2026 NCQA Annual Accreditation

PROVIDING QUALITY CARE

Wellcare is providing the following quality and safety information from our Quality Improvement (QI) program to valued practitioners like you as you work to deliver the very best care to your patients and members.

ANNUAL MEMBER EXPERIENCE SURVEYS

The Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS), the Qualified Health Plan Enrollee Experience Survey (QHPEES), and the Outpatient Mental Health Survey (OPMH) offer patients opportunities to report their satisfaction with their healthcare, including their experience with their practitioners, providers, and the health plan. Survey results are used to determine patient and member satisfaction, their likelihood of staying with their practitioner, provider, or health plan, and identify opportunities to improve satisfaction with their healthcare.

ANNUAL PROVIDER SATISFACTION SURVEY

You are essential to providing the highest-quality healthcare possible for members, and your satisfaction is equally important. Wellcare assesses your experience with the plan through an annual Provider Satisfaction Survey. These survey results are key to helping improve the provider experience. Your feedback informs improvement opportunities and quality initiatives, so please be sure to complete the survey if you receive one.

PROVIDER CREDENTIALING RIGHTS

During the credentialing process, Wellcare obtains information from various sources to evaluate your application. Ensuring the accuracy of this information is key, so please review and provide any corrected information as soon as possible. **Please review your provider manual regarding this correction process.** You also have the right to review the status of your credentialing or re-credentialing application at any time by calling your health plan Provider Engagement Representative.

PROVIDER DIRECTORY AND CONTINUED ACCESS TO CARE

If your address or telephone number changes, or if you can no longer accept new patients or are leaving the network, please notify Wellcare as soon as possible so we can update the Provider Directory. Having access to accurate provider information is vitally important to members, and [PLAN_NAME] wants to work together to ensure continuity of care can be maintained.

UTILIZATION MANAGEMENT

Utilization Management (UM) decisions are based only on the appropriateness of care and service and the existence of coverage.

Wellcare does not reward providers, practitioners, or other individuals for issuing denials of coverage or care and does not have financial incentives in place that encourage decisions resulting in underutilization. Denials are based on lack of medical necessity or lack of covered benefit. Nationally recognized criteria (such as InterQual or

MCG) are used if available for the specific service request, with additional criteria (e.g., clinical/medical policies) developed internally through a process that includes a review of scientific evidence and input from relevant specialists.

Submitting complete clinical information with the initial request for a service or treatment will help [PLAN_NAME] make appropriate and timely UM decisions. You may discuss any UM denial decisions with a physician or another appropriate reviewer at the time of notification of an adverse determination. You may also request UM criteria pertinent to a specific authorization request or for any other UM-related request or issue by contacting the UM department at the health plan.

CLINICAL CRITERIA

Clinical decision-making criteria are available to you electronically at the point of care through EHR, the provider portal and on the website.

TRANSITION TO OTHER CARE

Providing quality care to members includes helping adolescents transition to an adult care provider. If you or one of your patients need assistance in finding an adult primary care provider or specialist, or arranging care (if needed), contact Wellcare or reference the information in the Provider Manual.

PHARMACY

The health plan formulary/Preferred Drug List (PDL) is based on the benefits of the plan and is updated on a regular basis. If you believe a medication merits an addition to the PDL, a request may be submitted using the Formulary Change Request form. The current PDL, which includes information regarding covered drugs, restrictions, prior authorization requirements, limitations, etc., is located on the health plan website.

HEALTH EQUITY

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to:

- Address historical and contemporary injustices.
- Overcome economic, social, and other obstacles to health and healthcare.
- Eliminate preventable health disparities.

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities. For more information about Culturally and Linguistically Appropriate Services (CLAS) standards, see https://thinkculturalhealth.hhs.gov/clas.

LANGUAGE & INTERPRETER SERVICES

Together, we must make language assistance services available to people with Limited English Proficiency (LEP) at all points of contact, during all hours of operation, and at no cost to our members. We are here to provide language assistance to Wellcare members and providers without unreasonable delay at all vital points of contact. You can schedule language services, including telephone and face-to-face interpretation for non-English languages and American Sign Language, by calling our Provider Customer Contact Center or by calling the toll-free number on the back of the member ID card. Additional resources can be found on the website.

CULTURAL HUMILITY RESOURCES

The health plan encourages providers to engage in Cultural Humility training and education to promote positive interaction with diverse cultures.

For more information about the Cultural and Linguistic Competency resources from the Office of Minority Health (OMH), see the Communication Guide - Think Cultural Health. This program is designed to build knowledge, skills, and awareness of cultural and linguistic competency and CLAS as a way to improve quality of care.

ACCESS TO CASE MANAGEMENT

Our Care Management team is available for members who may benefit from increased coordination of services. The team supports providers with member issues including non-adherence to medications/medical advice, multiple complex co-morbidities, or to offer guidance with a new diagnosis.

The Care Management team helps members:

- Achieve optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Determine and access available benefits and resources.
- Develop goals and coordinate with family, providers, and community organizations to achieve these goals.
- Facilitate timely receipt of appropriate services in the right setting.

Early intervention is essential to maximizing treatment options and minimizing potential complications associated with illnesses, injury, or chronic conditions. Members can receive services through face-to-face visits, over the phone, or in a provider's office. You can directly refer members to the Care Management program at any time by calling the health plan or initiating a referral on the Provider Portal.

APPOINTMENT ACCESSIBILITY STANDARDS

Every year Wellcare assesses appointment accessibility with PCPs, specialists, and behavioral health practitioners. There are established standards for each type of appointment (routine care, urgent/sick visits, etc.) and type of practitioner. Please review the Provider Manual for the expectations of how quickly our members should be able to get an appointment.

MEMBER RIGHTS AND RESPONSIBILITIES

Providers are expected to follow member rights. Members are informed of their rights and responsibilities in their member handbook.

Member rights include, but are not limited to:

- Receiving all services the health plan provides.
- Being treated with dignity and respect.
- Knowing their medical records will be kept private, consistent with state and federal laws and health plan policies.
- Being able to see their medical records.

- Being able to receive information in a different format in compliance with the Americans with Disabilities Act.
- Access to language services at all points of contact during all hours of operation and at no cost to the member.

Member responsibilities include:

- Understanding their health problems and telling their healthcare providers if they do not understand their treatment plan or what is expected of them.
- Keeping scheduled appointments and calling the physician's office whenever possible if there is a delay or cancellation.
- Showing their member ID card at appointments.
- Following the treatment plans and instructions for care that they have agreed on with their healthcare practitioner.

We encourage you to reference the Provider Manual to review the full list of rights and responsibilities.