Medicare Managed Care Manual.

Disenrollment may only be requested if a Member's behavior is disruptive to the extent that his/her continued enrollment substantially impairs the organizations ability to arrange for or provide service to either that particular Member or other Members. A Member may not be disenrolled because:

- Wellcare shall adhere to CMS guidelines when an IPA requests to disenroll a Member.
- The Member exercises the option to make treatment decisions with which the IPA or Wellcare disagrees, including the option of no treatment and/or no diagnostic testing
- The Member chooses not to comply with any treatment regimen developed

Disenrollment for disruptive behavior requires three written notices:

- Advance notice to inform the Member that the consequences of continued disruptive behavior will be disenrollment
- Notice of intent to request CMS permission to disenroll the Member
- A planned action notice advising that CMS has approved the request

If the Member's disruptive behavior continues despite the IPAs efforts, then the IPA must notify the Member of its intent to request CMS permission for disenrollment. This notice must also advise the Member of their right to use the grievance process to submit any information or explanation.

Before requesting CMS approval, the IPA must make a serious effort to resolve the problems. Such efforts include providing reasonable accommodations, as determined by

CMS, for individuals with mental or cognitive conditions, including mental illness and development disabilities.

The IPA must submit to Wellcare documentation of the specific case to include:

- The disruptive behavior
- The IPA's efforts to resolve the problem with the Member
- The IPA's efforts to provide reasonable accommodations for individuals with disabilities, or applicable in accordance with the Americans with Disabilities Act
- Establishing the Member's behavior is not related to the use, or lack of use, of medical services
- Describing any extenuating circumstances cited under 42 CRR §422.74 (d)(2)(iii)
- That the IPA provided the Member with appropriate written notice of the consequences of continued disruptive behavior
- That the IPA provided written notice of its intent to request involuntary disenrollment

The Wellcare Compliance Department will review each IPA request to disenroll a Member and retains the right to make final determination to deem the case warranted and appropriate for submission to CMS.

(Medicare Managed Care Manual, Chapter 2 – Enrollment and Disenrollment)

Section 11: Medicare Star Ratings

Overview – Star Ratings

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the healthcare system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

The ratings are posted on the CMS consumer website, **www.medicare.gov**, to help beneficiaries when choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize providers for demonstrating an increase in performance measures over a defined period of time.

CMS's Star Rating Program is based on measures in 9 different domains

Part C

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long-term) conditions
3. Member experience with the health plan
4. Member complaints, problems getting services and improvement in the health plan's performance
5. Health plan customer service

Part D

6. Drug Plan Customer Service
7. Member Complaints and Changes in the Drug Plan's Performance
8. Member Experience with the Drug Plan
9. Drug Safety and Accuracy of Drug Pricing

How Can Providers Help to improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or as recommended including but not limited to:
    - Breast and/or Colon Cancer Screening
    - Annual Flu Vaccine
- Continue to monitor and assess the health and well-being of patients with known chronic conditions including but not limited to:
    - Diabetes Care
    - Retinal Eye Exam
    - Routine monitoring to ensure HbA1c control (<9)
    - Ensure Members remain adherent to their diabetic medications and receive necessary statin therapy
    - Controlling High Blood Pressure (<140/90)
    - Ensure Members remain adherent to their hypertension medications (RAS antagonists)
    - Statin Therapy for patients with cardiovascular disease
    - Ensure Members remain adherent to their cholesterol medications (statin therapy)
- Timely Osteoporosis Management for women who have had a fracture through one of the following (within six months of the fracture):
    - Bone mineral density test
    - Medication therapy to treat osteoporosis
- Continue to talk to your patients and document interventions regarding topics such as: improving or maintaining their mental and physical health; issues with bladder control and fall prevention
- Create office practices to identify noncompliant patients at the time of their appointment
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all Members

- Review the gap in care files listing Members with open gaps which is available on our secure portal
- Follow up with patients within 14 days post hospitalization; complete post hospitalization medication reconciliation
- Identify opportunities for you or your office to have an impact on Member gaps in care

Healthcare Effectiveness Data and Information Set

HEDIS is a set of standardized performance measures developed by NCQA. CMS utilizes HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its Members.

As federal and state governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual Provider.

HEDIS Rate Calculations

HEDIS rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include Breast Cancer Screening (routine mammography), and use of Disease Modifying Anti-Rheumatic Drugs for Members with Rheumatoid Arthritis, Osteoporosis Management in Women Who Had a Fracture, Access to PCP Services, and Utilization of Acute and Mental Health Services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT II, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include: Comprehensive Diabetes Care (screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressures), Colorectal Cancer Screening (colonoscopy, sigmoidoscopy, FOBT, CT, colonography, or FIT-DNA test). Medication Review Post Hospitalization and Controlling Blood Pressure (blood pressure results <140/90 for Members with high blood pressure).

Who conducts Medical Record Reviews (MRR) for HEDIS?

Wellcare may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS can occur anytime throughout the year but are usually conducted March through May each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare that allows them to collect PHI on our behalf.

How can Providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Wellcare. Claims and encounter data is the most efficient way to report HEDIS.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each Member service and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.
- If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement Department.

Consumer Assessment of Healthcare Provider Systems (CAHPS®) Survey

The CAHPS survey is a Member satisfaction survey that is included as a part of the Star rating system. It is a standardized survey administered annually to Members by CMS certified survey vendor. The survey provides information on the experiences of Members with health plan and practitioner services and gives a general indication of how well practitioners and the plan is meeting the Members' expectations. Member responses to the CAHPS survey are used in various aspects of the Star rating program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the Member received an annual flu vaccine
- Whether Members perceive they are getting needed care, tests, or treatment needed including specialist appointments and prescriptions
- Whether the Member's personal doctor's office followed up to give the Member test results
- Appointment availability and appointment wait times
- Whether the Member's personal doctor is informed and up to date on care received from specialist

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in the Medicare Star rating program. The goal of the Medicare HOS is to gather data to help target quality improvement.

The HOS assesses practitioners and Medicare Advantage Organization's (MAO) ability to maintain or improve the physical and mental health of its Medicare Members over time. Wellcare HOS questions that may reflect on the service of providers includes:

- Whether the Member perceives their physical or mental health is maintained or improving
- Look for opportunities to discuss and address concerns regarding the following:
    - Mobility: Address potential needs for assistive devices

- Physical Activity: Discuss starting, increasing, or maintaining patients' level of physical activity
- Mental Health: Address social interactions and other Behavioral Health needs that may require further follow-up if provider has discussed fall risks and bladder control with the Member by considering the following:
    - Fall Risk Prevention: Educate patients on fall risk prevention by addressing any needs for assistive devices and reviewing any potential high-risk medications that could increase their fall risk o
    - Bladder Control: Assess the need for bladder control education and potential treatment

The goal of Star ratings is to improve the quality of care and general health status for Medicare beneficiaries and support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other Providers. Wellcare supports these goals, and the organization strives for the highest rating of 5 stars in all domains. The Quality Improvement Committee receives Star rating results annually.

Section 12: Care/Case Management

IPAs may be delegated for Care/Case Management functions related to all Wellcare Members or just one benefit plan (Medicare Advantage or Dual Eligible SNP) within Wellcare. The Care Management Program Requirements and Delegation Activities grid is available in Section 15: Attachments to reference Care Management responsibilities of an IPA.

Access to Care and Disease Management Programs

To refer a Wellcare Member as a potential candidate to the Care Management or Disease Management Programs, or to receive more information about either of these programs, Providers may call the Wellcare Care Management Referral Line, or complete and fax a request to the number on the Quick Reference Guide. Members may self-refer by calling the Care Management toll-free line or the Nurse Advice Line after hours or on weekends (TTY available).

For more information on the Care Management Referral Line, refer to the Quick Reference Guide on Wellcare's website at **www.wellcare.com/en/California/Providers/Medicare**.

Care/Case Management Program

Care Management provides comprehensive and complex Care Management services targeting Members in need of social support and medically complex services. Candidates for Care Management may include all Members with complex or chronic conditions, Members with ESRD, and Members who are frail, disabled or near the end of life.

Wellcare Care Management is Member-centric, dedicated to providing coordination and support services for acute and preventive care; it may or may not lower the cost of care. Care Management is a multi-disciplinary program designed to respond to the needs of Wellcare Members across the continuum of care. Program components include providing coordination through episodic Care Management, including management across care transitions that include timely follow-up post hospitalization, emergency department (ED) visits, stays in other institutional settings, movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another, symptom

and disease management, medication reconciliation and management, and support for exacerbations of chronic illness.

Complex Care Management is the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.

The goal of Care Management is to help Members regain optimum health and to optimize care transitions from one care setting to the next, resulting in improved functional capability in the right setting. It involves the comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of an individualized Care Management plan with performance goals, monitoring and follow-up.

To refer a participant for complex case management:

- Call: **866-999-3945**
- Online: **www.wellcare.com/California**

SNP Model of Care – Care Management

The Special Needs Plan (SNP) Model of Care is the architecture for Care Management policy, procedures and operational systems for special needs plans. The Model of Care (MOC) is a vital quality improvement tool and integral component for ensuring that the unique needs of each SNP member are identified and addressed through the plan's care management practices. Members that are eligible for enrollment into the SNP Care Management program have the right to opt out of the program.

Model of Care elements include:

- Description of the SNP population and supplemental services available for the most vulnerable members.
- Care coordination and care transitions protocols:
    - Health Risk Assessment (HRA) – Every SNP member is outreached to complete a Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently if needed based on the member's needs. The HRA collects information about the member's medical, psychosocial, cognitive, and functional needs, and behavioral

health history. The results of the HRA are used to develop the individualized care plan

- Individualized care plan (ICP) – Every SNP member receives an ICP that includes goals and objectives, specific services and benefits to be provided, and has measurable outcomes. The ICP should be reviewed and revised annually or when the Member's health status changes.
- Interdisciplinary care team (ICT) – Each SNP Member must be assigned to an ICT. The team develops and annually updates an ICT, and manages the medical, cognitive, psychosocial, and functional needs of the Members. ICPs are shared with members of the ICT in an effort to provide feedback and promote collaboration regarding the Member's goals and current health status. The core members of the ICT are the member, caregivers and PCP. For members enrolled in care management, the Care Manager is also a part of the core ICT and serves as a primary point of contact for members and providers.
- Face-to-face encounter – Wellcare ensures that SNP Members are provided a face-to-face encounter either in person or virtually within the first twelve (12) months of their enrollment and annually thereafter. The face-to-face encounter is completed for the purpose of delivering health care, care management or care coordination services and can be completed with a treating provider on the member's interdisciplinary care team or with Wellcare care management/care coordination staff. Members who cannot be seen by their treating providers within a twelve (12) month period, either in-person or virtually, should contact Wellcare to schedule a virtual appointment at 855-538-0454.
- Transitions of care – When a SNP Member moves from one setting to another, Wellcare facilitates transitions through communication and coordination with the Member and their usual practitioner. During this communication with the Member, any changes to the Member's health status and any resulting changes to the care plan are discussed. The Member's usual Provider will be notified of the transition and will communicate any needs to assist with a smoother transition process.

- Provider network having special expertise and use of Clinical Practice Guidelines – Network facilities include, but are not limited to, labs and radiology facilities. Provider network includes, but is not limited to, medical specialists, Behavioral Health specialists and allied health professionals. The Provider network functions include collaboration with the interdisciplinary care team, provision of clinical consultation, and assistance with developing and updating the individualized care plan.

Providers can refer to the table below for an outline of responsibilities by Wellcare, the IPA and for those that are shared between both.

Wellcare (Health Plan)	Shared Responsibilities	IPA
• Outreach of members identified for Care Management as post discharge and/or high priority based on provider notifications and/or internally derived algorithms • Conduct assessments with members • Create member-centric and member approved individualized care plans (ICP) • ICP creation/revisions (and related outreach) • Provider collaboration as a member of the interdisciplinary care team (ICT) • Coordinate/collaborate with the ICT team based on member risk/acuity/needs • Facilitate ICT/ interdisciplinary care team (IDCT) meetings (and related outreach) as needed • Coordination of care • Assist with referrals to community-based resources for social determinants of health (SDoH) needs • Assist with access to benefits to address member identified needs • Address gaps in care	• Coordination or referral for services, as needed • Support managing chronic conditions to reduce hospitalizations	• Timely notification of admissions, transfers, or discharges to/from facilities to the Plan if the IPA is responsible for prior authorizations/claims • Authorize all needed services where the provider group is/remains delegated for utilization management, if applicable • Communicate with Wellcare Case Management, as needed, to exchange information and ensure smooth transitions • Participation on ICT/IDCT, if invited • Facility timely post-discharge appointments to PCP and or specialist, document efforts • Conduct care coordination on patient population based on need. • Refer high risk/catastrophic members to Wellcare for case management, if applicable • Coordinate activities with Wellcare case managers and ancillary providers as indicated

Quality Improvement Program – Wellcare has a quality improvement program that evaluates the effectiveness of the MOC program through the identification of objective, measurable, and population-specific quality indicators. Goals are set to ensure quality of care is delivered and optimal health outcomes are achieved.
SNP Model of Care goals include:

- Improve access to medical, mental health and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and Providers
- Improve access to preventive health services
- Ensure appropriate utilization of services
- Ensure cost-effective service delivery
- Improve beneficiary health outcomes
    - Reduce hospitalization and SNF placements
    - Improve self-management and independence
    - Improve mobility and functional status
    - Improve pain management
    - Improve quality of life as self-reported
    - Improve satisfaction with health status and health services

Both participating and non-participating providers that routinely treat SNP members are required to complete MOC training annually. Wellcare offers an online training printable self-study training guide which can be found at **https://www.wellcare.com/Providers/Model%20of%20Care%20Notice.** Providers who would like a copy mailed at no cost can contact Customer Service or their Provider Relations representative.

Practitioners are expected to help Wellcare and IPA Providers coordinate the submission of Member care plans through care transitions from one setting of care to another. Providers and practitioners may use the Wellcare Individualized Care Plan (ICP) or submit appropriate care planning to the receiving setting. NCQA/CMS identifies a care plan as a "set of information about the patient that facilitates communication,

collaboration and continuity of care across settings when Members experience transitions." The care plan may contain and is not limited to medical or non-medical information (e.g., current problem list, medication regiment, advance directive, allergies).

Health Risk Assessment

The HRA assesses member-risk in the following areas: functional, psychosocial, behavioral, cognitive, and medical. Once completed, the HRA is stratified into a risk level. The risk level of the HRA is an indicator of the needs of the Member. Wellcare uses three risk levels: low, moderate, and high. Members identified for enrollment into the care management program have their HRA systematically reviewed by a care manager and also complete a comprehensive needs assessment.

The HRA is a questionnaire that assesses a member's current health and functional status; diseases they have been diagnosed with; medications required to control their disease and access to healthcare services. Completion of the HRA is voluntary, but strongly recommended.

Once completed, the HRA is stratified as either low, moderate, or high. Members identified for enrollment into the care management program have their HRA systematically reviewed by a care manager and also complete a comprehensive needs assessment. Based on the member's HRA responses, ICP is developed and shared with the Member, PCP and Interdisciplinary Care Team (ICT).

IPA Reporting Requirements

Care Management activities specific to Wellcare Members are required to be reported on a daily and monthly basis. The following table indicates the reporting requirements and due dates.

DATE	REPORT
MONTHLY (Due by the 10th)	• Care Management Log Please use the IPA Reporting Templates found under Section 15: Attachments of this manual if your organization cannot produce a report with the required fields.

DATE	REPORT
	If you have none to report, please submit the applicable Attestation Form also available under the IPA Reporting Templates in Section 15: Attachments. Please do not submit blank reports.

As reports are received, they are reviewed for the correct data elements and/or an Attestation Form in lieu of a report where there is no data. Reports with missing data elements are returned to the IPA with a request for a corrected report. Wellcare uses the date that a valid report is received as the receipt date.

Initial and Annual Health Assessment

When the IPA is delegated for care management, Wellcare requires contracted Providers to ensure that the Initial Health Assessment (IHA) is completed within the required 90-day timeframe and then perform an Annual Health Assessment. A reassessment of the Member's healthcare needs is performed annually and when the Member's health status changes.

Wellcare provides monthly eligibility files to the PCPs, and it is the responsibility of the PCP to contact all new Members to set an appointment for the IHA within 90 days of enrollment and to keep detailed notes regarding attempts, successes and failures to contact Members for the purpose of the IHA. The PCP shall make a minimum of three attempts to contact the Member to set an appointment. A missed appointment letter should be sent if the Member fails to keep their appointment for the IHA. Wellcare also provides a list of Members not seen in the calendar year. The PCP shall make attempts to contact Member and schedule an appointment to perform the Annual Health Assessment.

The Initial Annual Health Assessment should include a comprehensive history and physical examination, including an initial preventive medical evaluation, as well as the preventive health requirements delineated in the *Guide to Preventive Services, a Report of the U.S. Preventive Services Task Force*. These include a complete history and physical examination including inspection of ears, nose, mouth, throat, teeth and gums, blood pressure, cholesterol testing, clinical breast exam, Pap smear and mammogram, prostate exam, immunizations as appropriate and health education. In addition, Providers should perform medication review/reconciliation and review Advance Directive with each Member.

The PCP should document the IHA Annual Health Assessment in the Member's medical Annual Health Assessment record. The PCP maintains documentation of any follow-up necessary as a result of the IHA, including diagnosis and plans for treatment for any disease.

If the IPA is not delegated for Care Management or assistance is required in managing a highly complex Member, the PCP shall refer Members to the Wellcare Population Health Clinical Operations Department. Those Members who are determined to be at high risk for medical or social problems, a care manager performs a comprehensive assessment and develop a care plan that includes informing the Member of preventive measures and self-care recommendations.

Results of the tracking of IHAs may be subject to review at the time of the annual audit and may be reported to the Wellcare Quality Improvement Committee (QIC).

Section 13: Credentialing and Re-Credentialing

Credentialing and Re-Credentialing

Credentialing of physicians and healthcare professionals is delegated by Wellcare to the IPAs. Each IPA is expected to credential and re-credential all physicians and other healthcare professionals within their network who provide services to Wellcare Members. Credentialing and re-credentialing processes are to be developed in alignment with NCQA and CMS guidelines.

In addition to physicians and other healthcare professionals, pursuant to CMS guidelines, credentialing is required for the following types of Providers:

- Hospitals
- Home health agencies
- Hospices
- Clinical laboratories
- Skilled nursing facilities
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Ambulatory Surgery Centers (ASCs)
- Providers of end stage renal disease services
- Provider of outpatient diabetes self-management training
- Portable X-ray suppliers
- Rural Health Clinic (RHCs) and Federally Qualified Health Center (FQHCs)

Wellcare credentials the above types of Providers when a direct contract with the plan exists. However, if any of the above types of Providers are contracted with an IPA and are reimbursed by the IPA for services rendered to Wellcare Members, the IPA is also required to ensure that the Provider has been credentialed.

(Medicare Managed Care Manual, Chapter 6 – Relationships with Providers. Section 70)

Initial Credentialing

Procedures for initial credentialing involve a written application, verification of information from primary and secondary sources, confirmation of eligibility for payment under Medicare, and site visits as appropriate.

Verification of information from primary and secondary sources includes, but is not limited to:

- Current valid license to practice
- Education and training
- Board certification
- Clinical privileges
- Current adequate malpractice insurance
- Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate
- History of professional liability claims
- Information from the National Practitioner Data Bank (NPDB)
- Information from the National Plan and Provider Enumeration System (NPPES/NPI)
- Information regarding sanctions or limitation on licensure
- Results from exclusion screening, i.e., OIG, GSA/SAM
- Medicare Opt Out
- Results from screening of the Social Security Death Master File (SSDMF) Results from Preclusion List checks

(Medicare Managed Care Manual, Chapter 6 – Relationships with Providers. Section 60.3)

Re-Credentialing

Re-credentialing is to take place at least every three years. Procedures for re-credentialing include obtaining updates from information obtained during initial credentialing, in addition to performance indicators and such other requirements set forth in the IPA's Provider Agreement.

(Medicare Managed Care Manual, Chapter 6 – Relationships with Providers. Sections 60.3)

IPA Reporting Requirements

The Delegation Oversight Quarterly Credentialing Scorecard must be submitted to Wellcare on a quarterly basis submitted via FTP in folder "Delegation Reports."

As the report is received, it will be reviewed to ensure correct data elements have been submitted. Reports with missing data elements will be returned to the IPA with a request for a corrected report. Wellcare will use the date that a valid report is received as the receipt date.

Compliance with report submissions is reported to Wellcare, which in turn reports this information to the Wellcare Delegation Oversight Committee (DOC) on a quarterly basis.

Practitioner Rights

Practitioner Rights are listed below and are included in the application/re-application cover letter.

Practitioner's Right to Be Informed of Credentialing/Recredentialing Application Status

Written requests for information may be emailed to **credentialinginquiries@wellcare.com**. Upon receipt of a written request, Wellcare will provide written information to the practitioner on the status of the credentialing/recredentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

Practitioner's Right to Review Information Submitted in Support of Credentialing/ Re-credentialing Application

All practitioners participating within the Wellcare network have the right to review information obtained by Wellcare that is used to evaluate their credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source, such as the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, malpractice insurance carriers, and state licensing agencies. A practitioner is not allowed however to review peer review-protected information such as references, personal recommendations, or other information.

The practitioner may review documentation submitted by him or her in support of the credentialing or recredentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and

certification boards, subject to any Wellcare restrictions. Wellcare, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or recredentialing.

The Provider may not review peer-review information obtained by Wellcare.

Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Wellcare, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. Wellcare will provide written notification to the practitioner of the discrepant information.

Wellcare's written notification to the practitioner will include:

- The nature of the discrepant information
- The process for correcting the erroneous information submitted by another source
- The format for submitting corrections
- The timeframe for submitting the corrections
- The addressee in the Credentialing Department to whom corrections must be sent
- Wellcare's documentation process for receiving the correction information from the Provider
- Wellcare's review process

Section 14: Behavioral Health

Overview

Behavioral Health authorizations shall be made by the IPA unless otherwise specified in the in the Wellcare Provider Agreement. The following Behavioral Health services may be covered:

- Psychiatric diagnostic interviews
- Individual psychotherapy
- Interactive psychotherapy
- Family psychotherapy (with the patient present and the primary purpose is treatment of the individual's condition)
- Family psychotherapy (without the patient present, is medically reasonable and necessary, and the primary purpose is treatment of the individual's condition)
- Group psychotherapy
- Psychoanalysis
- Pharmacologic management
- Electroconvulsive therapy (ECT)
- Diagnostic psychological and neuropsychological tests
- Hypnotherapy
- Biofeedback therapy
- Individualized activity therapy (as part of a Partial Hospitalization Program [PHP] and that is not primarily recreational or diversionary)
- Screening for depression (The Centers for Medicare & Medicaid Services [CMS] may cover annual screening up to 15 minutes for Medicare patients when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. At a minimum level, staff-assisted supports consist of clinical staff [for example, nurses and physician assistants] in the primary care setting who can advise the physician of screening results and facilitate and coordinate referrals to mental health treatment.)

Behavioral Health Oversight and Partnership Program (BHOP)

Wellcare provides Behavioral Health and chemical dependency services in accordance with CMS standards and regulations. Wellcare operates on a delegated model of managed care. Wellcare and its delegates (First Tier and downstream entities) agree to comply with the Medicare laws, regulations, and CMS instructions. Behavioral Health and chemical dependency benefits and services have been fully delegated to the respective First Tier Entities unless otherwise specified in the Wellcare Provider Agreement.

The purpose of the Behavioral Health Oversight and Partnership (BHOP) program is to systematically monitor and evaluate the provision (delivery) of behavioral healthcare services and the impact of these services on Member outcomes, Member experience and total medical expense (TME). Wellcare uses data analysis to develop metrics and interventions designed to improve Member care and services. The BHOP program implements oversight, joint operations, clinical collaboration and reporting cadences with its delegates on an at least quarterly basis. This program is designed to hold delegates and their downstream entities accountable, and to ensure partnership for the execution of our Behavioral Health mission, vision, goals, metrics and products.

The BHOP mission is to facilitate the provision of whole person care to our Members in a supportive and integrated model of care. BHOP supports the Institute for Healthcare Improvement's Triple Aim objectives, which include:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of healthcare

Wellcare is NCQA accredited and strives to ensure that the quality of Behavioral Health services meet or exceed NCQA standards. Objectives and measures are developed based on data analyses of, among other things, claims, encounters, pharmacy, authorizations, triage and timeliness reports, appeals, denials, complaints, grievances, Member and Provider satisfaction surveying, and joint operation committee meetings. Quantitative and qualitative analyses of objectives, measures and performance against NCQA standards and HEDIS metrics as well as opportunities and actions for improvement are conducted quarterly and reported to respective MSO and IPAs for planning and intervention.

Behavioral Health Performance Metrics and Benchmarks (subject to change annually)

Utilization Management Data		
UM Data	Metrics	Target
	Behavioral Health Beddays per 1000	LOB-Specific
	Behavioral Health Average Length of Stay	≤ 6.7
	Behavioral Health 7-Day Readmission Rate	≤ 10.10%
	Behavioral Health 30-Day Readmission Rate	< 23.50%
Performance Metrics	Aggregate Metrics: Meet or exceed national 90th percentile as published in Annual Quality Compass NCQA for BH Measures (AMM, FUH) and other measures related to coordination of care between medical and Behavioral Health Providers for designated IPA's only	
	Respective IPA metrics established in JOC's or as needed collaborative meetings	
	Respective IPA's to score at least 90% on BH Oversight Tool (not initiated for current year)	
	Achieve and maintain "Excellent" NCQA accreditation	
	Increase Member and Provider experience composite scores for Getting Needed Care and Utilization and Quality Management by 5%	

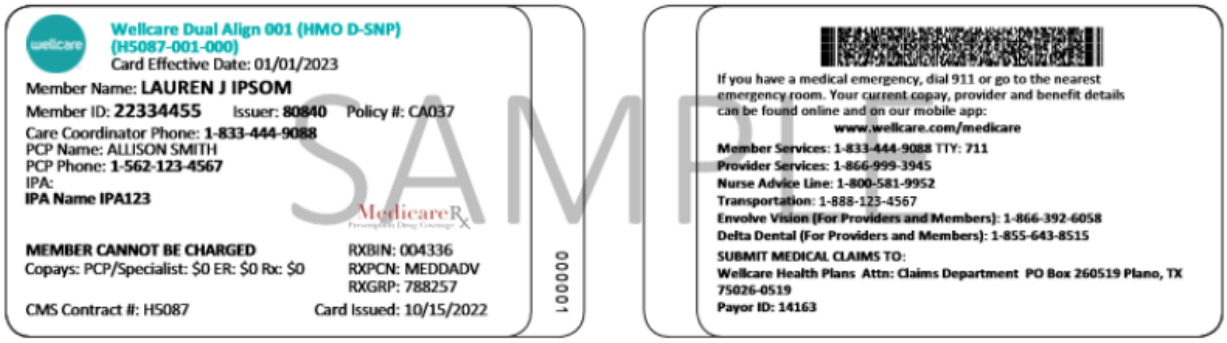
Opioid Program

Wellcare has sponsored and created a comprehensive Opioid Program for Medicaid and Medicare Members who are at risk of or currently over-utilizing opioid medications. The goal of the program is to improve health outcomes by reducing the risk of opioid misuse, dependence and overdose through promotion of appropriate healthcare resource and medication utilization. Wellcare's Opioid Program includes such interventions as pharmacy Care Management for Members in the Opioid Drug Management Program, and Care Management for Members with low back pain receiving a high number of opioid prescriptions, or who have been proactively identified as being at high risk of opioid misuse. Wellcare invites our Providers to work collaboratively with this program to minimize inappropriate opioid prescribing, provide responses to plan outreach, and refer beneficiaries to appropriate treatment as

necessary. For more information about Wellcare's Opioid Program, visit the provider portal at **https://provider.wellcare.com/**.

Section 15: Attachments

Member ID Card Sample



These are sample ID cards only. The information included in them is subject to change. Providers should refer to a member's ID card when they present for services for current benefit and health plan information.

Member Rights and Responsibilities

SECTION 1 Our plan must honor your rights as a Member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are on the front cover).

Our plan has people and translation services available to answer questions from non-English speaking Members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at **800-MEDICARE** (**800-633-4227**), 24 hours a day, seven days a week, and tell them that you want to file a complaint. TTY users call **877-486-2048**.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **800-368-1019** (TTY **800-537-7697**) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your Covered Services and drugs

As a Member of our plan, you have the right to choose a PCP in the plan's network to provide and arrange for your Covered Services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan Member, you have the right to get appointments and Covered Services from the plan's network of Providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 of this booklet tells what you can do.

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a Member of our plan through Medicare, we must give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are on the cover of this booklet).

Section 1.5 We must give you information about the plan, its network of Providers and your Covered Services

As a Member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are on the cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by Members and the plan's performance ratings, including how it has been rated by plan Members and how it compares to other Medicare Advantage health plans.

- **Information about our network Providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the Providers and pharmacies in our network and how we pay the Providers in our network.
    - For a list of the Providers in the plan's network, see the *Provider Directory.*
    - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
    - For more detailed information about our Providers or pharmacies, you can call Customer Service (phone numbers are on the cover of this booklet) or visit our website at **www.wellcare.com/california**.
- **Information about your coverage and rules you must follow in using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
    - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network Provider or pharmacy.
    - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
    - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your healthcare

You have the right to get full information from your doctors and other healthcare Providers when you go for medical care. Your Providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your healthcare. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help Members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a Provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for healthcare** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the California Department of Health Services by phone at **800-236-9749** or by mail at:

California Department of Health Services
Licensing and Certification Division
P.O. Box 997413
Sacramento, CA 95899-1413

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your Covered Services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other Members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are on the cover of this booklet).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at **800-368-1019** or TTY **800-537-7697**, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2 Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website (**www.medicare.gov**) to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call **800-MEDICARE** (**800-633-4227**) 24 hours a day, 7 days a week. TTY users should call **877-486-2048**.

SECTION 2 You have some responsibilities as a Member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a Member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are on the cover of this booklet). We're here to help.

- **Get familiar with your Covered Services and the rules you must follow to get these Covered Services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your Covered Services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- **If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us.** Please call Customer Service to let us know.
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your Covered Services from our plan. This is called **coordination of benefits** because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.

- **Tell your doctor and other healthcare Providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other Providers help you by giving them information, asking questions, and following through on your care.**

    - To help your doctors and other health Providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - If you have any questions, be sure to ask. Your doctors and other healthcare Providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.**

    - We expect all our Members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan Member, you are responsible for these payments:
    - You must pay your plan premiums to continue being a Member of our plan.
    - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total

cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are on the cover of this booklet).

    - **If you move outside of our plan service area, you cannot remain a Member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
    - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have to improve our plan.

    - Phone numbers and calling hours for Customer Service are on the cover of this booklet.

For more information on how to reach us, including our mailing address, please see Chapter 2.

[Please Note: This section came from the Wellcare 2017 *Evidence of Coverage*. Please refer to this document for additional information.]

Wellcare Monthly Capitation Detail Data File

Wellcare CA Eligibility file

	Field Name	Notes	Max Length	Note
1	Member Last Name		50	
2	Member First Name		50	
3	Member Middle Name		50	
4	Member Gender	M: Male, F: Female	1	
5	Member DOB	YYYYMMDD	8	
6	Status	01: Active, 04:PreEnroll, 05: Retro Enroll/Reinstatement 06: Retro Cancel/Disenroll 08: Disenrolled, 09: Cancelled, 07: Termed	2	
7	Member No	Wellcare Member ID	15	The ID can be 10 or 8 or 6 Digits
8	MBI	Member Beneficiary Identifier (MBI) i.e. 1EG4TE5MK72	15	
9	Member Effective Date	Effective with ECHP	10	
10	Member Term Date	Term with ECHP	10	
11	Product Code	"MCR" = Medicare	3	
12	PBPID (Plan Code)	Plan Benefit Package ID	3	* See note below
13	Group Number		3	
14	Wellcare Plan Code	H5087	5	
15	Office Visit Copay		10	
16	DME Benefit		10	
17	ER Benefit		10	
18	Provider ID	Wellcare Assigned provider ID	15	
19	Provider Effective Date	YYYYMMDD	8	
20	Provider Term Date	YYYYMMDD	8	
21	Provider First Name		75	
22	Provider Last Name		75	
23	Medicaid indicator		1	
24	CINNum		15	
25	Mem Address1		75	
26	Mem Address2		50	
27	Mem City		50	
28	Mem State		2	
29	Mem Zip Code	999999999	10	
30	Mem Home Phone	9999999999	10	
31	Mem County	County Name	50	
32	Mem Language	Language Name	50	
33	IPA Eff Date	YYYYMMDD	8	
34	IPA Term Date	YYYYMMDD	8	
35	PBP Eff Date	YYYYMMDD	8	
36	PBP TermDate	YYYYMMDD	8	
37	PCP NPI No		10	
38	Mem Mobile Phone	9999999999	10	new field in Dec 2020
39	Mem Alternate Phone 1	9999999999	10	new field in Dec 2020
40	Mem Alternate Phone 2	9999999999 (Phone from CVS)	10	new field in Dec 2020
41	ESRD Flag		1	new field in Dec 2020

**** For PBP 001 which is our Exclusively Aligned DSNP program for LA County, starting 1/1/23 Health Net will be the Medi-Cal carrier (Payor ID 95567). Please submit all COB/secondary claims to Health Net.***

*****Please note that this Eligibility file is an accumulative file (full file), if the member records in your system cannot be found in the file provided, please perform TBA (Term By Absent)***

Wellcare Eligibility Member File Layout

Length – Comma delimited with double quote text qualifiers

	Field Name	Notes	Max Length	Note
1	Member Last Name		50	
2	Member First Name		50	
3	Member Middle Name		50	
4	Member Gender	M: Male, F: Female	1	
5	Member DOB	YYYYMMDD	8	
6	Status	01: Active, 04:PreEnroll, 05: Retro Enroll/Reinstatement 06: Retro Cancel/Disenroll 08: Disenrolled, 09: Canceled, 07: Termed	2	
7	Member No	EZ ID	15	
8	HICNum		15	
9	Member Effective Date	Effective with ECHP	10	
10	Member Term Date	Term with ECHP	10	
11	Product Code	"MCR" = Medicare	3	
12	PBPID (Plan Code)	Plan Benefit Package ID	3	
13	Group Number		3	
14	Wellcare Plan Code	H5087	5	
15	Office Visit Copay		10	
16	DME Benefit		10	
17	ER Benefit		10	
18	Provider ID	ECHP Assigned Provider ID	15	New PCP ID
19	Provider Effective Date	YYYYMMDD	8	
20	Provider Term Date	YYYYMMDD	8	
21	Provider First Name		75	
22	Provider Last Name		75	
23	Medicaid indicator		1	
24	CINNum		15	
25	Mem Address1		75	
26	Mem Address2		50	
27	Mem City		50	
28	Mem State		2	
29	Mem ZIP code	999999999	10	
30	Mem Home Phone	9999999999	10	
31	Mem County	County Name	50	
32	Mem Language	Language Name	50	
33	IPA Eff Date	YYYYMMDD	8	
34	IPA Term Date	YYYYMMDD	8	
35	PBP Eff Date	YYYYMMDD	8	
36	PBP TermDate	YYYYMMDD	8	
37	PCP NPI No		10	New field added

Monthly Claims Timeliness Report

Monthly Medicare Advantage
Claims Timeliness Report

HEALTH PLAN NAME		**Group/IPA/Hospital Name**	
Medicare Advantage			

Management Company / TPA / Etc.
enter name of Management Company/TPA (if applicable)

Report Preparer

Name	enter Report Preparer Name here	Phone	enter Phone# of Report Preparer
Title	enter Title of Report Preparer here	Fax	enter Fax# of Report Preparer
E-Mail	enter e-mail address of Report Preparer here		

Month	Year	Month One	Month Two	Month Three	CMS Reporting Quarterly Data
30 Day, Unaffiliated Provider Medicare Advantage					
Number of claims paid **(Fully Favorable)** during this reporting month					0
Number of claims paid **(Partially Favorable)** during this reporting month					0
Sub-total of claims paid during this reporting month		0	0	0	0
Total number of claims paid (Fully Favorable and Partially Favorable) within 30 days					0
Result: % On Time		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
60 day, Affiliated, Unaffiliated Unclean Provider Claims					
Total number of claims paid **(Fully Favorable)** during this reporting month					0
Number of Unclean, unaffiliated claims paid **(Fully Favorable)** during this reporting month					0
Total number of claims paid **(Partially Favorable)** during this reporting month					0
Total number of member liability claims denied **(Fully Unfavorable)** during this reporting month					0
Number of unaffiliated member liability claims denied **(Fully Unfavorable)** during this reporting month					0
Total number of provider denials **(Fully Unfavorable)** during this reporting month					0
Total number of unaffiliated provider denials **(Fully Unfavorable)** during this reporting month					0
Sub-total of claims paid and denied during this reporting month		0	0	0	0
Total number of claims paid or denied within 60 days or less					0
Result: % On Time		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DROH*					

Monthly Result % below 95% Requires A Corrective Action Plan

All other claims should be Paid and Denied within 60 calendar days from date of receipt. Monthly Result % The Industry Threshold is 95%, If Below 95% A Corrective Action Plan Is Required

This best practice item is not required unless three (3) consecutive months of non-compliance have been reported or confirmed through audit

The data submitted is for Federal reporting and is accurate & complete.

Date

Signature (Please fill out data below for signor.)

Health Plan Submission

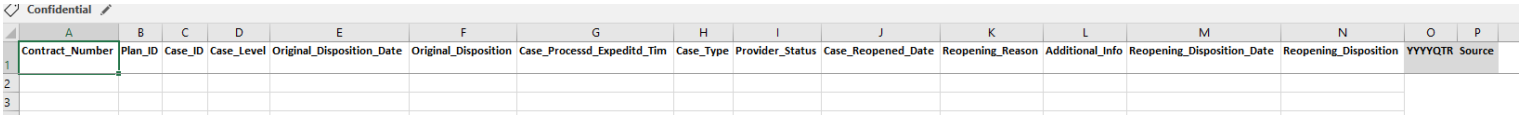
Printed Name	Appropriate Management Staff
Primary Title	Appropriate Management Staff
Phone Number	Appropriate Management Staff
E-Mail Address	Appropriate Management Staff
fax	[Health plan contact fax number]
phone	[Health plan contact phone number]

If the 30-day standard falls below 95% and/or if the 60-day falls below the threshold of 95%, please describe corrective action below:

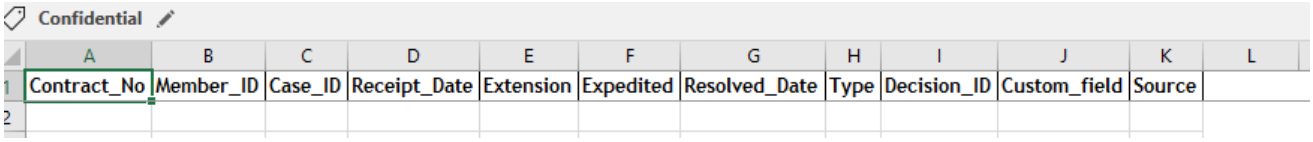
Rows and columns with headers that have yellow background must be completed. DROH is to be completed if % on time is below timeliness standard.
Please see complete instructions, notes and definitions for this report format in tab titled, **"Instructions"**
DROH data is only reported under certain conditions as explained in that document

Original: 1994 Revised:
May 2012
ICE Approved
May 2012

Part C ODR Reporting UM (Preservice)and Payment (Claims) Organization Derminations /Reopenings - ODR Reopen and ODR Detail reports



Contract_Number	Plan_ID	Case_ID	Case_Level	Original_Disposition_Date	Original_Disposition	Case_Processd_Expeditd_Tim	Case_Type	Provider_Status	Case_Reopened_Date	Reopening_Reason	Additional_Info	Reopening_Disposition_Date	Reopening_Disposition	YYYYQTR	Source



Contract_No	Member_ID	Case_ID	Receipt_Date	Extension	Expedited	Resolved_Date	Type	Decision_ID	Custom_field	Source

CMS PDR Quarterly Reporting

CMS PDR Quarterly Reporting									
NOTE: Rows and Columns with headers that have yellow background must be completed.									
Capitated Provider Name									
Reporting Period									
	Total Submitted During Reporting Period	Total Resolved In Qtr in Favor of Provider	Total Resolved in Qtr in Favor of Payer	Total # w/ Pending Resolution	Total Forward to C2C in Qtr	Subtotal Resolved in Qtr (B+C)	No. Resolved Within 30 Calendar Days	% Resolved w/in 30 Calendar Days (F/E)*	Total Resulting in Written Determination
Claims/Billing	A	B	C	D		E	F	G	H
Non-Contracted**				-					
Professional**									
Institutional**									
Other Providers**									
GRAND TOTAL	-	-	-	-		-		#DIV/0!	

Provide an informative summary on any emerging or established patterns of Provider disputes and demonstrate how that information has been used to improve the payer's administrative capacity, payer-Provider relations, claim payment procedures, quality of care assurance system (process) and quality of patient care (results):

(Attach summary if the average in column G is less than 95% on the quarterly report. Always provide a summary on the Annual (4th qtr) report. If your reported results do not show any emerging or established patterns that could be used for improvement activities, please so state.)

I certify (or declare) that I have read and reviewed the above report and all attachments thereto and know the contents thereof, and that the statements therein are true and correct to the best of my knowledge and belief.

Date			
			(Signature of Designated Principal Officer Above)
		Print Name	
*If the average (Grand Total) percentage in the "% Resolved Within 30 Calendar-Days" column (G) is less than 95%, attach a corrective action plan		Primary Title	
		Phone #:	
		E-Mail:	

Updated Delegated Reports List, Frequency and Method of Submission

Report Category	Function	2023 Wellcare Required Reports	Format	Frequency	FTP Submission Method to Health Plan
Payment	CL	Provider Dispute Request (PDR)	Excel	Quarterly	FTP in folder "Delegation Reports"
Payment	CL	Monthly Timeliness Report (MTR) Report	Excel	Monthly	FTP in folder "Delegation Reports"
Regulatory	CL	Part C ODR Report - Claims - Payment (Details,Reopens, Attestation)	Excel	Quarterly	FTP in folder "Part C Claims"
Regulatory	CL	ODAGs - Claims (most current format)	Excel	Quarterly	FTP in folder "Delegation Reports"
Care Mgmt	CM	Complex Care Management Log	Excel	Monthly	FTP in folder "CM"
Care Mgmt	CM	SNP CM Work Plan and Report	Excel	Semiannual	FTP in folder "CM"
Network	CR	Credentialing Scorecard	Excel	Quarterly	FTP in folder "Delegation Reports"
Regulatory	IT	Encounter Data (daily, weekly but no less than monthly)	837	Monthly	FTP in folder "Encounters"
Accreditation	QI	Multi-function Scorecard	Excel	Monthly	FTP in folder "Delegation Reports"
Accreditation	QI	Quarterly QI/UM/CM Work Plan Evaluation (Wellcare info only)	Excel	Quarterly	FTP in folder "CM"
Accreditation	QI	QI/ UM/ CM Program Description/ Work Plan/ Prior Year Eval (Wellcare info only)	PDF	Annual by 3/15 each year	FTP in folder "Delegation Reports"
Regulatory	UM	Serious Reportable Adverse Events Report	PDF	Monthly	FTP in folder "UM"
Regulatory	UM	Part C ODR Report – UM (Details reopens Attestation)	Excel	Quarterly	FTP in folder "Part C Preservice"
Regulatory	UM	ODAG - UM (most current format)	Excel	Quarterly	FTP in folder "Delegation Reports"
Care Mgmt	UM	Daily Inpatient census for acute and skilled admissions	Excel	Daily	FTP in folder "UM"
Care Mgmt	UM	Daily UM Authorization Log	Excel	Daily	FTP in folder "UM"
Network	CR	* TPV files continue to send via email as instructed by your Provider rep			

Ice 2014 UM Delegation Required Reports Table of Contents

ICE 2014 UM Delegation Required Reports	
	Table of Contents
	The templates contained in this workbook are generic and can be modified for any information or data sets for reporting. This tool represents minimum regulatory and accrediting reporting requirements. Regulatory requirements specify that UM data must specific to each Health Plan. **NOTE: Please reference individual Health Plan communications, delegation agreements, and contracts for additional Provider Organization reporting responsibility.**
Tab #	
A.	**Instructions**
	Instructions and Examples
B.	**Definitions**
	Definitions and Formulas
C.	**Signature Page**
	Attestation, UM Program Information, UM Chair Signature
1	**Inpatient Utilization Metrics**
2	Inpatient Work Plan & Report
3	**Referral Metrics**
4	Referrals Work Plan & Reports
5	**Emergency Room (ER) Utilization Metrics**
6	ER Work Plan & Reports
7	**Appeal Metrics and Turnaround Time**
8	Appeals Work Plan & Reports
9	**Complex Case Management (CCM) Metrics**
10	CCM Work Plan & Reports
11	**Special Needs Plans (SNP) Metrics**
12	SNP Work Plan & Reports
13	**Experience (Satisfaction) with UM Process Work Plan & Reports**
14	**Utilization and Referral Timeframe Compliance Metrics**
15	Over/Under Utilization and Referral Timeframe Compliance Work Plan & Reports
16	**Other UM Work Plans & Reports**

A. Instructions

GENERAL INSTRUCTIONS:

Please complete the entire **"Signature Page"** tab before submitting each report to Health Plans. NOTE: The **Provider Organization Name** and **Report Type** will auto-populate on each tab after this information is entered on the signature page.

Areas denoted in red font and italics are EXAMPLES only. The work plan tool template may be used to complete UM delegation reports required by Health Plans. The report templates contained in this Excel workbook are generic and can be modified for any information or data sets for reporting. This tool represents minimum regulatory and accrediting reporting requirements. Regulatory requirements specify that UM data must be specific to each Health Plan. **Stastistics may be documented using the "METRIC" tabs or via separate organization internal system generated reports.** NOTE: Please reference individual Health Plan communications, delegation agreements, and contracts for additional Provider Organization reporting responsibility.

HEALTH PLAN EVALUATION GUIDELINES:

X = Complete = All elements are appropriately addressed
P = Partially Complete = At least one element is appropriately addressed
0 = Not Complete = None of the elements are documented
NA = Element is not applicable for evaluation

WORK PLAN, SEMIANNUAL/QUARTERLY REPORTS, AND ANNUAL EVALUATION INSTRUCTIONS

Component	Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
▪ Work Plan is due to Health Plans by Feb. 15. ▪ Each year must start with a new work plan as a separate document from the previous year's evaluation or 4th quarter report. ▪ Each component listed must be addressed. ▪ Complete all columns for each component specified. State reasons if not completed or NA.	▪ Describe goals in specific and measurable terms. ▪ List benchmarks if available. ▪ List thresholds for identification of improvement opportunities. ▪ Improvement goals should be based on the previous year's Annual UM Evaluation.	▪ List specific activities planned to address component and achieve goals. ▪ Describe measurement and data analysis methods.	▪ List specific date(s) for completion or timeframe for each planned activity.	▪ List name(s) and title(s) or Department(s) responsible for the completion of planned activities.

Component	Report Period & Due Dates	Key Findings & Analysis	Interventions/Follow-up Actions	Re-Measurement
▪ Semiannual report ▪ Quarterly report	▪ 1st semi-annual report covers period from Jan. 1–June 30. Report is due to Health Plans by Aug. 15. ▪ 2nd semiannual report/annual evaluation covers period from July 1-Dec. 31. Report is due to Health Plans by Feb. 15th. ▪ 1st QTR - Report is due to Health Plans by May 15. ▪ 2nd QTR - Report is due to Health Plans by Aug. 15. ▪ 3rd QTR - Report is due to Health Plans by Nov. 15. ▪ 4th QTR/annual evaluation - Reports are due to Health Plans by Feb. 15.	▪ For each reporting period, list key findings as specified by measures set in goals. For example, if goal is based on # Per Member Per Month, list findings as # Per Member Per Month. ▪ Key findings should be objective and quantitative. ▪ State whether goals were met or not met. State reasons if goals were not met. For example, document the effectiveness of interventions including any progress that was made towards improving performance. ▪ Document your analysis of the findings listed including any patterns or trends. ▪ Describe any barriers for attaining goals. ▪ Include findings on any follow-up issues from the previous reporting period. ▪ For annual evaluation, list progress in the last reporting period and an overall summary for the entire 12-month period. State if goal was not met, add topic to work plan for next year.	▪ List what your organization will do to either maintain your current performance and/or what further actions are needed to improve performance. ▪ For each reporting period, document the activities that were implemented and/or completed as described in the Work Plan Planned Activities Section. ▪ Document any additional activities that may have not been included in the work plan. ▪ For the annual evaluation, list interventions that were taken during the last reporting period as well as an overall summary of the interventions for the 12-month period.	▪ Update if responsible party or department has changed or additional departments or individuals are added. ▪ Update with target date(s) for re-measurement or completion of follow-up actions.

EXAMPLES			
INPATIENT STATISTICS Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
▪ Document for each product on statistic page. ▪ Identify benchmarks (community standard range or formulas/resources used to determine benchmarks) *1. Decrease commercial readmission rates by 10%.* *2. Maintain Senior BH Days within 5% from last YTD.*	*1. Track and trend readmissions for senior/Medicare products.* *2. Develop and implement referral process to high-risk clinic.*	*1. Monthly presentation to UMC* *2. 1st quarter 2017*	▪ *Nancy Nurse, LVN, UM Nurse* ▪ *Christy Case, RN, Care Manager*
INPATIENT STATISTICS Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	▪ Document the statistics that are outside of the stated thresholds/goals. *1. Only 2 commercial readmissions during the 1st quarter. Acute Beddays were increased in the 1st quarter. This was due to an increased number of admissions as the ALOS was within goals.* *2. Document whether the interventions were effective in improving inpatient statistics.* *3. Readmission rates were found to be within an acceptable range. It is too early to assess the outcome of High Risk Clinic Referrals in regard to decreasing the senior beddays per 1000.*	▪ Document what your organization did to improve any indicator that was outside the threshold/goal. *1. Readmission rates were trended and presented to the UMC for discussion.* *2. A referral process was developed and implemented for High Risk Clinic. Members are identified before discharge from acute facility for risk of readmission. If assessed as high risk, the Member is referred to the High Risk Clinic for follow-up by the IPA Hospitalists in collaboration with the Member's PCP.* *3. Continue to analyze outcome of high risk clinic.*	*Report to UMC by 7/30/18.*

REFERRAL STATISTICS Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
NOTE: Only Medical Necessity (MN) denials are evaluated in this statistic. If unable to separate MN from administrative, please indicate such and document plans going forward to address. ▪ Define and document what will be included in total number of referrals (e.g., authorization requests, pre-certifications inpatient, and direct referrals).	*1. Provide education to PCPs regarding senior covered benefits.* *2. Track and trend referrals and denials per PCP and analyze data for over/under utilization. Present to UMC.*	*1. 1st quarter 2018 and quarterly thereafter.* *2. 2nd quarter 2018 and quarterly thereafter.* *3. 1st quarter 2018.*	▪ *Nancy Nurse, RN, UM Manager* ▪ *Stanley Stat, MD, Medical Director*

REFERRAL STATISTICS Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
▪ Define and document what will be included in total number of denials (e.g. pre-service denials, claims). ▪ Document formula that will be used for determining denial % or denial rate PTMPY. (Refer to "Definitions" tab for denial rate formulas. ▪ Identify benchmarks (community standard range or formulas/resources used to determine benchmarks)	*3. Present individual referral data to PCPs.* *4. Set up capitation arrangements with high volume specialists.* *5. Develop and implement PCP corrective actions as necessary.*		
1. UM referral goals are 1.5 per commercial and Medi-Cal Members and 3.0 for senior Members. *2. Inpatient goals are documented on the statistics page as admissions/1000 and beddays/1000. Current information system is not able to separate outpatient referrals from pre-certification inpatient referrals. Inpatient pre-certification is included in the outpatient referral data.* *3. The IPA denial rate goal is less than 3% for both inpatient and outpatient referrals.*			

REFERRAL STATISTICS Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	Interventions/Follow-up Actions State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	Re-Measurement State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	**NOTE: Only Medical Necessity (MN) denials are evaluated in this statistics. If unable to separate MN from administrative, please indicate such and document plans going forward to address.** ▪ If the Provider Organization Information System (IS) does not allow for the collection of data that differentiates between the UM Referral categories, i.e. Outpatient, Inpatient, Urgent, Non-Urgent, Concurrent, etc., then document a statement describing what cannot be reported due to systems limitations. ▪ *Decrease in referrals requiring pre-certification can be attributed to the new capitation arrangement with orthopedists and the addition to the services that are now a direct referral from the Provider's office. Goal met to date.* ▪ *Denial rate within Provider Organization goal and industry standard. Benefit-related denials continue to be the most prevalent reason for denials.*	▪ *Tracked and trend referrals per PCP and analyzed data for over/under utilization.* ▪ *Executed new capitation agreement with Orthopedists.* ▪ *Continue to monitor referrals quarterly.* ▪ *MIS Department to develop UM dashboard* ▪ *Tracked and trend all denials per PCP.* ▪ *Implement use of the ICE "Carve Out" letter for appropriate situations vs. issuing denials.* ▪ *Continue to monitor quarterly.*	• *MIS department, late fall*

ER UTILIZATION Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
▪ ER utilization is any visit to the ER that does	▪ Document any planned activities that will reduce the number of ER visits.	*Quarterly*	▪ *Nancy Nurse, RN, UM Manager*

not result in a hospital stay. Members admitted to the hospital should not be counted. ▪ ER data should include information from claims. *1. Reduce ER utilization by 10%.*	*1. Educate Members to call PCP before going to the ER.* *2. Care Management to monitor frequent ER utilizers and assess need for alternative care.*		▪ *Christy Case, RN, Care Manager*

ER UTILIZATION Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	▪ Document any trends noted in increase/decrease of ER utilization. ▪ Document reasons for denials.	*Continue with plan as noted*	*Continue with plan as noted*

APPEALS Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
1. Maintain commercial appeals upheld at 80%.	▪ Document activities that will decrease the number of appeals. *1. Analyze overturn decisions to identify trends, educational and process improvement opportunities.*	*Quarterly*	*Stanley Stat, MD, Medical Director*

APPEALS Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	▪ Document the number of appeals by the number of denials in the reporting period. ▪ Document the total number of appeals and % upheld for each line of business. ▪ Document appeal turnaround time (applicable only if delegated). ▪ Identify any trend issues that would account for any deviation from the norm regarding the number of appeals and whether they were upheld.	*1. Develop or adopt evidence-based guidelines for UM determinations.* *2. Develop & provide training on UM tools to all staff that make UM determinations.* *3. Work collaboratively with health plan on process improvement such as EOB interpretation.* *4. State actions to reverse number of appeals related to that trend (if not already part of the planned activities).*	▪ *AG Department, Immediately, Report to QIC monthly* ▪ *UM Department, immediate sub report to QIC monthly*

EXPERIENCE WITH UM PROCESS Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
▪ *Increase Member satisfaction with UM process by 5%.* ▪ *Increase Provider satisfaction with UM process by 5% over last year rate.*	• Conduct Member and Provider satisfaction survey on an annual basis. ▪ *Track and analyze Member complaints related to UM.* ▪ *Track and analyze Provider complaints related to UM.* ▪ *Conduct biannual Provider satisfaction surveys with specific questions about the UM process.*	*2nd and 4th quarters 2019*	*Nancy Nurse, RN, UM Manager*

SATISFACTION WITH UM PROCESS Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Interventions/Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Re-Measurement State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	• Document the type of survey performed (PAS, monkey, group created, etc.) • Document a brief synopsis of the survey results including response rate and data analysis. • Document if goal met or not met and why not met. Indicate when an action is or is not expected; for example : >90% no action needed *1. Member - Awaiting PAS results* *2. Provider - Provider satisfaction with UM process was 87%.* *Provider satisfaction increased by 6% compared to 2019 survey. Increase may be attributed to changes in workflow processes and timely f/u on all Provider complaints. Goal met.*	• Document actual actions and inventions in response to the results. • Document details UM process improvement opportunities. *1.Member* *Will conduct survey in September* *2. Provider* *Continue to monitor Provider complaints.* *Develop a subcommittee to explore improvement processes.*	*Continue with plan as noted*

UTILIZATION & REFERRAL TIMEFRAME COMPLIANCE Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
▪ Identify 4 chosen data types (must include 1 data type per product line and one data type related to Behavioral Health). Examples: LOS data, Admits/1000, Unplanned readmissions, Rates of selected procedures, Referral rates ▪ Document thresholds for each data type using external or internal sources that provide distribution of performance data.	▪ Document planned activities to achieve data results within thresholds. ▪ Conduct qualitative analysis to determine cause/effect of data not within thresholds by practice site. ▪ For referrals that require prior-authorization state your interventions for improvement.	▪ *Monitor daily report for opportunities for improvement* ▪ *Report to UMC monthly*	*Nancy Nurse, RN, UM Manager*

UTILIZATION & REFERRAL TIMEFRAME COMPLIANCE Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
▪ Document specific goals that describe how you plan to detect potential over or under-utilization of services. ▪ *Hysterectomy rates – 10th % threshold for under utilization and 90th % for over utilization.* ▪ *Admits/1000 – 1.5 standard deviation above and below network average.* ▪ *Decrease number of unnecessary CT/MRI requests by 5%.* ▪ *Maintain TAT average at 3 days. Improve % meeting standard by 10%.*	Document what types of referrals are included in your statistics (urgent, non-urgent, post-service and direct). ▪ *Educate ordering practitioners to provide complete medical history pertinent to ordering scans.* ▪ *Educate licensed staff on use of Imaging Module of Interqual® guidelines to increase consistency of review.*		

UTILIZATION & REFERRAL TIMEFRAME COMPLIANCE Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	Interventions/Follow-up Actions State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	Re-Measurement State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	▪ List the average TAT and the percent meeting TAT of 5 days for the reporting period. If your non-urgent TAT standard is different from the 5-day standard, please indicate standard. ▪ *Commercial Hysterectomy rates at the 90th percentile of the western region.* ▪ *Senior Hysterectomy rates at 75th percentile for western region. Target review effective.* ▪ *Medi-Cal 5% decrease noted in volume of referrals for CTs.* ▪ *All product lines show significant decrease in number of CT requests. Decrease attributed to Medical Director direct communication with frequent requesting practitioners.* ▪ *BH referrals decreased by 5% in 2Q*	▪ *Identify hysterectomy as a target procedure. Remove from auto-approval list. Medical Director review of all hysterectomy requests that do not meet criteria.* ▪ *Continue with plan as noted* ▪ *Continue to monitor CT referral data quarterly.* ▪ *MIS department to run a report on psychotropic medication usage for 12-month period for review and analysis.* ▪ *UM Manager to provide in-service and education regarding TAT standard.*	*Continue with plan*

OTHER UM ACTIVITIES Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
UM Interrater Reliability Evaluation ▪ Document improvement goals or scoring benchmark for physician and non-physician reviewers (may include other UM staff depending on Health Plan requirements) ▪ Additional items may be listed here based on your Health Plan delegation agreement.	▪ UM Interrater Reliability (IRR) evaluation must be performed and assessed at least annually; 12 months from previous IRR evaluation ▪ *Maintain a 95% interrater reliability for licensed nursing staff and physicians.*	▪ *Evaluate interrater reliability annually on all physician and licensed nurse reviewers.* ▪ *Develop policy and procedures to establish use of Interqual guidelines.*	*Nancy Nurse, RN, UM Manager*

OTHER UM ACTIVITIES Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	Interventions/Follow-up Actions State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	Re-Measurement State target date(s) for re-measurement or completion of follow-up actions.
1st semiannual report	▪ Document method of review (side by side comparison, rounds, audits). For each reviewer type, the file sample size, # of reviewers, goal outcomes, and reasons met or unmet should be stated. ▪ *Interrater reliability average score for physician reviewers was 85%.* ▪ *Two of 7 physician reviewers scored less than 95%. These 2 physicians were new UMC Members.*	▪ *Medical Director will educate or train physician reviewers with score of less than 95%.*	*Continue with plan*

B. Definition

ACUTE ADMITS
The number of admissions to a general hospital/acute care facility, including mental health. (See definition for non-acute care.)
ACUTE BEDDAYS
Those hospital days incurred during a specific reporting period that include medical, surgical, OB and Behavioral Health (in and out of area) that represent any risk (shared or full) to the Provider Organization. These exclude: newborns that leave the hospital with the mother and are considered "normal newborns". (This may or may not include subacute/acute rehab days.)
ADMINISTRATIVE DENIAL
Administrative Denials are based on eligibility and carve-outs and are not included in denial counts, as they are contract issues and therefore not reported to the Health Plans. Administrative Denials are usually contracting issues with a facility rather than issues related to a practitioner or Member; the facility may use the Provider dispute resolution process; the Member is held harmless and no Member notification is sent.
APPEAL
A formal request by a practitioner or covered person for reconsideration of an adverse decision such as a utilization recommendation, with the goal of finding a mutually acceptable solution.
APPEALS MECHANISM
The formal process a service Provider and/or Member can use to request reconsideration of an adverse decision.
AVERAGE LENGTH OF STAY
Total beddays divided by total discharges or admits.
BENCHMARK
For a particular indicator or performance measure, the benchmarking process identifies the best performance in the industry (healthcare or non-healthcare) for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance. Other comparative data Provider Organizations might use includes: ○ Information obtained from other organizations through sharing or contributing to external reference databases; ○ Information obtained from open literature, data gathering and evaluation by independent organizations regarding industry data; ○ Performance of competitors; or ○ Comparisons with other organizations providing similar healthcare services. (Definition modified from Baldrige National Quality Program Health Care Criteria for Performance Excellence 2003.)

BEHAVIORAL HEALTH
Term for Mental Health services which may include substance abuse, chemical dependency for inpatient and outpatient. This broad term may also include evaluation and treatment of psychological and substance abuse disorders by either PCP or Behavioral Health Providers.
CARE MANAGEMENT
The process for identifying covered persons with specific healthcare needs in order to facilitate the development and implementation of a plan to efficiently use healthcare resources to achieve optimum Member outcome.
COMPLEX CARE MANAGEMENT
Complex care management is the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate the appropriate delivery of care and services.
COMMERCIAL POPULATION
Those Members (subscribers and their dependents), usually birth through 64 years of age, which obtain healthcare coverage through their employers. This does not include Medicare or Medi-Cal.
CONCURRENT REVIEW
An assessment which determines Medical Necessity or appropriateness of services as they are being rendered.
DELEGATION
A formal process by which a Managed Care Organization (MCO) gives another entity the authority to perform certain functions on its behalf. The authority may be delegated, but the **responsibility** for ensuring that the function is performed appropriately cannot be delegated.
DENIAL
The decision to refuse, deny or modify a request for services/referral.
EMERGENCY ROOM (ER) VISITS
Any visit to an emergency room that does not result in a hospital stay. (Patients admitted to the hospital from the ER should not be counted.)
ENROLLMENT
Current actual number of HMO covered lives that make up the Provider Organization managed care population. This number is usually categorized as commercial, senior and Medi-Cal.
GOALS
A future condition or performance level that one intends to attain. Goals can be both short term and long term. Goals are ends that guide actions. Quantitative goals frequently referred to as “targets,” include a numerical point or range. Targets can be projections based on comparative and/or competitive data.

GRIEVANCE/COMPLAINT
An expression of dissatisfaction by a Member, either written or oral.
INPATIENT
Medical, surgical, OB and Behavioral Health services rendered in a facility. May or may not include services provided in subacute/acute rehab facilities.
INTERVENTION
An action taken to increase the probability that desired outcomes will occur.
LENGTH OF STAY
The number of days from admission to discharge, excluding the last day of the stay and any denied days.
MEDI-CAL POPULATION
Those Members enrolled in the California state Medicaid program and who participate in the Managed Medi-Cal Program.
MEMBER
An individual who is a participant in a health plan (and your Provider Organization), and who, with other participants, make up the enrollment.
MEMBER MONTHS
The sum of the enrollment for the reporting period, e.g., total of three months' enrollment.
MONITOR
A periodic or ongoing performance measurement to determine opportunities for improvement and/or the effectiveness of interventions.
NON-ACUTE CARE
Inpatient care, including: hospice, nursing home, rehabilitation, skilled nursing, transitional care and respite care; regardless of the type of facility.
OUTCOME
The results achieved through the performance of a function or process.
OUTPATIENT
All services not included in the definition of Acute Beddays or inpatient.
OVERTURNED
When an appeal for denied services is deemed appropriate, and the denial is reversed and services are approved.

OVERUTILIZATION
Provision of services that were not clearly indicated or provision of services that were indicated in either excessive amounts or in a higher-level setting than appropriate.
PEER REVIEW
Evaluation of the performance of colleagues by professionals with similar types of degrees and/or specialty.
PERFORMANCE GOALS
The desired level of achievement of standards of care or service. These may be expressed as desired minimum performance levels (thresholds), industry best standards (benchmarks), or the permitted variance from the standard. Performance goals are usually not static, but change as performance improves and/or the standard of care is redefined.
PRACTICE GUIDELINES
Systematically developed descriptive tools or standardized specifications for care to assist practitioners in making decisions about appropriate healthcare for specific clinical circumstances.
PRIOR REVIEW/PRECERTIFICATION/AUTHORIZATION/CERTIFICATION/DETERMINATION
Prior assessment that proposed services are appropriate for a particular patient and will be covered by the Managed Care Organization (MCO). Payment for services depends on whether the patient and the category of service are covered by the Member's benefit plan and the eligibility of the patient at the time of service.
READMISSION
Admission within 31 days of discharge for the same or similar diagnosis.
REFERRAL
A request for authorization of services.

RETROSPECTIVE REVIEW
Assessment of the appropriateness of medical services on a case-by-case basis or aggregate basis after the services have been provided.
SENIOR/MEDICARE POPULATION
Those Members eligible for Medicare, age 65 or older and/or disabled.
SPECIAL NEEDS PLANS (SNP)
Medicare managed care plans, which are focused on vulnerable groups of Medicare beneficiaries: the institutionalized, dual-eligible (Medicare, Medi-Cal), and beneficiaries with severe or disabling chronic conditions. The goal of Special Needs Plans is for improvement in care for beneficiaries with special needs through improved coordination and continuity of care.

STANDARDS

Authoritative statements of (1) minimum levels of acceptable performance or results; (2) excellent levels of performance or results; or (3) the range of acceptable performance or results.

THRESHOLD

A pre-established level of performance that, when not met, results in initiating further in-depth review to determine if a problem or opportunity for improvement exists. A pre-established level of performance refers to a minimum performance position on a performance measurement scale determined by the organization. A threshold performance level permits evaluation relative to past performances, assists in projection and establishing future goals, and provides appropriate comparison. When a threshold is not met, it triggers the initiation of further in-depth review to identify a problem or opportunity for improvement.

TRANSITIONS OF CARE

1. Transitions of care refer to the movement of patients between healthcare practitioners and settings as their conditions and care needs change during the course of a chronic or acute illness. (National Transition of Care Coalition)

2. Movement of a Member from one care setting to another as the Member's health status changes; for example, moving from home to a hospital as a result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery. (NCQA)

TURNAROUND TIME (TAT)

The amount of time (usually days) from the receipt of a request/referral until the determination is made.

UPHELD

When an appeal for denied services is not overturned (denial stands).

UNDERUTILIZATION

Failure to provide appropriate services.

FORMULAS

These formulas are generic. Use population-specific membership and utilization data where indicated. Note that when completing a quarter or semiannual report the formulas should cover the 3- (or 6-) month reporting period for each quarter or 6-month period being reported.

BEDDAYS per 1000

Total Raw Beddays (for report period) X 365 X 1000
Enrollment #days in report period

NOTE: Divide total raw beddays incurred by enrollment, multiply this result by result of 365 divided by # days in reporting period, multiply that result by 1000.

ADMITS per 1000

Total Admissions (for report period) X 365 X 1000 Enrollment #days in report period
NOTE: Divide total admissions incurred by enrollment, multiply this result by 365 divided by # of days in reporting period, and multiply that result by 1000.
AVERAGE LENGTH OF STAY
Total Raw Beddays (for report period)
Total Discharges (for report period) *OR* Total Admits (for report period)
NOTE: Divide total raw beddays incurred by total discharges OR total admits
READMITS per 1000
Total Raw Readmissions (for report period) X 365 X 1000 Enrollment #days in report period
NOTE: Divide total raw readmissions incurred by enrollment, multiply this result by 365 divided by # days in reporting period, and multiply that result by 1000.
EMERGENCY ROOM DENIAL RATE per 1000
Total Raw ER Visits (for report period) X 365 X 1000 Enrollment #days in report period
NOTE: Divide total raw # ER days incurred by enrollment, multiply this result by result of 365 divided by # days in reporting period, and multiply that result by 1000.
DENIAL RATE (%)
Total # Denials (for report period) X 100 Total # Referrals Processed (for report period)
NOTE: Divide total # denials by total # referrals processed, multiply this result by 100 **Administrative Denials are not to be included in reported denial statistics. Administrative Denials are based on eligibility and carve-outs. Benefits should be included in denial stats and would not be considered an administrative denial.*
DENIAL RATE per 1000
Total Raw # of Denials (for report period) X 365 X 1000 Enrollment #days in report period
NOTE: Divide total raw # denials incurred by enrollment, multiply this result by result of 365 divided by # days in reporting period, multiply that result by 1000. **Administrative denials are not to be included in reported denial statistics. Administrative denials are based on eligibility and carve-outs. Benefits should be included in denial stats and would not be considered an administrative denial.*
REFERRAL TURN AROUND TIME (TAT) PERCENT (% OF REFERRALS MEETING TAT STANDARDS)
Total # Referrals Meeting TAT (for report period) X 100
Total # Referrals Processed (for report period)
NOTE: Divide total # referrals meeting TAT by total # referrals processed, multiply this result by 100.

C. Signature Page

Provider Organization Name:			
Report Type:			

Attestation Questions	Response (Yes/No)/ Comments	
Are the reported **inpatient statistics** health plan specific?		
Are the reported **referral statistics** health plan specific?		
Are the reported **ER statistics** health plan specific?		
Indicate if any **ER visits** have been denied during this report period?		
Indicate if **ER statistics** are based on ***date of service?***		
Indicate if **ER statistics** are based on ***date of claim payment?***		
Are the reported **appeal statistics** health plan specific?		
Are the reported **CCM statistics** health plan specific?		
Are the reported **SNP statistics** health plan specific?		
Are the reported **over/under utilization statistics** health plan specific?		

NOTE: Reports that are sent electronically must state "Signature on File" on the signature line. This will be verified at the annual oversight audit.			
I. UM COMMITTEE MEETINGS	**Frequency**	**Day of the Week**	**Time**
UM Committee			
II. UM PROGRAM CONTACTS	**Name**	**Phone #**	**E-mail**
UM Manager			
UMC Chairperson			
III. PERSON SUBMITTING REPORTS	**Name**	**Phone #**	**Fax #:**
Initial Work Plan			
1st Semiannual Report			
2nd Semiannual Report			
Quarter 1 Report			
Quarter 2 Report			
Quarter 3 Report			
Quarter 4 Report			
Annual Evaluation			
IV. UM COMMITTEE APPROVAL	**UMC Chair Signature**	**Date to UM Committee**	**Date to Governing Board**
Work Plan			
1st Semiannual Report			
2nd Semiannual Report			
Quarter 1 Report			
Quarter 2 Report			
Quarter 3 Report			
Quarter 4 Report			
Annual Evaluation			

1. Inpatient Utilization Metrics

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.

INPATIENT METRICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
COMMERCIAL									
Enrollment (self-reported)									
Acute Beddays/1000									
Acute Admits/1000									
Acute Average LOS									
Acute Readmits/1000									
SNF Beddays/1000									
SNF Admits/1000									
SNF Average LOS									
SNF Readmits/1000									
SENIOR									
Enrollment (self-reported)									
Acute Beddays/1000									
Acute Admits/1000									
Acute Average LOS									
Acute Readmits/1000									
SNF Beddays/1000									
SNF Admits/1000									
SNF Average LOS									
SNF Readmits/1000									
BH Beddays/1000									
BH Admits/1000									
BH Average LOS									
BH Readmits/1000									
Medi-Cal									
Enrollment (self-reported)									
Acute Beddays/1000									
Acute Admits/1000									
Acute Average LOS									
Acute Readmits/1000									
SNF Beddays/1000									
SNF Admits/1000									
SNF Average LOS									
SNF Readmits/1000									
BH Beddays/1000									
BH Admits/1000									
BH Average LOS									
BH Readmits/1000									

2. Inpatient Work Plan & Reports

Inpatient Utilization: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

3. Referral Metrics

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.
NOTE: Do not include administrative denials in the reported denial statistics.

REFERRAL METRICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
COMMERCIAL									
Enrollment (self-reported)									
Outpatient Pre-Service									
Routine Raw									
Urgent Raw									
Urgent Concurrent Raw									
Routine PTMPY									
Urgent PTMPY									
Urgent Concurrent PTMPY									
Inpatient Pre-Service									
Routine Raw									
Urgent Raw									
Urgent Concurrent Raw									
Routine PTMPY									
Urgent PTMPY									
Urgent Concurrent PTMPY									
Denied									
Total									
%									
PTMPY									
SENIOR									
Enrollment (self-reported)									
Outpatient Pre-Service									
Routine Raw									
Urgent Raw									
Urgent Concurrent Raw									
Routine PTMPY									
Urgent PTMPY									
Urgent Concurrent PTMPY									
Inpatient Pre-Service									
Routine Raw									
Urgent Raw									
Urgent Concurrent Raw									
Routine PTMPY									
Urgent PTMPY									
Urgent Concurrent PTMPY									
Denied									
Total									
%									
PTMPY									

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.
NOTE: Do not include administrative denials in the reported denial statistics.

REFERRAL METRICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Medi-Cal									
Enrollment (self-reported)									
Outpatient Pre-Service									
Routine Raw									
Urgent Raw									
Urgent Concurrent Raw									
Routine PTMPY									
Urgent PTMPY									
Urgent Concurrent PTMPY									
Inpatient Pre-Service									
Routine Raw									
Urgent Raw									
Urgent Concurrent Raw									
Routine PTMPY									
Urgent PTMPY									
Urgent Concurrent PTMPY									
Denied									
Total									
%									
PTMPY									

4. Referral Work Plan & Reports

Referrals: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

Need to capture specifics for clinical staff (nurses and physicians specifically) as well as non-clinical staff handling UM requests.

Submit via FTP in folder "Delegation Report"

5. Emergency Room Utilization Metrics

The Provider Organization may attach a separate internal system-generated report that includes all of the listed data types.

ER UTILIZATION METRICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Commercial									
Enrollment (self-reported)									
Total # ER visits Raw									
Denied ER visits Raw									
Denied ER visits by %									
Total # ER visits PTMPY									
Denied ER visits PTMPY									
Senior									
Enrollment (self-reported)									
Total # ER visits Raw									
Denied ER visits Raw									
Denied ER visits by %									
Total # ER visits PTMPY									
Denied ER visits PTMPY									
Medi-Cal									
Enrollment (self-reported)									
Total # ER visits Raw									
Denied ER visits Raw									
Denied ER visits by %									
Total # ER visits PTMPY									
Denied ER visits PTMPY									

6. Emergency Room Work Plan and Reports

ER Utilization: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

7. Appeal Metrics and Turnaround Time

The Provider Organization may attach a separate internal system-generated report that includes all of the listed data types.

APPEAL METRICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
PRE-SERVICE APPEALS									
Commercial									
Total # appeals									
Member Appeals									
Provider Appeals (1st level)									
Total # appeals PTMPY									
Total # upheld									
% upheld									
Senior									
Total # appeals									
Member Appeals									
Provider Appeals (1st level)									
Total # appeals PTMPY									
Total # upheld									
% upheld									
Medi-Cal									
Total # appeals									
Member Appeals									
Provider Appeals (1st level)									
Total # appeals PTMPY									
Total # upheld									
% upheld									
ALL PRE-SERVICE APPEALS									
Total # appeals									
Total # appeals PTMPY									
Total # upheld									
% upheld									
APPEAL TURNAROUND TIME	**2023 YTD**	**2023 Goal**	**Q1**	**Q2**	**1st Semi-Annual**	**Q3**	**Q4**	**2nd Semi-Annual**	**Annual**
PRE-SERVICE APPEALS									
Commercial									
Average TAT in days									
Senior									
Average TAT in days									
Medi-Cal									
Average TAT in days									
Healthy Families									
Average TAT in days									
ALL PRE-SERVICE APPEALS									
Average TAT in days									

8. Appeal Work Plan and Reports

Appeals: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

9. Complex Case Management Metrics

The Provider Organization may attach a separate internal system-generated report that includes all of the listed data types.

COMPLEX CASE MANAGEMENT (CCM) METRICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Total # Patients Identified									
Commercial									
Senior									
Medi-Cal									
Total # CCM Cases Open									
Commercial									
Senior									
Medi-Cal									
CCM Member Experience									
% Positive Experience									
Measuring Effectiveness									
(Measure 1)									
(Measure 2)									
(Measure 3)									

10. Complex Case Management Work Plan and Reports

Complex Case Management (CCM): Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
CCM Population Assessment: CCM program design must meet the needs of its population. Relevant characteristics of the population must be considered in defining program's structure. Source: 2014 NCQA QI7 A			
CCM Member Experience: (Report SNP separately) Evaluate experience by obtaining feedback from Members and analyzing Member complaints. Source: 2014 NCQA QI7 I			
CCM Program Effectiveness Analysis: Describe 3 effectiveness measurement goals and describe activities to achieve these goals Source: 2014 NCQA QI7 J			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			
2nd Semiannual **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			
Annual **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			

Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	Interventions/Follow-up Actions State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	Re-Measurement State target date(s) for re-measurement or completion of follow-up actions.
Q1 **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q2 **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			
Q3 **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			
Q4 **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			
Annual **CCM Population Assessment** **CCM Member Experience** **Measuring Effectiveness**			

11. Special Needs Plan Metrics

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.

*Recommend use of the **ICE Transition of Care (TOC) log** for data-related reporting elements.*

MEDICARE SPECIAL NEEDS PLANS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
SNP Case Management (CM) Metrics									
Total # of SNP Members									
% SNP Members identified for CM									
% SNP Members enrolled in CM									
% SNP Members refusing CM/Opt-Out									
Total # SNP assessments completed (HRA?)									
Total # SNP care plans developed									
Total # SNP IDTs held									
Total # SNP CM cases opened to date (optional unless required by Health Plan)									
Total # of C-SNP Members									
% C-SNP Members identified for CM									
% C-SNP Members enrolled in CM									
% C-SNP Members enrolled in CM									
% C-SNP Members refusing CM/Opt-Out									
Total #C-SNP CM cases opened to date (optional unless required by Health Plan)									
SNP Member Experience									
% Positive Experience									
Measuring Effectiveness									
(Measure 1) (optional unless required by Health Plan)									
(Measure 2) (optional unless required by Health Plan)									
(Measure 3) (optional unless required by Health Plan)									
Annual SNP Program Education Efforts									
Staff (enter target completion date under goal; indicate actual completion under reporting period)									
Practitioners (enter target completion date under goal; indicate actual completion under reporting period)									
SNP Transitions of Care									
Data Elements									
Total # SNP hospital admits									
Total # SNP Member SNF/LTC admits									
Total # SNP admits through ER									
Total # ER visits SNP Members									

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.

*Recommend use of the **ICE Transition of Care (TOC) log** for data-related reporting elements.*

MEDICARE SPECIAL NEEDS PLANS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Total # of outpatient/ambulatory care transitions (as required by Health Plan)									
Compliance with Timeframes									
Managing Transition									
% Care plan transition in 1 business day (TOC-AC)									
% Practitioner notification within set timeframe (TOC-AE)									
Supporting Member									
% Member/caregiver communication about care transition process within set timeframe (TOC-Y)									
% Member/caregiver communication about changes to Member's health status and plan of care within set timeframe (TOC-AA)									
% Member/caregiver provided consistent person or unit responsible through transitions (TOC-W)									
Identification of Transitions									
% SNP Member hospital admits identified in 1 business day (TOC-V)									
% SNP SNF/LTC facility admits identified in 1 business day (TOC-V)									
Reducing Unplanned Transition									
% Monthly identification of Members at risk of admission. (Information may be extracted from the following: data from claims, UM Report e.g. Readmission Report, Frequent ER Visit, Provider report, predictive modeling, etc.)									
% Annual identification of Members at risk of admission through analysis of Member admissions to hospital and ED visit									

12. Special Needs Plan Work Plan and Reports

Special Needs Plans: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
SNP Population Assessment:			
SNP Member Experience: % Positive Experience			
SNP CM Program Effectiveness Analysis: (optional unless required by Health Plan)			
Transitions Processes:			
Member/Caregiver Communication:			
Reducing Transitions:			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions			
2nd Semiannual a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions			
Annual a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions g. Annual SNP Program Education			

Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	Interventions/Follow-up Actions State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	Re-Measurement State target date(s) for re-measurement or completion of follow-up actions.
Q1 a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q2 a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions			
Q3 a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions			
Q4 a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions			
Annual a. SNP Population Assessment b. Member Experience c. SNP CM Program Effectiveness d. Transitions Processes e. Member/Caregiver Communication f. Reducing Transitions g. Annual SNP Program Education			

13. Experience Work Plan and Reports

Experience (Satisfaction) with UM Process: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

14. Utilization and Referral Timeframe Compliance Metrics

The Provider Organization may attach a separate internal system-generated report that includes the listed data types. Below are suggested over/under utilization metrics. Health Plans to inform contracted Provider Organizations regarding any required over/under utilization metrics.

OVER- & UNDERUTILIZATION STATISTICS	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
COMMERCIAL									
Enrollment (self-reported)									
Medical									
Total # auths									
Total # auths PTMPY									
SENIOR									
Enrollment (self-reported)									
Medical									
Total # auths									
Total # auths PTMPY									
Behavior Health									
Total # auths									
Total # auths PTMPY									
Medi-Cal									
Enrollment (self-reported)									
Medical									
Total # auths									
Total # auths PTMPY									

REFERRAL TIMEFRAME COMPLIANCE	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
COMMERCIAL									
Routine									
Total # auths compliant									
Auths compliant by %									
Average TAT in days									
Urgent									
Total # auths compliant									
Auths compliant by %									
Average TAT in hours & minutes									
SENIOR									
Routine									
Total # auths compliant									
Auths compliant by %									
Average TAT in days									
Urgent									
Total # auths compliant									
Auths compliant by %									

REFERRAL TIMEFRAME COMPLIANCE	2023 YTD	2023 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Average TAT in hours & minutes									
Medi-Cal									
Routine									
Total # auths compliant									
Auths compliant by %									
Average TAT in days									
Urgent									
Total # auths compliant									
Auths compliant by %									
Average TAT in hours & minutes									

Need to capture specifics for clinical staff (nurses and physicians specifically) as well as non-clinical staff handling UM requests.

Submit via FTP in folder "Delegation Report."

15. Over/Under Utilization and Referral Timeframe Compliance Work Plan & Reports

Utilization and Referral Timeframe Compliance: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

16. Other UM Work Plan & Reports

Other UM Activities: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities: Describe IRR Measurement Process**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Annual Inter-rater Reliability Evaluation – Non-clinical UM staff **# of Staff:** **Goal Reliability Rate:**			
Annual Inter-rater Reliability Evaluation – Clinical Staff **# of Staff:** **Goal Reliability Rate:**			
Annual Inter-rater Reliability Evaluation – Physician Staff **# of Staff:** **Goal Reliability Rate:**			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up Actions** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan, add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semiannual			
2nd Semiannual			
Annual			
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e., state if goals were met or not met, include what caused the problem/issue)	**Interventions/Follow-up** State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan: add a specific new process, etc.)	**Re-Measurement** State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

Need to capture specifics for clinical staff (nurses and physicians specifically) as well as non-clinical staff handling UM requests.

Submit via FTP in folder "Delegation Report."

Case Management Report

MSO Name <if none, leave blank>	IPA Name or IPA Identifier	Beneficiary HICN <Medicare No. (9-digit plus a letter)>	Date Referred to Case Management (CM) <mm/dd/yyyy>	Who referred Member to CM? <Indicate referral source- UM, PCP, SW, etc.>	Date of outreach to Member to offer enrollment in CM <mm/dd/yyyy>	What CM Program did Member enroll? <Indicate Complex, SNP, etc.> <If not enrolled, leave blank>
CM Status - Active, Closed, Declined, or Unable to Contact (UTC) <Indicate Active, Closed, Declined, or UTC>	Date Completed Assessment? <mm/dd/yyyy> <If none leave blank>	Date Plan of Care (POC) completed? <If none, leave blank>	Was POC completed within 30 days of enrollment? <Indicate Y/N or N/A>	Was PCP informed of Member enrollment in CM? <Indicate Y/N or N/A>	Member's ICT Team (interdisciplinary team) identified? <Indicate Y/N or N/A>	Member's Risk Level Stratification < Indicate High, Medium or Low>
Is the POC updated no less than annually and upon change in Member's status? <Indicate Y/N or N/A>	Primary DX Code <Insert Dx Code>	CM Closed Date <Indicate date CM enrollment closed <mm/dd/yyyy> <if N/A, leave blank>	Provide Satisfaction with CM Score <Percentage with no percent sign> <if none, insert N/A>			

IPA/Medical Group: _____

Reporting Month: _____

Complex & High Risk Case Management Referral

Date of Referral: _____

From: _____ Department: _____

Phone: _____ Fax: _____

Please email the completed form to:

Wellcare Health Plan
Case Management Department
ECCaseManagement@wellcare.com
Or fax to **855-538-0455**

The patient is being referred for Complex Case Management due to the following unmet need:

☐Special Needs (D-SNP) Member	☐Transplants or transplant listed (major organ, stem cell, bone marrow)
☐End Stage Renal Disease (on dialysis)	☐Cancer (requiring hospitalization but not on hospice, multiple non-chemo admits, failed chemo)
☐Complex Behavioral Health Needs	☐Diabetes Management
☐Readmission within 30 days for the same diagnosis	☐Asthma/COPD Management
☐Traumatic Injuries (Spinal cord, multiple major fractures)	☐Congestive Heart Failure
☐Multiple admissions for the same/similar diagnoses	☐Clinical Complex issues requiring multifaceted, high-cost care
☐Multiple Chronic Illnesses	☐Neurological Impairment (ALS, MS, Guillain-Barre)
☐Extensive Burns	☐Extensive Wounds
☐Physician Referral	☐Patient Request

Member Name: _____ ID Number: _____

Phone Number: _____ Date of Birth: _____

Physician's Name: _____ Phone Number: _____

Pertinent Clinical History:

_____

_____

_____

_____

_____

Mailing Address: P.O. Box 6025 | Cypress, CA 90630
Telephone: 866-999-3945 **| E-mail:** ECCaseManagement@wellcare.com

Population Health Process/lel

Delegated IPA Case Management Program Requirements

- **Identification of Members for Inclusion to the Case Management Program** (applicable to Medicare Advantage and benefit plan) – The IPA must use the following sources to identify Members for Case Management services and specify the criteria:
    - Claim or encounter data
    - Hospital discharge data
    - Pharmacy data
    - Data collected through the UM process
    - Data collected by purchasers
    - Data supplied by Member or caregiver
    - Data supplied by practitioners

Data sources reviewed to determine compliance – documented process and reports.

- **Access to Case Management** (applicable to Medicare Advantage benefit plan) – The IPA must have a multitude of avenues for Members to be considered for Case Management services, including:
    - Disease Management referral
    - Discharge planner referral
    - UM referral
    - Member self-referral – The IPA must demonstrate it provides a means for Member referral by communicating the availability of the program and contact information
    - Practitioner referral – The IPA must demonstrate it provides a means for practitioner referral by communicating the availability of the program and contact information
    - Health information line referral

Data sources reviewed to determine compliance – documented process, reports, and materials

Data sources reviewed to determine compliance – documented process and reports.

- **Case Management Systems** (applicable to Medicare Advantage benefit plan) – The IPA uses systems that support:
    - Evidence based clinical guidelines or algorithms to conduct assessment and management – Algorithmic logic scripts or other prompts to guide

case managers through the assessment and ongoing management of the Member. The IPA must provide documentation of the clinical evidence used to develop the systems.
    - Automatic documentation of staff ID and the date and time of action on the case or interaction with the Member.
    - Automated prompts for follow-up as needed.

  Data sources reviewed to determine compliance – documented process, reports, and file review.

- **Case Management Process** (applicable to Medicare Advantage benefit plan) – The IPAs procedures must address the following:
    - The Member's right to decline participation or disenroll from the program.
    - Documentation of clinical history, including disease onset, key events such as acute phases and inpatient hospitalizations, treatment history and current and past medications.
    - Development of an individualized care plan, including long- and short-term goals and barriers to meeting the goals or complying with the plan.
    - Initial assessment of the following:

        - Health status, including condition-specific issues.
        - Activities of daily living.
        - Mental health status, including psychosocial factors and cognitive functions such as the ability to communicate, understand instructions and process information about their illness.
        - Life-planning activities such as wills, living wills or advance directives and healthcare power of attorney. If expressed life-planning instructions are not on record, determine if such a discussion is appropriate.

    - Evaluation of the following:
        - Cultural and linguistic needs, preferences or limitations.
        - Visual and hearing needs, preferences or limitation
        - Caregiver resources such as family involvement in and decision-making about the care plan
        - Assessment of the Member's eligibility for health benefits and other financial information regarding benefits

    - Development of a schedule for follow-up and communication with the Member that includes counseling, referral to a Disease Management program, education and self-management support.

- Development and communication of Member self-management plans – Instructions or material provided to the Member or their caregiver to help them manage their condition. There must be documentation in the file of the information provided and the means of communication.
- A process to assess progress toward overcoming barriers to care and meeting treatment goals and reassessment and adjusting the care plan and its goals if needed.
- Facilitation of Member referrals to resources and follow-up processes to determine whether Members act on referrals. Data sources reviewed to determine compliance – documented process and file review.

- **Satisfaction with Case Management** (applicable to Medicare Advantage benefit plan)
  - At least annually the IPA must evaluate satisfaction with its program by:
    - Obtaining feedback from Members. Feedback must be specific to the Case Management Program. CAHPS and other general survey questions do not meet the intent of this element.
    - Analyzing Member complaints and inquiries.

Data sources reviewed to determine compliance – documented process and reports.

- **Measure Effectiveness** (applicable to Medicare Advantage benefit plan) – Using three measures, the IPA measures the effectiveness of the program. For each measure the IPA must:

  - Identify a relevant process or outcome. The IPA must select measures or processes that have significant and demonstrable bearing on a defined portion or subset of the Case Management population or process so that appropriate interventions would result in significant improvement for the population. Participation rates cannot be consistently measures and are not measures of effectiveness.
  - Uses valid methods that provide quantitative results.
  - Establish an explicit, quantifiable performance goal for each measure.
  - Clearly identify measure specifications.
  - Analysis of the findings to include a comparison of results against goals and an analysis of the causes of any deficiencies (if appropriate). The analysis must go beyond data display or simple reporting of the results.
  - Identify opportunities for improvement, if applicable.
  - Develop a plan for intervention and re-measurement.

Data sources reviewed to determine compliance – documented process and reports.

- **Action and Re-measurement** (applicable to Medicare Advantage benefit plan) – Based on the results and analysis the IPA must:
    - Implement at least one intervention to improve performance.
    - Re-measure to determine performance. Re-measurement methods must be consistent with initial measurements.

Data sources reviewed to determine compliance – documented process and reports.

- **Managing Transitions** – Facilitate safe transitions by the following tasks and monitoring system performance:

    - Identify that a planned transition is going to happen to the hospital and from the hospital to the next setting. A planned transition may include an elective surgery or a decision to enter a SNF.
    - For planned and unplanned transitions to and from the hospital, sharing the sending settings care plan with the receiving setting within 1 business day of notification of the transition. A care plan is a set of information about the Member that facilitates communication, collaboration and continuity across settings. The care plan may contain both medical and non-medical information (current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, contact information for professional care Providers and informal care Providers).
    - For planned and unplanned transitions to and from any setting, notify the Member's PCP of the transition within 1 business day.
    - At least annually conduct an analysis of the IPAs aggregate performance of managing the transitions as outlined above.

Data sources reviewed to determine compliance – Documented process, reports, and materials.

- **Supporting Members Through Transitions** – Facilitates safe transitions by the following tasks and monitoring system performance:
    - For planned and unplanned transitions to and from any setting communicating with the Member or responsible party about the care transition process within 1 business day.
    - For planned and unplanned transitions to and from any setting communicating with the Member or responsible party about changes to the Member's health status and plan of care within 1 business day.
    - For planned and unplanned transitions to and from any setting, providing each Member with a consistent person within the IPA to support the

Member through transitions between any points in the system within 1 business day.
    - At least annually conduct an analysis of the IPAs aggregate performance of managing the transitions as outlined in above.

Data sources reviewed to determine compliance – Documented process and reports, and materials.

- **Identification of Unplanned Transitions** – The IPA reviews the following:
    - Reports of acute hospital admissions within 1 business day of admit.
    - Reports of SNF admissions within 1 business day of admit.

Data sources reviewed to determine compliance – documented process and reports.

- **Reducing Transitions** – The IPA minimizes unplanned transitions by:
    - At least monthly analyzing data to identify Members at risk of a transition.
    - Coordinating services for Members at risk of having a transition.
    - Educating Members or responsible parties about transition and how to prevent unplanned transitions.
    - At annually analyzing Member admit and ER visit rates and identify areas for improvement.

Data sources reviewed to determine compliance – documented process, reports, and materials.

- **Coordination of Benefits** – The IPA coordinates Medicare and Medicaid benefits by:

    - Informing Members how to maintain their Medicaid eligibility.
    - Providing information to Members about benefits they are eligible to receive from both programs.
    - Providing access to staff who can advise Members on using both Medicare and Medicaid.
    - Giving Members clear explanations of benefits and communication they may receive regarding claims or cost-sharing information.
    - Giving Members clear explanations of their right to files grievances and appeals under Medicare and Medicaid.

Data sources reviewed to determine compliance – documented process, reports, and materials.

Connectivity and Communication (FTP)/Testing

Wellcare only supports EDI through encrypted File Transfer Protocol (FTP) over the Internet.

Wellcare will accept batched electronic file/data exchange through the use of Wellcare's FTP servers.

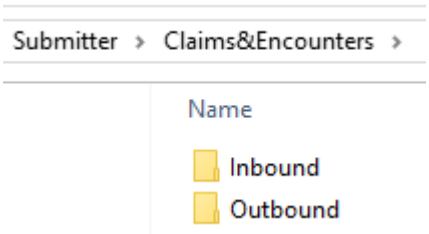
Due to patient confidentiality and HIPAA regulations, all transmissions must be secure. Therefore, Wellcare's implementation of FTP requires that trading partners using Wellcare's FTP servers connect using one of these three connection types:

- SFTP – Secure FTP over SSH
- FTPES – FTP over explicit TSL/SSL
- FTPS – FTP over implicit TSL/SSL

Note: All connection must use at least 128-bit encryption.

When using a Wellcare FTP server, trading partners must authenticate with a user name and password to establish an encrypted channel. Wellcare, based on schedules in the Trading Partner Agreement, will check Wellcare FTP servers and process data as necessary. Please note that when a request for FTP access is established for a trading partner, subfolders are automatically created, which corresponds to the data type requestors indicate on their request form. For example, if a trading partner requests access to the Claims/Encounter data type, the Claims & Encounters subfolder will be created in the trading partner's FTP top level folder.

The relevant data type with respect to this companion guide would be the claim/encounter data type. Included in the Claims & Encounters folder will be the inbound, outbound and test sub-folders. The usage of these folders is described below:



This is read-only data-type folder contains data and files pertaining to ANSI 837 transmissions.

Inbound – New production 837 files should be submitted here. This is a read-and-write folder.
Outbound – New and old production acknowledgements, reports and other feedback can be downloaded from here. This is a read-only folder.

See the image above. The top-level directory indicates the Trading Partner; it often will be the trading partner's name. The next sub-level of folders indicates data types (e.g., claims, eligibility, claim/encounter). As one progresses down the hierarchy, there may be additional subfolders.

If there are ever any question about the organization or use of an FTP folder, please direct your question to the appropriate Wellcare representative.

Specifications for FTP

The following items are required to exchange data with Wellcare using FTP. The trading partner is responsible for the acquisition and installation of these items.

- Internet Connectivity – if large files are to be transmitted, then the trading partner should consider a broadband connection.
- Computer with FTP client and internet connectivity. The FTP client must support at least one of the connection types list above (SFTP, FTPS, FTPES) utilizing at minimum 128-bit encryption
- Email capability to exchange configuration and test information.

Testing

This section details the testing procedures for anyone who wants to submit electronic claims/encounters directly to Wellcare. Before implementing direct 837 EDI claims/encounter submission with Wellcare, testing must be successfully completed. The following series of tests will be run.

- Connection testing

The first phase of testing ensures the ability to exchange files securely. Testing involves exchanging test files (dummy data) through the chosen FTP interface.

Submitter should have already submitted an Wellcare FTP Access Request Form to Wellcare before testing. Once an FTP folder is set up here at Wellcare, the IP address, username and password necessary for FTP transmissions will be given to the submitter. Submitter should also have FTP client software installed.

Test Goals: Successful transmission of 837 files and reception of feedback

- Initial Content & Process Testing

The second phase of testing checks that the claim files are in acceptable form. The submitter is asked to send a file of 15-25 claims using real Wellcare claims/encounter data. A file naming convention (including some form of incremental date stamp designation) that will work with submitter's file production/automation processes will be discussed and tested.

Please note that test claims will NOT be processed. If test claims are sent as a subset of your production batch, you must make sure that those claims included in the test are also submitted on paper to the usual claims mailing address. In addition, Wellcare will run the submitted 837 against a HIPAA testing/certification service to check for HIPAA compliance. Results of that compliance test will be communicated back to the submitter.

Contact List

EDI Team: **ec_edi@wellcare.com** (General inquiries about ramp-up process, FTP issues, notifications of data transmission, and other general electronic data interchange related questions)

Compliance Program Manual

Compliance Program – Overview

Wellcare's Corporate Ethics and Compliance Program, as may be amended from time to time, includes information regarding Wellcare's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Wellcare, Wellcare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider employees and Provider sub-contractors and their employees, are required to comply with Wellcare Compliance Program requirements. Also, physicians and other providers, including delegated independent practice associations (IPAs), must comply with federal and state false claims laws. Wellcare's compliance-related training requirements include these initiatives:

- HIPAA Privacy and Security Training
    - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA
    - Training includes to discussion on:

        - Proper uses and disclosures of PHI
        - Member rights
        - Physical and technical safeguards
- Fraud, Waste and Abuse (FWA) Training
    - Must include:
        - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.)
        - Obligations of the Provider including Provider employees and Provider sub-contractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse
        - Process for reporting suspected fraud, waste and abuse
        - Protections for employees and subcontractors who report suspected fraud, waste and abuse
        - Types of fraud, waste and abuse that can occur

Wellcare's compliance responsibilities extend to delegated entities, including, without limitation:

- Compliance Plan
- HIPPA Privacy and Security
- Fraud, Waste and Abuse Training
- Cultural Competency Plan
- Disaster Recovery and Business Continuity

Providers, including Provider employees and/or Provider sub-contractors, must report to Wellcare any suspected fraud, waste or abuse, misconduct or criminal acts by Wellcare, or any Provider, including Provider employees and/or Provider sub-contractors, or by Wellcare Members. Reports may be made anonymously through the Fraud, Waste and Abuse Hotline at **866-685-8664**. Details of the Corporate Ethics and Compliance Program can be found at **www.centene.com/who-we-are/ethics-and-integrity.html**.

Marketing Medicare Advantage Plans

Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V (replacing regulations formerly at 42 CFR 422.80), and the CMS *Managed Care Manual*, Chapter 3, *Medicare Marketing Guidelines for MA Plans, MA-PDs, PDPs and 1876 Cost Plans* (Marketing Guidelines), including without limitation materials governing "Provider Based Activities" in Section 70.8.3.

Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including without limitation 42 CFR Part 422, Subpart V and the Marketing Guidelines.

CMS holds plan sponsors such as Wellcare responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting Providers. Providers are not authorized to engage in any marketing activity on behalf of Wellcare without the prior express written consent of an authorized Wellcare representative, and then only in strict accordance with such consent.

Code of Conduct and Business Ethics

Overview

Wellcare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance.

The Code of Conduct and Business Ethics is the foundation of iCare, Wellcare's Corporate Ethics and Compliance Program. It describes Wellcare's firm commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity. All associates, covered persons as defined by the CIA, participating Providers and other contractors should familiarize themselves with Wellcare's Code of Conduct and Business Ethics. Wellcare associates, covered persons, participating Providers and other contractors of Wellcare are encouraged to report compliance concerns and any suspected or actual misconduct using the Ethics and Compliance Hotline at **800-345-1642**. Report suspicions of fraud, waste and abuse by calling the Fraud, Waste and Abuse Hotline at **866-685-8664**.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or their case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members' medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where

required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice must provide Members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to Member records and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include:

- Medical records
- Communication between a Member and a physician regarding the Member's medical care and treatment
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws
- Any communication with other clinical persons involved in the Member's health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security number (SSN), etc.)
- Member transfer to a facility for treatment of drug and/or alcohol use disorders, or Behavioral Health concerns
- Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law

The NPP informs the patient or Member of their Member rights under HIPAA and how the Provider and/or Wellcare may use or disclose the Member's PHI. HIPAA regulations require each covered entity to provide an NPP to each new patient or Member.

Disclosure of Information

Periodically, Members may inquire as to the operational and financial nature of their health plan. Wellcare will provide that information to the Member upon request. Members can ask for the above information verbally or in writing.

For more information on how to request this information, Members may call Customer Service using the toll-free phone number found on the Member's ID card.

Medicare Regulatory Requirements

As a Medicare contracted provider, you are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare Members in any way based on the health status of the Member.
- Providers may not discriminate against Medicare Members in any way on the basis of race, color, national origin, sex, age, or disability in accordance with subsection 92.8 of Section 1557 of the Patient Protection and Affordable Care Act.
- Providers must ensure that Members have adequate access to covered health services.

- Providers may not impose cost sharing on Members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow Members to directly access screening mammography and influenza vaccinations.
- Providers must provide Members with direct access to health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Wellcare will provide you with at least 180 days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 180 days. Providers agree to notify Wellcare according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operations are convenient to the Member and do not discriminate against the Member for any reason. Providers will ensure necessary services are available to Members 24 hours a day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Wellcare Members without CMS and/or Wellcare approvals of the materials and forms.
- Services must be provided to Members in a culturally competent manner, including Members with limited reading skills, limited English proficiency, Members who are deaf or hard of hearing or are blind or have low vision and diverse cultural and ethnic backgrounds.
- Providers will work with Wellcare procedures to inform our Members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the Member's medical record whether the Member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Wellcare to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit Members to make an informed choice about their Medicare coverage.
- Providers must cooperate with Wellcare in notifying Members of provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any Wellcare medical policies, QI programs and medical management procedures.

- Providers will cooperate with Wellcare in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Wellcare procedures for handling grievances, appeals, and expedited appeals.
- Providers must request prior authorization from the plan if the provider believes an item or service may not be covered for a Member, or could only be covered under specific conditions. If the provider does not request prior authorization, the claim may be denied and the provider will be liable for the cost of the service. Note: if the item or service is never covered by the plan as clearly denoted in the Member's Evidence of Coverage, no prior notice of denial is required and the Member may be held responsible for the full cost of the item or service.
- Providers must allow CMS or its designee access to records related to Wellcare services for a period of at least ten (10) years following the final date of service or termination of this agreement, unless a longer period is required by applicable state or federal law.
- Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- Provider shall provide services in accordance with Wellcare policy: (a) for all Members, for the duration of the Wellcare contract period with CMS, and (b) for Members who are hospitalized on the date the CMS contract with Wellcare terminates, or, in the event of an insolvency, through discharge.
- Provider shall disclose to Wellcare all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

Provider Accessibility Initiative

Wellcare is committed to providing equal access to quality healthcare and services that are physically and programmatically accessible for our Members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards.

One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that Members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access.

- Wellcare expectation, for Providers, as communicated through the Provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final

rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act).

Delegated Entities

Overview

Wellcare, may, by written contract, delegate certain functions under Wellcare's contracts with CMS and/or applicable state governmental agencies. These functions include contracts for administration and management services, marketing, utilization management, Care Management, disease management, claims processing, claims payment, credentialing, network management, Provider claim appeals, customer service, enrollment and disenrollment. Wellcare may delegate all or a portion of these activities to another entity (a Delegated Entity).

Wellcare oversees the provision of services provided by the delegated entity and/or sub-delegate, and is accountable to the federal and state agencies for the performance of all delegated functions. It is the ultimate responsibility of Wellcare to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Wellcare policies and procedures.

Delegation Oversight Process

Wellcare's Delegation Oversight Committee (DOC) was formed to provide oversight for all subcontracted vendors where specific services are delegated to an entity. Wellcare defines a delegated entity" as a subcontractor that performs a core function under one of Wellcare's government contracts. The Delegation Oversight Committee is chaired by the Director, Compliance Oversight, G&A Compliance. The committee members include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and market representatives from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

Refer to *Section 8: Compliance* of this Manual for additional information regarding compliance requirements.

Wellcare monitors compliance through the delegation oversight process and the Delegation Oversight Committee by:

- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function
- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory requirements and accreditation standards
- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated
- Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements of Wellcare's Medicare and Medicaid program
- Track and trend compliance with oversight standards, entity performance, and outcomes