

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

**PLAN - SPECIFIC REPORT
FOR
WELLCARE OF NEW YORK, INC.**

Reporting Year 2009

April 2011

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Acronyms Used in This Report

(in alphabetical order)

ACOG: American College of Obstetrics and Gynecology
ALOS: Average Length of Stay
AO: Area Office
BAO: Buffalo Area Office (Region 1)
CHP: Child Health Plus
CO: Central Office
COM (C): Commercial
DBA: Doing Business As
DSS: Data Submission System
EQR: External Quality Review
EQRO: External Quality Review Organization
F/A: Failed Audit
FAR: Final Audit Report
FFS: Fee For Service
FHP: Family Health Plus
F/U: Follow-Up
FTE: Full Time Equivalent
HEDIS: Health Effectiveness Data and Information Set
HIE: Health Information Exchange
HIT: Health Information Technology
HMO: Health Maintenance Organization
HPN: Health Provider Network
LIAO: Long Island Area Office (Region 7)
MARO: Metropolitan Area Regional Office
MCO: Managed Care Organization
MED (M): Medicaid
MMC: Medicaid Managed Care
MMCOR: Medicaid Managed Care Operating Report
N: Denominator
N/A: Not Available
NCQA: National Committee for Quality Assurance
NEAO: Northeast Area Office (Region 4)
NERO: Northeast Regional Office
NP: Not Provided
NR: Not Reported
NRAO: New Rochelle Area Office (Region 5)

NV: Not Valid
NYC: New York City
NYCAO: New York City Area Office (Region 6)
NYCRR: New York Code Rules and Regulations
NYSDOH: New York State Department of Health
OB/GYN: Obstetrician/Gynecologist
OHIP: Office of Health Insurance Programs
OPMC: Office of Professional Medical Conduct
OP: Optimal Practitioner Contact
PCP: Primary Care Practitioner/Provider
PIP: Performance Improvement Project
PNDS: Provider Network Data System
POC: Plan of Corrective Action
PMPY: Per Member Per Year
PSR: Plan-Specific Report
PTMY: Per Thousand Member Years
PHSP: Prepaid Health Services Plans
Q1: First Quarter (Jan. – March)
Q2: Second Quarter (Apr. – June)
Q3: Third Quarter (July – Sept.)
Q4: Fourth Quarter (Oct. – Dec.)
QARR: Quality Assurance Reporting Requirements
R: Rotated
RAO: Rochester Area Office (Region 2)
RHIO: Regional Health Information Organization
ROS: Rest of State
RY: Reporting Year
SAO: Syracuse Area Office (Region 3)
SN: Safety Net
SOD: Statement of Deficiency
SS: Small Sample (Less than 30)
SSI: Supplemental Security Income
SWA: Statewide Average
TANF: Temporary Aid to Needy Families
UR: Utilization Review

I. About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed health care plans. The New York State Department of Health's (NYSDOH) Office of Health Insurance Programs (OHIP) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans and to maintain the continuity of care to the public.

The Plan-Specific Reports (PSRs) are individualized reports on the managed care organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2009 External Quality Review (EQR) to evaluate access to, timeliness of and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per federal regulation 42 CFR §438.358) reported include validation of performance improvement projects (PIPs), validation of plan-reported and NYSDOH-calculated performance measures and review for plan compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per federal regulation 42 CFR §438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified vendor and technical assistance by the NYS EQRO to plans regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment and disenrollment data, provider network information, encounter data summaries, PQI/compliance/satisfaction/quality points and incentive, appeal summaries and financial ratios.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, Health Information Technology, Deficiencies and Appeals, and Financial Data. Although the reports focus primarily on Medicaid data, selected sections of these reports also include data from the plans' Family Health Plus (FHP), Commercial and Child Health Plus (CHP) product lines. Additionally, when available and appropriate, the plans' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section IX provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has addressed effectively the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

In an effort to provide the most consistent presentation of this varied information, the PSR is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2009.

II. Corporate Profile

WellCare of New York, Inc. (WellCare) is a regional, for-profit health plan that services Medicaid, Family Health Plus (FHP), Child Health Plus (CHP) and Medicare populations. As of February 2006, the NYSDOH approved the plan's conversion to a prepaid health services plan (PHSP). The following report presents plan-specific information for the Medicaid line of business and selected information for the FHP and CHP product lines.

- Plan ID: 1240287
- DOH Area Office: MARO
- Corporate Status: PHSP
- Tax Status: For-profit
- Medicaid Managed Care Start Date: February 12, 1987
- Medicaid Service Area: Albany, Bronx, Dutchess, Kings, New York, Orange, Queens, Rensselaer, Rockland and Ulster
- Product Line(s): Medicaid, FHP, CHP and Medicare
- Contact Information: 110 Fifth Avenue, 3rd Floor
New York, NY 10011
(212) 463-6100
- NCQA Accreditation as of 6/30/10: Did not apply
- Medicaid Dental Benefit Provided as of 12/09: Not Provided

III. Enrollment and Provider Network

Enrollment/Disenrollment

Figure 1 depicts total membership for the plan’s Medicaid product line for calendar years 2007 to 2009, as well as, the percent change from the previous year. Membership has fluctuated over this period, increasing by 0.8% from 2007 to 2008 and decreasing by 2.5% from 2008 to 2009. Figure 1a represents the membership for other product lines carried by the plan. Figure 1b trends Medicaid membership and membership in these other product lines.

Figure 1: Membership: Medicaid – 2007-2009

	2007	2008	2009
Number of Members	72,675	73,237	71,417
% Change From Previous Year		0.8%	-2.5%

Data Source: MEDS II

Figure 1a: Membership: Other Product Lines¹ – 2007-2009

	2007	2008	2009
FHP	30,147	23,877	12,630
CHP	9,066	7,070	5,137

¹ While the Medicaid membership data presented in Figure 1 are derived from MEDS II in order to ensure consistency with the MEDS II data presented in Figure 2, the enrollment data in Figure 1a are obtained from the NYSDOH’s Managed Care Enrollment Report.

Figure 1b: Enrollment Trends – All Product Lines

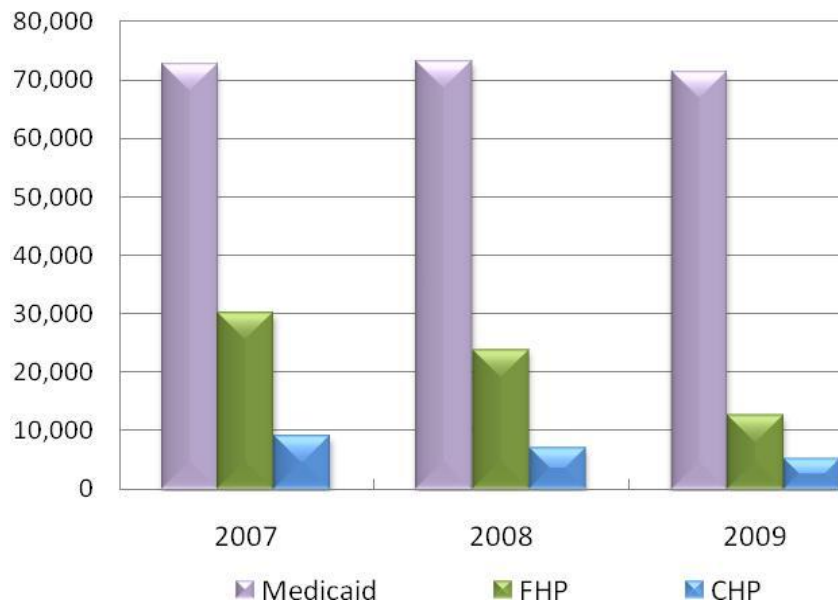


Figure 2 gives a breakdown of the plan's Medicaid membership by age and sex as of December 31, 2009. Children under 20 years of age comprise 45.2% of the total Medicaid enrollment, with 22.7% in the 5-14 age group. Thirty-four percent (33.8%) of the plan's Medicaid membership is women between the ages of 15-64 (women most likely to utilize OB/GYN services). The Figure also indicates whether the plan's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average. The plan's age distribution of enrollees includes a lower percentage of members aged under 1-year and a higher percentage of members aged 45 and older in comparison to the statewide distribution. Figure 2a displays the percentage of enrollees by age group for WellCare in comparison to the statewide percentages.

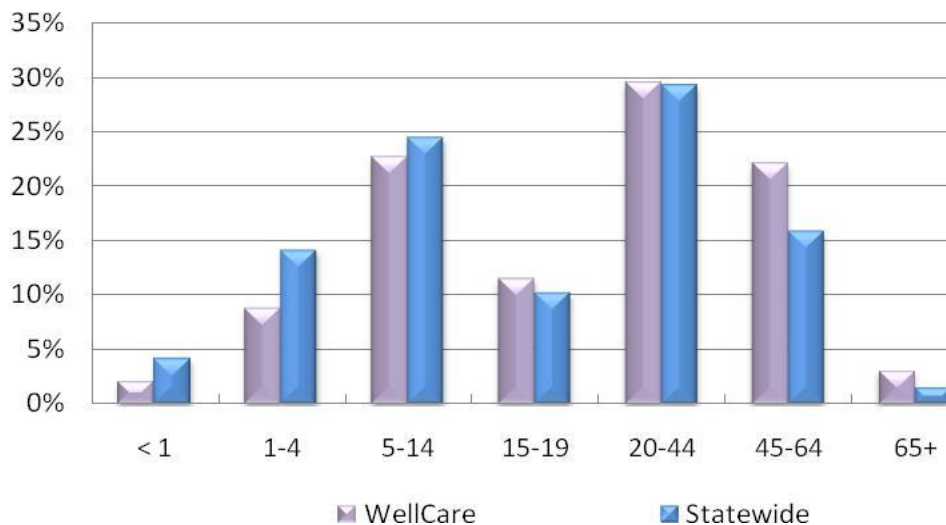
Figure 2: Medicaid Enrollee Age and Sex Distribution – December 2009

Age in Years	Male	Female	Total	Plan Distribution	Statewide
Under 1	777	728	1,505	2.1% ▼	4.3%
1-4	3,187	3,142	6,329	8.9%	14.1%
5-14	8,509	7,699	16,208	22.7%	24.5%
15-19	4,204	4,042	8,246	11.5%	10.2%
20-44	9,536	11,577	21,113	29.6%	29.4%
45-64	7,307	8,509	15,816	22.1% ▲	15.9%
65 and Over	880	1,320	2,200	3.1% ▲	1.6%
Total	34,400	37,017	71,417		
Under 20	16,677	15,611	32,288	45.2% ▼	53.1%
Females 15-64¹		24,128		33.8%	33.6%

Data source: MEDS II

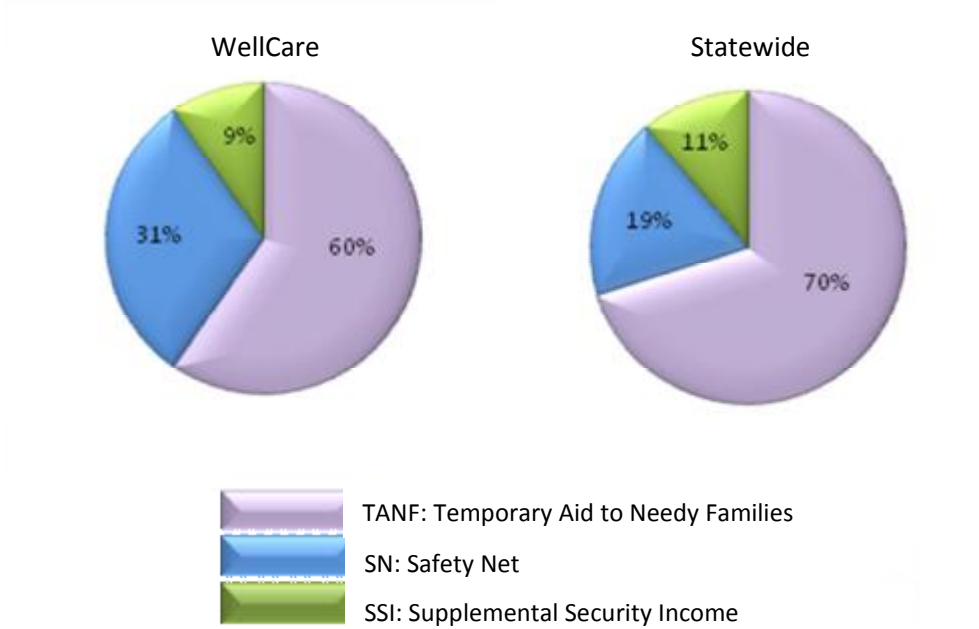
¹ Females between the ages of 15 to 64 were grouped for this category, since this grouping is inclusive of most women utilizing OB/GYN providers.

Figure 2a: Percentage of Medicaid Enrollees by Age – December 2009



A breakdown of plan membership by aid category, as reported by the NYSDOH for December 31, 2009, is shown in Figure 3. Members in the Temporary Aid to Needy Families (TANF) comprise a smaller percentage of the plan's membership than is seen statewide, while members in the Safety Net (SN) category comprise a larger percentage.

Figure 3: Medicaid Enrollees by Aid Category – December 2009



The percentage of members by each method of enrollment in the plan's Medicaid product line for 2007 through 2009 is presented in Figure 4. Whether a plan received a qualifying Medicaid auto assignment quality algorithm score is also available for each of these years. These scores determine 75% of auto-assignee distribution. WellCare received a score qualifying the plan for Medicaid auto assignment in 2007.

Figure 4: Method of Medicaid Enrollment – 2007-2009

Category	2007		2008		2009	
	WellCare	SWA	WellCare	SWA	WellCare	SWA
Auto Assigned	23.2%	13.6%	27.8%	13.3%	8.0%	7.3%
Self-Selected ¹	76.8%	86.4%	72.2%	86.7%	91.6%	92.8%
Qualifying Score ²	Y		N		N	

¹ These figures include new enrollees and enrollees who have transferred from another plan.

² Qualifying scores are based on the quality, satisfaction and compliance points that a plan achieves. For further information on how these scores are calculated, see Figure 17.

Figure 5 shows the plan's 2009 Medicaid and FHP disenrollment rates. Rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. For Medicaid and FHP, the rates are similar to those of the average plan in the state.

Figure 5: Medicaid and FHP Disenrollment Rates (by percentage of enrollees) – 2009

Enrollment Status ¹	Medicaid		FHP	
	WellCare	SWA	WellCare	SWA
Voluntary Disenrollment	1.30%	3.83%	1.23%	3.92%
Involuntary Disenrollment	0.04%	0.12%	0.01%	0.05%
Loss of Eligibility	2.41%	2.58%	2.99%	2.89%
Still Enrolled	96.26%	93.48%	95.76%	93.14%

¹ These data are derived from aggregating monthly enrollment figures.

Provider Network

Figure 6 shows the percentages of various provider types in the plan for the fourth quarter of 2009 in comparison to the statewide rates. PCPs are 25.3% of all providers in WellCare's provider network, which is similar to the statewide percentage of 23.4%. Other Specialties account for a higher percentage of the plan's provider network than is seen statewide, while Other PCPs and Behavioral Health providers account for smaller percentages. For this figure, plan percentages above statewide rates are indicated by ▲, while percentages below the statewide rates are indicated by ▼.

Figure 6: Medicaid Providers by Specialties – 2009 (Q4)

Specialty Type	Number	% of Total Panel	% Statewide
Primary Care Providers	3,576	25.3%	23.4%
<i>Pediatrics</i>	889	6.3%	5.8%
<i>Family Practice</i>	827	5.9%	4.2%
<i>Internal Medicine</i>	1,815	12.8%	11.3%
<i>Other PCPs</i>	45	0.3% ▼	2.1%
OB/GYN Specialty ¹	772	5.5%	5.0%
Behavioral Health	1,800	12.7% ▼	22.6%
Other Specialties	7,858	55.6% ▲	46.3%
Non-PCP Nurse Practitioners	126	0.9%	2.6%
Dentistry ²	1,231		
Total (excluding dentists)	14,132		

Data Source: HPN

¹ Includes OB/GYN specialists, certified nurse midwives and OB/GYN nurse practitioners.

² Dental providers are not included in the provider distribution by specialty or total provider count, since not all plans provide a dental benefit.

Figure 6a displays the ratio of enrollees to providers as well as the number of Full Time Equivalents (FTEs) and the ratio of enrollees to FTEs. Statewide data are also included. For this figure, rates above the 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

Figure 6a: Ratio of Enrollees to Providers for Medicaid – 2009 (Q4)

Specialty Type	WellCare			Statewide		
	Ratio of Enrollees to Providers	Total Number of FTEs	Ratio of Enrollees to FTEs	Median ¹ Ratio of Enrollees to Providers	Total Number of FTEs	Median ¹ Ratio of Enrollees to FTEs
Primary Care Providers	20:1	615.9	116:1	50:1	14,096.2	153:1
<i>Pediatrics (Under age 20)</i>	36:1			93:1		
OB/GYN (Females aged 15-64)	31:1			68:1		
Behavioral Health	40:1			44:1		

Data Source: Derived ratios calculated from MEDS II enrollment data and HPN provider data.

¹ The statewide median was used for this Figure as opposed to an average to control for substantial variability due to outliers.

The number of Medicaid PCPs with an “Open Panel” is presented in Figure 6b for the fourth quarters of 2007 through 2009. Panels are considered “open” if a provider has less than 1,500 Medicaid members. For this figure, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Figure 6b: Medicaid PCPs with an Open Panel – 2007-2009 (Q4)

	2007			2008			2009		
	WellCare		Statewide	WellCare		Statewide	WellCare		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Providers with Open Panel	2,876	94.1%	96.2%	3,262	95.5%	97.0%	3,316	94.2%	96.3%

Data Source: HPN

Figure 7 displays QARR *Board Certification* rates for 2007 through 2009 of providers in the plan's network in comparison to the statewide averages (SWAs). The Figure also indicates whether the plan's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average. The plan's 2009 Medicaid board certification rates are similar to the statewide averages.

Figure 7: QARR Board Certification Rates – 2007-2009

Provider Type	2007		2008		2009	
	WellCare	SWA	WellCare	SWA	WellCare	SWA
Medicaid:						
Family Medicine	85% ▲	80%	81%	82%	80%	81%
Internal Medicine	84% ▲	79%	83%	82%	83%	83%
Pediatricians	84% ▲	79%	84%	83%	82%	82%
OB/GYN	83% ▲	74%	82% ▲	76%	76%	77%
Geriatricians	83%	74%	88% ▲	75%	81%	73%
Other Physician Specialists	76% ▼	78%	82% ▲	81%	80%	79%

NYSDOH Primary Care Access & Availability Survey – 2009

On behalf of the NYSDOH's Division of Managed Care, the NYS EQRO annually conducts the Medicaid Managed Care Access & Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid/Family Health Plus Managed Care Contract. The 2009 survey evaluated the availability of routine and non-urgent "sick" office hour appointments with primary care physicians, including OB/GYNs, as well as the availability of after hours access.

The timeliness standard for routine office hour appointments with PCPs and OB/GYNs is within 28 days of the enrollee's request, while non-urgent "sick" office hour appointments with PCPs and OB/GYNs must be scheduled within 72 hours (excluding weekends and holidays) as clinically indicated. Prenatal appointments with OB/GYN providers within the 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a live voice representing the named provider is reached or if the named provider's beeper number is reached.

A random sample of 240 provider sites was selected from each region in which a health plan operated and provided primary care as a Medicaid and/or Family Health Plus benefit. Of these 240 provider sites, 120 were surveyed for routine appointments, 80 were surveyed for non-urgent "sick" appointments and 40 were surveyed for after hours access. For MCOs with less than the 240 available provider sites, all providers were selected.

For call type categories in which compliance is below the 75% threshold, plans will receive a Statement Of Deficiency (SOD) issued by the NYSDOH and will be required to develop a Plan Of Correction (POC). These POCs must be approved by the NYSDOH before implementation. Following an allowable time period for plans to execute their POCs, a resurvey will be conducted of the failed providers.

Figure 8 illustrates the plan's Primary Care Access & Availability results for 2009. WellCare exceeded the 75% threshold for routine and non-urgent "sick" appointments in Region 5, and exceeded the threshold for after hours access in Region 4.

Figure 8: Primary Care Access & Availability Survey – 2009

Region	Call Type	WellCare	Region Average
4	Routine	67.5%	63.7%
	Non-Urgent "Sick"	65.6%	63.4%
	After Hours Access	80.0%	80.6%
5	Routine	79.0%	69.3%
	Non-Urgent "Sick"	83.6%	71.8%
	After Hours Access	72.5%	78.7%
6	Routine	74.2%	71.3%
	Non-Urgent "Sick"	68.8%	65.3%
	After Hours Access	70.0%	63.0%

IV. Utilization

This section of the report explores utilization of the health plan's services by examining encounter and health screening data, as well as QARR Use of Services rates.

Encounter Data

Figure 9 depicts selected Medicaid encounter data for 2007 through 2009. The plan's rates for these periods are also compared to the average plan rates. For this figure, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Figure 9: Medicaid/FHP Encounter Data – 2007-2009

	Encounters (PMPY)					
	2007		2008		2009	
	WellCare	SWA	WellCare	SWA	WellCare	SWA
PCPs and OB/GYN	3.18	4.06	4.02	4.37	4.35	4.32
Specialty	1.17	1.62	1.62	1.81	1.61	1.76
Emergency Room	0.34	0.58	0.37	0.58	0.37	0.68
Inpatient Admissions	0.08	0.14	0.09	0.15	0.09 ▼	0.15
Dental – Medicaid	NP	0.72	NP	0.80	7.13 ▲	0.95
Dental – FHP	0.51	0.83	0.47 ▼	0.91	0.50 ▼	1.10

Data Source: MEDS II

PMPY: Per Member Per Year

NP: Dental Benefit Not Provided

Health Screenings

In accordance with 13.6(a)(ii) of the Medicaid Managed Care and Family Health Plus Model Contract, plans must make reasonable efforts to contact new enrollees within 30 days of enrollment either in person, by telephone or by mail and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. Plans are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the plan was able to complete health screenings. Plan statewide 2007 rates ranged from 11.5% to 69.7% for Medicaid and 8.5% to 70.2% for FHP, while plan statewide rates for 2008 ranged from 13.5% to 61.5% for Medicaid and 9.9% to 60.1% for FHP. Plan statewide 2009 rates ranged from 11.1% to 63.6% for Medicaid and 11.0% to 58.3% for FHP. Figure 10 summarizes the percentage of Medicaid and FHP enrollees receiving health screenings within 30 days of enrollment from 2007 through 2009, in addition to displaying the statewide averages for these years. For this figure, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼.

Figure 10: Health Screenings – 2007-2009

	2007		2008		2009	
	WellCare	SWA	WellCare	SWA	WellCare	SWA
Medicaid						
Enrollee Health Screenings	20.3%	27.4%	23.1%	27.5%	18.2%	33.8%
FHP						
Enrollee Health Screenings	22.2%	30.1%	25.3%	26.9%	12.7% ▼	32.6%

QARR Use of Services Measures

For this domain of measures, the QARR reports assess performance by indicating whether the plan's rates reached the 90th or 10th percentiles. Figure 11 lists the Use of Services rates for the selected plan product lines for 2007 through 2009. The Figure indicates whether the plan's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the plan's rate was lower than 90% of all rates for that measure (indicated by ▼).

Figure 11: QARR Use of Services – 2007-2009

Measure	Medicaid/FHP				Child Health Plus			
	2007	2008	2009	SWA 2009	2007	2008	2009	SWA 2009
Outpatient Utilization (PTMY)								
Outpatient Visits	4,785.2	5,338.9	5,398.7	5,389.1	3,417.1	3,906.8	4,276.0	4,243.8
Outpatient ER Visits	352.3 ▼	371.5	395.5	583.0	198.0 ▼	222.0	281.4	312.5
Ambulatory/Surgery Encounters	53.3	65.0	56.9	100.2	13.8	23.2	21.1	34.2
Inpatient ALOS								
Medicine	3.6	3.8	3.8	3.8	3.1	2.7	2.4	2.9
Surgery	6.7 ▲	7.2 ▲	6.6	6.0	4.5	6.3 ▲	SS	5.1
Maternity	3.0	2.9	3.0	2.9	SS	SS	SS	2.8
Total (Medicine, Surgery & Maternity)	3.8	4.2 ▲	4.1 ▲	3.8	3.3	3.7 ▲	2.6 ▼	3.5
Inpatient Utilization (PTMY)								
Medicine Cases	39.7	42.0	41.4	55.1	14.0	12.3	10.8	13.2
Surgery Cases	9.6 ▼	11.5 ▼	11.7	14.3	4.3	5.1	SS	4.9
Maternity Cases	23.3 ▼	21.6 ▼	18.7 ▼	48.3	SS	SS	SS	1.9
Total Cases	67.8 ▼	70.5 ▼	67.9 ▼	103.4	19.4	18.4	16.7	19.3

PTMY: Per Thousand Member Years

ALOS: Average Length of Stay. These rates are measured in days.

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

V. Quality Indicators

To measure the quality of care provided by the plans, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports including HEDIS[®] 2010/QARR 2009 audit findings, as well as results of quality improvement studies, enrollee surveys and plan Performance Improvement Projects (PIPs).

Validation of Performance Measures Reported by Plans and Performance Measures Calculated by the NYSDOH

Performance measures are reported and validated using several methodologies. Plans submitted member and provider-level data for several measures to the NYSDOH. The NYS EQRO audited all member and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, plans report a subset of HEDIS[®] measures to the NYSDOH annually, along with several NYS-specific measures. Plan-reported performance measures were validated as per HEDIS[®] 2010 Compliance Audit[™] specifications developed by the National Committee for Quality Assurance (NCQA). The results of each plan's HEDIS[®] 2010 Compliance Audit[™] are summarized in its Final Audit Report (FAR).

Summary of HEDIS[®] 2010 Information System Audit[™]

As part of the HEDIS[®] 2010 Compliance Audit[™], auditors assessed the plan's compliance with NCQA standards in the six designated information system categories, as follows:

1. Sound Coding Methods for Medical Data
2. Data Capture, Transfer and Entry – Medical Data
3. Data Capture, Transfer and Entry – Membership Data
4. Data Capture, Transfer and Entry – Practitioner Data
5. Data Integration Required to Meet the Demands of Accurate HEDIS[®] Reporting
6. Control Procedures that Support HEDIS[®] Reporting and Integrity

In addition, two HEDIS[®] related documentation categories were assessed:

1. Documentation
2. Outsourced or Delegated HEDIS[®] Reporting Functions

The NYS EQRO provided technical assistance to plans throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new plans, 3) serving as a liaison between the plans and NCQA to clarify questions regarding measure specifications, 4) preparation of and technical support for the Data Submission System (DSS) used to submit data to the NYSDOH, and 5) clarifications to plan questions regarding the submission of member- and provider-level data, as well as, general questions regarding the audit process.

The HEDIS[®] 2010 Final Audit Report (FAR) prepared for WellCare indicates that the plan had no significant problems in any area related to reporting. The plan demonstrated compliance with all areas of the Information Systems and all areas of measure determination required for successful HEDIS[®]/QARR reporting.

The plan used NCQA-certified software to produce HEDIS[®] measures. Supplemental databases used to capture additional data were validated and determined to be HEDIS[®]-compliant by the auditors. No issues were identified with the transfer or mapping of the data elements for reporting.

The plan passed Medical Record Review for the measures validated. The plan was able to report all measures for the Medicaid and CHP product lines.

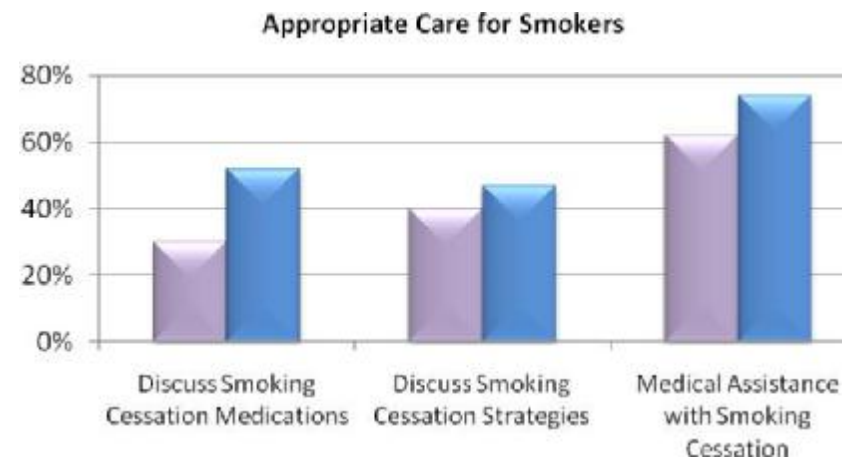
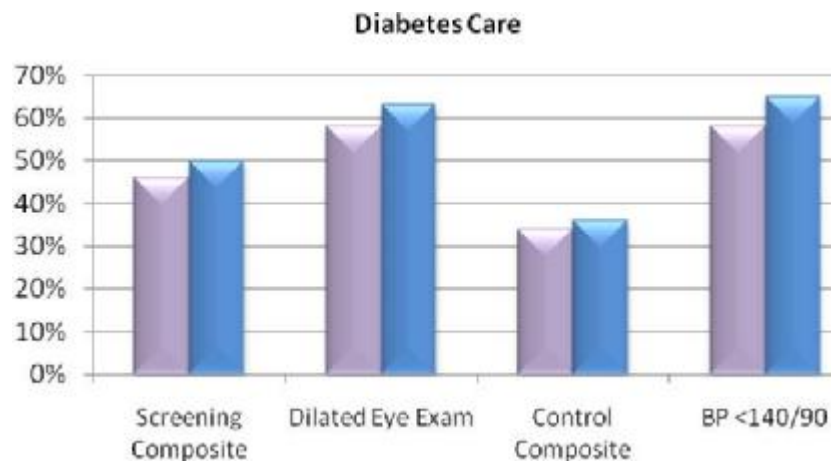
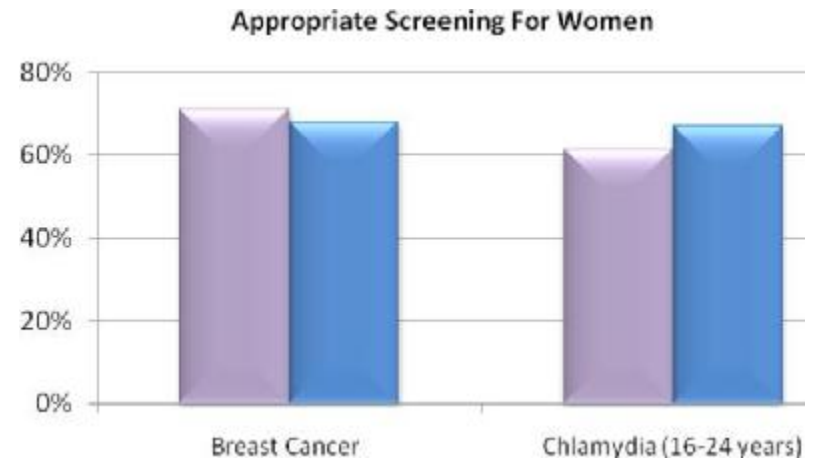
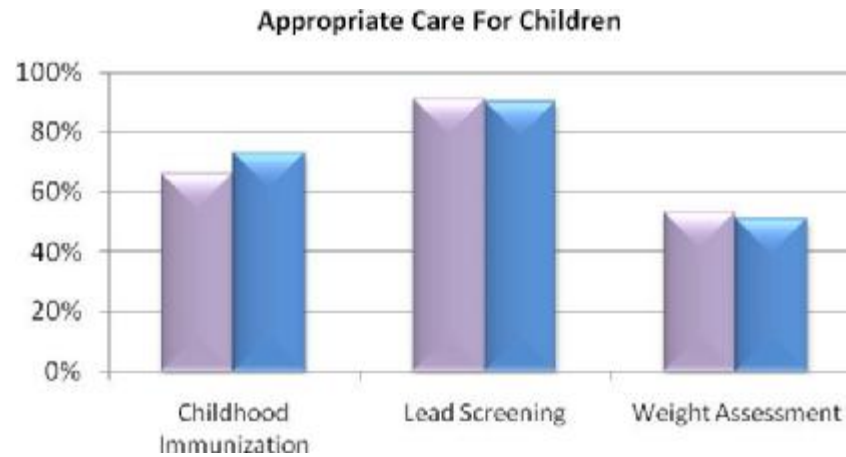
Figure 12 displays 2007, 2008 and 2009 QARR performance rates, as well as the SWAs. The Figure indicates whether the plan's rate was statistically better than the SWA (indicated by ▲) or whether the plan's rate was statistically worse than the SWA (indicated by ▼). Figure 12a illustrates selected 2009 measures for the Medicaid product line in comparison to the SWAs.

Table Notes for Figure 12	
R:	Rotated measure
SS:	Sample size too small to report (less than 30 members) but included in the SWA.
NR:	Not reported
FY:	First year measure. Data collected but plan specific rates not publicly reported.
NP:	Dental benefit not provided.

Figure 12: QARR Plan Performance Rates – 2007-2009

Measure	Medicaid/FHP				Child Health Plus			
	2007	2008	2009	2009 SWA	2007	2008	2009	2009 SWA
Adult BMI Assessment	FY	35	48 ▼	55				
Annual Dental Visit (2-18 years)	NP	NP	NP	52	47 ▼	48 ▼	57 ▼	63
Appropriate Asthma Medication: 3+ Controller Dispensing Events (5 -50 years)		78	75	75		FY	72	78
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	36 ▲	28 ▲	34 ▲	26				
Breast Cancer Screening	63 ▼	69 ▲	71 ▲	68				
Childhood Immunization Status (Combo 3)	65	R	66 ▼	73	50 ▼	R	68	66
Chlamydia Screening for Sexually Active Women (16-24 years)	53 ▼	54 ▼	62 ▼	67				
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Control <100 mg/dL)	41 ▼	R	47	51				
Diabetes BP < 140/90	60	R	58 ▼	65				
Diabetes Control Composite	27 ▼	R	34	36				
Diabetes Dilated Eye Exam	60	R	58 ▼	63				
Diabetes Screening Composite	48	R	46	50				
Discussing Smoking Cessation Medications	47	R	30 ▼	52				
Discussing Smoking Cessation Strategies	40	R	40	47				
Follow-Up After Hospitalization for Mental Illness – 7 Days	46 ▼	45 ▼	52 ▼	68				
Follow-Up After Hospitalization for Mental Illness – 30 Days	64 ▼	59 ▼	66 ▼	80				
Follow-Up Care for Children Prescribed ADHD Medication	SS	62	60	62	SS	SS	SS	53
Lead Screening in Children	86	R	91	90	76	R	72	82
Medical Assistance With Smoking Cessation (CAHPS®)	67	R	62	74				
Rating of Health Plan (CAHPS®)	63	R	64 ▼	69				
Use of Imaging Studies for Low Back Pain	84 ▲	NR	83 ▲	80				
Use of Spirometry Testing in the Assessment & Diagnosis of COPD	45	43	52 ▲	45				
Weight Assessment (BMI Percentile) for Children/Adolescents (3-17 years)		FY	53	51		FY	59	55

Figure 12a: QARR Medicaid/FHP Rates for Selected Measures – 2009



WellCare Statewide

QARR Access to/Availability of Care Measures

The QARR Access to/Availability of Care measures examine the percentages of children and adults who access certain services, including PCPs or preventive services, prenatal and postpartum care and dental services for selected product lines. Figure 13 displays the Access to/Availability of Care measures for QARR 2007 through 2009. The Figure indicates whether the plan's rate was higher than 90% of all plans for that measure (indicated by ▲) or whether the plan's rate was lower than 90% of plans for that measure (indicated by ▼).

Figure 13: QARR Access to/Availability of Care Measures – 2007-2009

Measure	Medicaid/FHP				Child Health Plus			
	2007	2008	2009	SWA 2009	2007	2008	2009	SWA 2009
Children and Adolescents' Access to PCPs (CAP)								
12–24 months	94%	92%	92% ▼	95%	90% ▼	93% ▼	SS	99%
25 months–6 years	91%	91%	91% ▼	92%	89%	95%	96%	96%
7–11 years	94%	95%	94%	95%	94% ▼	95%	97%	98%
12–19 years	91%	91%	91%	91%	92%	92%	95%	95%
Adults' Access to Preventive/Ambulatory Services (AAP)								
20–44 years	78%	79%	81% ▼	82%				
45–64 years	86%	88%	88%	88%				
65+ years	92% ▲	89%	90%	88%				
Access to Other Services								
Timeliness of Prenatal Care	R	75% ▼	R	R				
Postpartum Care	R	62% ▼	R	R				
Annual Dental Visit* ¹	29% ▼	27% ▼	28% ▼	51%				

R: Rotated measure

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

*For the Annual Dental Visit measure, the Medicaid/FHP age group is 2-21 years, while the Child Health Plus age group is 2-18 years.

¹ Since this plan does not provide a dental benefit for its Medicaid members, the Medicaid/FHP rate reflects annual dental visits for only FHP members.

QARR Prenatal Care Measures Calculated by the NYSDOH

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the plans as well as from NYSDOH's Vital Statistics Birth File. Since some health events such as low birth weight births and cesarean deliveries do not occur randomly across all plans, risk adjustment is used to remove or reduce the effects of confounding factors that may influence a plan's rate. Figure 14 presents prenatal care rates calculated by the NYSDOH for QARR 2006 through 2008. This Figure indicates whether the plan's rate was significantly better than the average (indicated by ▲) or whether the plan's rate was significantly worse than the average (indicated by ▼).

Figure 14: QARR Prenatal Care Measures Calculated by the NYSDOH – 2006-2008

Measure	Medicaid/FHP					
	2006		2007		2008	
	WellCare	NYC/ROS Average	WellCare	NYC/ROS Average	WellCare	NYC/ROS Average
	NYC					
Risk-Adjusted Low Birth Weight*	8%	7%	5%	7%	8%	8%
Prenatal Care in the First Trimester	67% ▼	73%	72%	72%	67%	70%
% of Low Birth Weights at Facilities for High-Risk Deliveries	97%	99%	SS	99%	100%	100%
	ROS					
Risk-Adjusted Low Birth Weight*	12% ▲	7%	6%	7%	4%	7%
Prenatal Care in the First Trimester	76%	69%	69%	68%	69%	68%
% of Low Birth Weights at Facilities for High-Risk Deliveries	SS	80%	SS	81%	SS	78%

*A low rate is desirable for this measure.

NYC: New York City

ROS: Rest of State

SS: Sample size too small to report (less than 30 members) but included in the average.

Consumer Satisfaction

In 2010, the CAHPS[®] survey of adult Medicaid managed care plan enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. Each selected category is compared to the respective SWA. Plans with a Commercial product line also collected these data from their Commercial members, using an NCQA-certified survey vendor. Figure 15 gives the question category, the plan's rate and the SWA for measurement years 2008 and 2010. The Figure indicates whether the plan's rate was significantly better than the SWA (indicated by ▲) or whether the plan's rate was significantly worse than the SWA (indicated by ▼).

Figure 15: CAHPS[®] – 2008 and 2010

Measure	Medicaid			
	2008	2008 SWA	2010	2010 SWA
Flu Shots for Adults Ages 50-64	35	43	34	35
Medical Assistance With Smoking Cessation	67	74	62	74
Getting Care Needed ¹	73	75	67 ▼	74
Satisfaction with Provider Communication ¹	86	88	84	86
Care Coordination	67	74	68	74
Customer Service ¹	78	80	71 ▼	80
Rating of Healthcare	63	65	58 ▼	65
Rating of Health Plan – High Users	62	67	63	71
Getting Care Quickly ¹	71 ▼	78	71 ▼	77
Overall Rating of Health Plan	63	66	64 ▼	69
Rating of Personal Doctor	73	74	71	74
Rating of Specialist	66	71	57 ▼	67
Getting Needed Counseling/Treatment			47	66
Rating of Counseling/Treatment			51	57
Recommend Plan to Family/Friends	87	90	86 ▼	90

¹ These indicators are composite measures.

**Quality Performance Matrix Analysis 2009 Measurement Year
(Effectiveness of Care Measures)**

Figure 16 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Use of Services and Access to/Availability of Care measures reported annually in the New York State Managed Care Plan Performance Report. This year's matrix includes sixteen for the Medicaid product line, fourteen for Commercial and two that apply to Child Health Plus. The matrix diagrams the plan's performance in relation to its previous year's quality rates and also compares its rates to the SWA.

With the issuance of the 2008 measurement year (MY) matrix, the NYSDOH modified its MCO requirements for follow-up action. In previous years, MCOs were required to develop root cause analyses and plans of action for all measures reported in the D and F categories of the matrix. Starting with the 2008 MY matrix, MCOs are now required to follow-up on no more than three measures from the D and F categories of the matrix. However, if an MCO has more than three measures reported in the F category, the MCO must submit root cause analyses and plans of action on all measures reported in the F category. If an MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow-up.

Figure 16: Quality Performance Matrix – 2009 Measurement Year

		Statewide Statistical Significance		
Trend *		Below Average	Average	Above Average
↑ No Change ↓	C Adult BMI Assessment (M)		B	A
	D Childhood Immunization Combo 3 (M) Rating of Health Plan (M)		C Childhood Immunization Combo 3 (CHP) Cholesterol Management (LDL-C <100) (M) Diabetes Control Composite (M) Diabetes Screening Composite (M) Discuss Smoking Cessation Strategies (M) Lead Testing in Children (CHP, M)	B Breast Cancer Screening (M)
	F Discuss Smoking Cessation Medication (M)		D	C

M: Medicaid and Family Health Plus

CHP: Child Health Plus

*Trending analysis used rates from 2007 when the measure was not collected in 2008.

Quality Incentive – PQI/Compliance/Satisfaction/Quality Points

The percentage of the potential financial incentive that a plan receives is based on quality of care, consumer satisfaction and compliance. Points earned are derived from an algorithm that considers QARR 2009 rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores conducted in spring 2010, and compliance information from 2008 and 2009. The total score, based out of 150 possible points, determines what percent of the 3% available premium increase the plan qualifies for. For 2009, there were three levels of incentive awards that could be achieved by plans based on the results (3%, 2% or 1% per member per month premium increase). Figure 17 displays the points the plan earned from 2007 to 2009, as well as the percent of the financial incentive that these points generated based on the previous measurement year's data. Figure 17a displays the measures that were used to calculate the 2009 incentive, as well as the points WellCare earned for each measure.

Figure 17: Quality Incentive – PQI/Compliance/Satisfaction/Quality Points – 2007-2009

Category	2007		2008		2009	
	WellCare	SWA	WellCare	SWA	WellCare	SWA
Total Points (150 Possible Points)	93	79	57	88	10	67
<i>PQI Points</i> (20 Possible Points)					10	10
<i>Compliance Points</i> (-20 Possible Points)	18	16	15	18	-8	-5
<i>Satisfaction Points</i> (30 Possible Points)	15	16	15	17	0	16
<i>Quality Points</i> (100 Possible Points)	60	47	27	54	8	46
Percent of Financial Incentive Earned	50%		0%		0%	

Figure 17a: Quality Incentive – PQI/Compliance/Satisfaction/Quality Measures and Points – 2009

Measure	WellCare
PQI (10 points each)	10
Adult PQI	5
Pediatric PQI	5
Compliance (-4 points each, except where noted)	-8
MMCOR	-4
MEDS	0
Access & Availability (-2 points)	-2
Provider Directory (-2 points)	-2
Member Services	0
QARR	0
Satisfaction (10 points each)	0
Getting Care Needed (CAHPS®)	0
Customer Service and Information (CAHPS®)	0
Rating of Health Plan (CAHPS®)	0
Quality (10 points each, except where noted)*	7.8
Follow-Up After Hospitalization for Mental Illness -7 Days (HEDIS®/QARR)	0
Use of Appropriate Medications for People with Asthma -3 or More Controller Dispensing Events (QARR)	0
Chlamydia Screening in Women (HEDIS®/QARR)	7.77
Cholesterol Management for Patients with Cardiovascular Conditions (HEDIS®/QARR)	0
Annual Dental Visit -Ages 2-18 (HEDIS®/QARR)	NP
Comprehensive Diabetes Care -Blood Pressure Below 140/90 (HEDIS®/QARR)	0
Comprehensive Diabetes Care -Screening Composite (QARR) (20 points)	0
Childhood Immunization Status -Combo 3 (HEDIS®/QARR)	0
Medical Assistance with Smoking Cessation (CAHPS®)	0
Total Points Earned	9.8

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

* Since MCO does not provide a Medicaid dental benefit, points for the dental measure were redistributed to the other measures within the category.

NP: Dental Benefit Not Provided

Performance Improvement Project

Each plan is required by the Medicaid Health Maintenance Organization contract to conduct at least one Performance Improvement Project (PIP) each year. A PIP is a methodology for facilitating plan and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through these projects, plans and providers determine what processes need to be improved and how they should be improved.

The NYS EQRO provided technical assistance to plans throughout the PIP process in the following forms: 1) review of the plan's Project Proposal prior to the start of the PIP, 2) quarterly teleconferences with the plan for progress updates and problem-solving, 3) feedback on methodology, data collection tools and implementation of interventions, and 4) feedback on drafts of the plan's final report.

In addition, the NYS EQRO validated the plan's PIP by reviewing the project topic, aim statement, performance indicators, study population, sampling methods (if sampling was used), data collection procedures, data analysis and interpretation of project results, as well as assessing the plan's improvement strategies, the likelihood that the reported improvement is "real" improvement and whether the plan is likely to be able to sustain its documented improvement. Validation teams met quarterly to review any issues that could potentially impact the credibility of PIP results, thus ensuring consistency among validation teams. The validation process concluded with a summary of the strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of the PIP results was at risk.

WellCare's 2009-2010 PIP topic is "Pediatric Obesity Among Medicaid WellCare Members". In 2009, the plan implemented the following interventions:

- Utilized an automated voice messaging system to call parents/guardians of member ages 2-19 years who had not had visit during the measurement.
- Member incentive program that encouraged members aged 2-19 years to complete their annual visit. Members were notified via mail about the incentive program.
- Established a community intervention program in The Bronx, NY, which identified free to low-cost local exercise and/or diet programs. Adolescent-aged members in this specific borough meeting the diagnosis criteria were included in a targeted mailing which included information about this program.
- Expanded the Periodicity Letters for age groups 6-12 years and 13-20 years to include BMI percentile, and nutrition and exercise counseling during well visits.
- Educated providers via mail regarding requirements of comprehensive adolescent well visits, and provided CDC website for on-line BMI calculator.
- Published related articles in the Provider Newsletter.
- Published related articles in the Member Newsletter.

Figure 18: Performance Improvement Project – 2009-2010

Results not displayed; 2009 was the first phase of a two-year study.

Clinical Study

Statewide case management trigger and enrollment data for New York Medicaid Managed Care organizations MCOs have not been previously collected. In order to better understand which MCO members are targeted for case management in NYS, the NYS EQRO, on behalf of the NYSDOH, conducted a study in 2008 and 2009 to describe New York MCOs' case managed populations using Clinical Risk Groups (CRGs) to identify members' health status complexity and severity, which are associated with future resource utilization. It was postulated that the CRG system, a predictive modeling system designed to project future resource utilization, would identify the same potential high resource users that MCOs target for case management, since cost and utilization are common drivers for establishing case management programs among MCOs.¹

The overall proportion of members enrolled in case management was small, as would be expected for an intervention as resource intensive as case management. Less than 1% of the study population was enrolled in case management, and only 3% of the total population was triggered for assessment for case management.

Adults (age greater than or equal to 20) were more likely than children to be triggered and to be enrolled in case management. This is not unexpected, since chronic conditions increase with age, and chronic conditions are associated with increased resource use, a common driver for case management program enrollment. Women were more likely to be triggered and to be enrolled than men, and female gender was predictive of triggering and enrollment, likely due to the prevalence of pregnant women among case managed members. While the MCOs' practice of targeting pregnant women is undoubtedly reflected in this finding, it is also possible that other factors impact gender differences in triggering and enrollment, such as differential case management refusal rates or differential practitioner and self referral rates. There may also have been gender differences in prevalence of diagnoses that are specifically targeted for case management by MCOs.

Black, Hispanic, and other racial/ethnic minority groups were less likely to be triggered and enrolled in case management than white members were, and Hispanics were less likely to be enrolled than all other races combined. This apparent disparity warrants further study, since it is not possible from study data to ascertain the reasons for differential enrollment. Contributing factors could include language and cultural barriers, and, as noted above, differential refusal and referral rates.

Members with a Supplemental Security Income (SSI) eligibility category were significantly more likely to be triggered and enrolled than members in other eligibility categories. This is consistent with the prevalence of chronic conditions and disability among SSI recipients that would make these members likely candidates for case management. However, it should be noted that some case managed members receiving SSI benefits were in Health Status 1 and 2 rather than in the chronic condition health status categories, and could have been identified by referral or Health Risk Assessment, which has been shown to be equivalent to claims-based risk modeling in predicting the need for case management among SSI recipients.²

There was wide variation among MCOs for rates of triggering and enrollment in case management, as well as for the distribution of case managed members across CRG categories. This is not surprising, given the broad range of target populations, triggering processes, and enrollment criteria among MCOs' case management programs. Aside from one of the smallest MCOs, which had very high rates, trigger rates ranged from only 0.4% of members to 7.7% of members, and the percentage of members actually enrolled in case management also varied widely, from .1% to 4.2% of members. This would suggest

¹ New York State DOH Medicaid MCO Case Management Workgroup. Gap Analysis Comparing New York State Health Plans with URAC's CM and DM Standards and CMSA's Standards of Practice. 2005.

² Drozda JP, Libby D, Keiserman W. et al. Case management decision support tools: predictive risk report or health risk assessment? *Population Health Management* 2008; 11(4); 193-196.

that some MCOs may enroll only the few members thought to be at very high risk or those who are thought to be high cost.

There was a strikingly broad range of percentages of triggered members who were enrolled across MCOs, from a low of 1.4% to 100%. One of the three MCOs that reported 100% enrollment indicated that they enroll every member who is triggered, but there may have been triggered but not enrolled members who were not captured for the other two MCOs reporting 100% enrollment. The wide range of enrollment proportions illustrates the philosophical differences of MCOs regarding case management programs; it also demonstrates the balance between “sensitivity” versus “specificity” in identifying members for case management. Some MCOs appear to opt for procedures which are sensitive, i.e. identifying all possible case management candidates and enrolling few, while other MCOs appear to have more specific triggering criteria, i.e., they trigger few but enroll a high proportion of those triggered. This was not a consistent pattern; some MCOs had relatively high rates of both triggered and enrolled members.

The study found that there was a notable overlap of members targeted for case management and members identified as high risk by CRGs, and the predominant populations in case management were those for whom case management has been demonstrated to be of benefit (members who are pregnant or who have chronic conditions). However, there appeared to be risk factors identified by MCOs for case management that were not evident in the CRG system, and members identified as high risk by the CRG grouper who were not triggered or enrolled by MCOs. The variation in MCO triggering practices, enrollment criteria and focus of MCO case management programs was reflected by the varied distribution of case managed members among CRG categories in different plans. Some MCOs had very high proportions of case managed members among the healthy populations, with some MCOs appearing to be very successful in identifying case management candidates among non-users of the health care system. This finding may be due to the different case finding mechanisms among MCOs, which may include HRA or referral systems, and result in very different target populations than predictive modeling or identification based on past utilization or cost.³ These case selection variations resulted in a widely variable scope and CRG distribution across MCO case management programs.

³ Weir S, Aweh G, Clark RE. Case selection for a Medicaid chronic care management program. Health Care Financing Review 2008; 30(1):61-74.

Health Disparities

For this year's technical report, the NYSDOH EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

1. Characterization, identification or analysis of the Plan's Medicaid population according to at-risk characteristics
2. Identification of differences in health outcomes or health status that represent measurable gaps between the Plan's Medicaid population and other types of health care consumers
3. Identification of gaps in quality of care for the Plan's Medicaid members and/or Medicaid subgroups
4. Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations
5. Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for plan members with at-risk characteristics

WellCare reported that no activities were performed in 2009 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population.

VI. Health Information Technology

According to the US Department of Health & Human Services, health information technology (HIT) allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of HIT will improve health care quality, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork and expand access to affordable care.

In 2009, the NYSDOH EQRO surveyed Medicaid MCOs regarding the use of HIT to improve the care of its Medicaid members. Specifically, MCOs were asked to report on:

1. Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
2. Use of telecommunications technologies
3. Use of electronic Disease and/or Case Management Systems
4. Use of electronic internal registries
5. Use of clinical risk group (CRG) or similar software
6. Secure electronic transfer of member data between the Plan, its vendors and network providers
7. Electronic communication with providers
8. Electronic communication with members
9. Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)¹
10. Participation in State, Federal or privately funded HIT initiatives
11. Participation in a medical home pilot or program
12. Future plans to implement HIT

Figure 19 displays the statewide results of the HIT survey. The most utilized forms of HIT include secure electronic transfer of member data, use of electronic Disease and/or Case Management systems, and electronic communication with providers. Seventy-four percent (74%) of MCOs reported having future HIT initiatives planned.

¹ Regional Health Information Organizations/Health Information Exchanges are organizations that exist to enable interoperable health information exchange through governance and collaboration with an overall mission to improve health care quality and safety, and reduce costs.

Figure 19: MCO Use of Health Information Technology – 2009 Survey of NYS MCOs

Health Information Technology	% of MCOs Reporting Use
Secure electronic transfer of member data between the Plan, its vendors and/or network providers	100%
Use of electronic Disease and/or Case Management Systems	95%
Electronic communication with providers	95%
Secure electronic transfer of protected health information to patients and/or providers	84%
Future plans to implement HIT	74%
Use of telecommunications technologies	68%
Use of clinical risk group (CRG) or similar software	68%
Participation in State, Federal or privately funded HIT initiatives	58%
Use of electronic internal registries	53%
Electronic communication with members	53%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	53%
Participation in a medical home pilot or program	47%

WellCare indicated that it performs the following HIT related activities:

- Electronic transfer/data sharing of protected information:
 - Member data is transferred to providers and vendors via secure file transfer protocol (FTP).
- Use of telecommunications technologies:
 - Case and disease management programs include telephonic member education and care coordination.
- Use of electronic disease and/or case management systems:
 - Electronic Medical Management Application (EMMA) enterprise-wide solution is utilized for the integrated care of its members. The modules in the system include prior authorization, intake, concurrent review, case management, disease management and behavioral health. Screening tools, comprehensive assessments, care plans and case notes are housed within the case management and disease management modules within the member's record.
- Use of electronic internal registries:
 - An electronic registry tracks medical records for HEDIS[®] related measures.
- Use of clinical risk group software or similar software:
 - Data mining is conducted through proprietary claims algorithms to identify members for case and disease management.
- Electronic communication with members and/or providers:
 - Case and disease managers communicate with providers via email.
 - Customer service staff communicates with members via the web and email.
- Future plans to implement additional HIT initiatives may include:
 - Implementing provider web portals that would allow real time reporting of quality and provider data.

- Implementing member web portals which would allow member specific health education to be dispersed to members securely.

VII. Deficiencies and Appeals

This section of the report examines deficiencies identified by the NYSDOH in operational and focused surveys as well as external appeals as part of the EQRO's evaluation of the plan's compliance with State structure and operation standards.

Compliance with NYS Structure and Operation Standards

To assess the compliance of a health plan with Article 44 of the Public Health Law and part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the plan's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories in Figure 20. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the plan is not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policy and procedures, executed contracts and credentialing files of randomly selected providers; adverse determination utilization review files; complaints and grievances files; meeting minutes and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys." The NYSDOH retains the option to deem compliance with standards for credentialing/recredentialing, quality assurance/improvement and medical record review.

The monitoring review report documents any data obtained and deficiencies cited in the survey tools. Any statements of deficiencies (SODs) are submitted to the plan after the monitoring review and the plan is required to respond with a plan of corrective action (POC). POCs must be submitted to the NYSDOH for acceptance. In some cases, revisions may be necessary and plans are required to resubmit. Ultimately, all plans with SODs must have a POC that is accepted by the NYSDOH. During the alternate years when the full review is not conducted, the NYSDOH reviews any modified documentation and follows up with the plan to ensure that all deficiencies or issues from the operational survey have been remedied.

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in Figure 20. Plans are also required to submit POCs in response to deficiencies identified in any of these reviews.

Figure 21 reflects the total number of citations for the most current operational survey of the plan, which ended in 2009, as well as from the focused reviews conducted in 2009. This figure reflects the findings from reviews of the plan as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can have multiple citations.

WellCare was in compliance with 8 of 14 categories. The categories in which WellCare was not in compliance were Complaints and Grievances (1 citation), Disclosure (1 citation), Organization and Management (5 citations), Quality Assurance (3 citations), Service Delivery Network (3 citations) and Utilization Review (9 citations).

Figure 20: Focused Review Types

Review Name	Review Description
Access & Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability, for routine and urgent visits; re-audits are performed when results are below 75%. See Figure 8 for a more detailed description.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HPN Networks to ensure providers that have been identified as having their license revoked or surrendered or otherwise sanctioned, are not listed as participating with the MCO.
MEDS (Medicaid Encounter Data Set)	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
Member Services Phone Calls	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
Other	Used for issues that do not correspond with the available focused review types.
Provider Directory Information	Provider Directories are reviewed to ensure that they contain the required information.
Provider Info-Web	Review of MCO's web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HPN network submissions for adequacy, accessibility and correct listing of primary, specialty and ancillary providers for enrolled population.
Provider Participation – Directory (In addition to the routine Provider Participation – Directory surveys, in 2008 there was a survey specific to dental)	Telephone calls are made to a sample of providers included in the provider directory to determine if they are participating, if panels are open, and if they are taking new Medicaid patients. At times, this survey may be limited to one type of provider.
QARR (Quality Assurance Reporting Requirements)	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
Ratio of PCPs to Medicaid Clients	Telephone calls are placed to PCP with a panel size of 1,500 or more Medicaid clients. The calls are used to determine if appointment availability standards are met for routine, non-urgent sick and urgent appointments.

AO: Area Office

HPN: Health Provider Network

SOD: Statement of Deficiency

Figure 21: Summary of Citations

Category	Review Type/Name (a indicates focused review)		Citations
Complaints and Grievances			1
<p>a) The MCO failed to process provider’s credentialing application within 90 days. In a letter dated 9/27/08 regarding the 2nd quarter 2008 HPN, the Plan stated that a specific Thoracic Surgeon will be reflected in the 4th quarter 2008 HPN submission. In the 4th quarter 2008 submission, this Thoracic Surgeon was not reflected. In a letter dated 9/19/08, the MCO stated it has an existing agreement with the Queens, LI, Medical Group and is credentialing the same Thoracic Surgeon (who is part of the group). In a letter dated 12/16/08, the Plan stated it is completing a credentialing audit and this Thoracic Surgeon is expected to be credentialed by the end of 1/09.</p>	a	Provider Network	
Credentialing			0
Disclosure			1
<p>b) The Plan failed to ensure that its printed provider directory contained information that was of accurate nature. Sixteen (16) out of 50 providers sampled for CHP from the printed provider directory were inaccurate in content. There are 6 out of 17 providers from the 1st half 2008 printed provider directory verification study who are still identified as non-participating providers. These providers are still incorrectly listed as participating providers in the current printed and web-based provider directories.</p>	a	Provider Participation - Directory	
Family Planning			0
HIV			0
Management Information Systems			0
Medicaid Contract			0
Medical Records			0
Member Services			0
Organization and Management			5
<p>c) The Plan failed to provide the Department with written notification within regulatory timeframes of a hospital termination. The Plan notified the Department of a termination with Continuum on 4/2/09 effective 4/6/09; the plan failed to provide the required 45 days prior written notice to the Commissioner.</p>	a	Contracts	
<p>d) The Plan failed to renew their management contract with Healthplex, Inc. and permitted it to expire without prior written notice to the Commissioner. The Plan continued to utilize Healthplex, Inc. to perform management functions without an approved management contract. No prior documentation was submitted prior to the termination of the MSA contract between the Plan and Healthplex, Inc. which terminated on 6/20/09 (2 citations)</p>	a	Contracts	
<p>e) Deficiency related to Part 98 Regulation 98-1.17(a).</p>	a	Provider Network	
<p>f) The governing authority of the MCO failed to ensure the implementation of the approved plans of correction for the printed and web-based provider directory verification studies dated 1st and 2nd half, 2007 and 1st and 2nd half, 2008 to correct the deficiency concerning providers identified as non-participating in the prior survey.</p>	a	Provider Participation- Directory	

Figure 21: Summary of Citations (Continued)

Category	Review Type/Name (a indicates focused review)		Citations
Prenatal Care			0
Quality Assurance			3
g) Although the Plan conducted an audit of the performance of its behavioral health vendor with regard to delegated utilization management functions, no problems were identified and Harmony Behavioral Health was given a score of 100%. However, upon review, it was revealed that incorrect Retrospective Final Adverse Determination letters were sent to providers, lacking required external appeal rights, instructions, and application, and no Final Adverse Determination letters were sent to the corresponding enrollees at all.		Operational	
h) See a.	a	Provider Network	
i) The Department received a complaint regarding the adequacy of the Plan's psychiatric network in Albany County. During a focus survey, the Department found that out of the 26 psychiatrists listed on the 4 th quarter HPN, only 10 of them confirmed participation with the Plan.	a	Provider Network	
Service Delivery Network			3
j) See a.	a	Provider Network	
k) See i.	a	Provider Network	
l) There are 2 out of 11 providers from the 2 nd half 2008 web-based provider directory verification study who were again identified as non-participating providers. These providers are still incorrectly listed as participating providers in the current web-based provider directory. [Repeat Deficiency]	a	Provider Participation - Directory	
Utilization Review			9
m) The Plan issued appeal acknowledgement letters which were incorrect. One (1) file contained no acknowledgement letter at all. [Repeat deficiency.] Several files contained acknowledgement letters which referred back to an incorrect denial date.		Operational	
n) The Plan rendered utilization review determinations which were inconsistent with program standards.		Operational	
o) The Plan issued initial adverse determinations which were lacking required content. One (1) file did not clearly state that the denial was based upon the requested healthcare service being not medically necessary. [Repeat deficiency.] Several notices of initial adverse determination did not specify what additional information needs to be provided in order to render a decision on appeal. All notices of initial adverse determination issued by the Plan erroneously inform enrollees, under the heading of Fair Hearings to file complaints with the State Insurance Department instead of the State Health Department. Several notices of initial adverse determination lacked enrollee specific clinical information regarding appropriate setting for care, sufficient to enable judgment regarding possible appeal.		Operational	

Figure 21: Summary of Citations (Continued)

Category	Review Type/Name (a indicates focused review)	Citations
<p><i>p) The Plan issued notices of final adverse determination which were lacking required content. Several notices of final adverse determination did not specify that the requested health services denial was being upheld as it was determined that the services were not medically necessary. In several instances, the Plan failed to issue final adverse determination notices and its accompanying appeal rights, most notably the right to a NYS External Appeal to enrollees, as required. Several notices of final adverse determination lacked specificity regarding the appropriate clinical settings for care. (6 citations)</i></p>	Operational	
Total		22

External Appeals Summary Report

Figure 22 displays external appeals for 2007 to 2009 for the Medicaid product line. This Figure reflects absolute numbers, and is not weighted by plan enrollment.

Figure 22: External Appeals – 2007-2009

	2007	2008	2009
Medicaid			
Overtured	2	2	0
Overtured in Part	0	0	1
Upheld	0	2	7
Total	2	4	8

VIII. Financial Data

The financial summary is based on data reported in each plan's 2007, 2008 and 2009 Medicaid Managed Care Operating Report (MMCOR). The data contained in the MMCOR reflect the plan's Medicaid line of business only. The data are not audited and are reported on an accrual basis; thus total expenses are impacted by a plan's estimate of services that have been incurred by plan members but have not been billed to the plan. The following is a list of the ratios displayed in Figure 23 and their definitions.

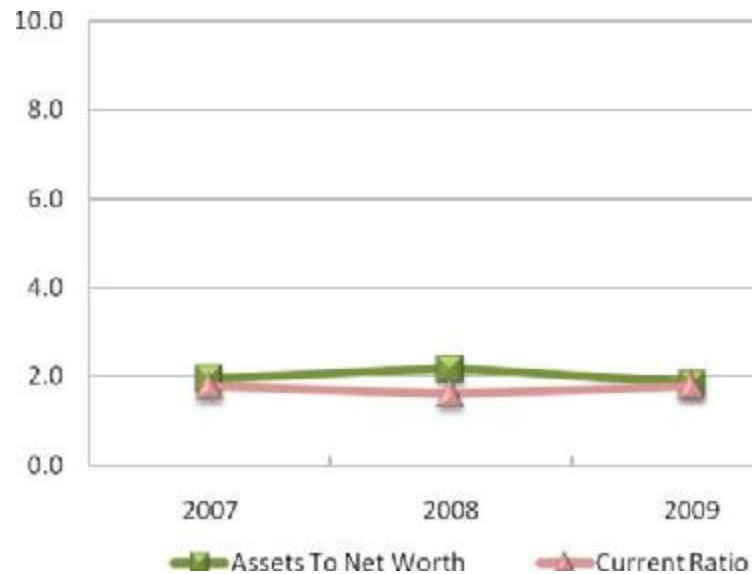
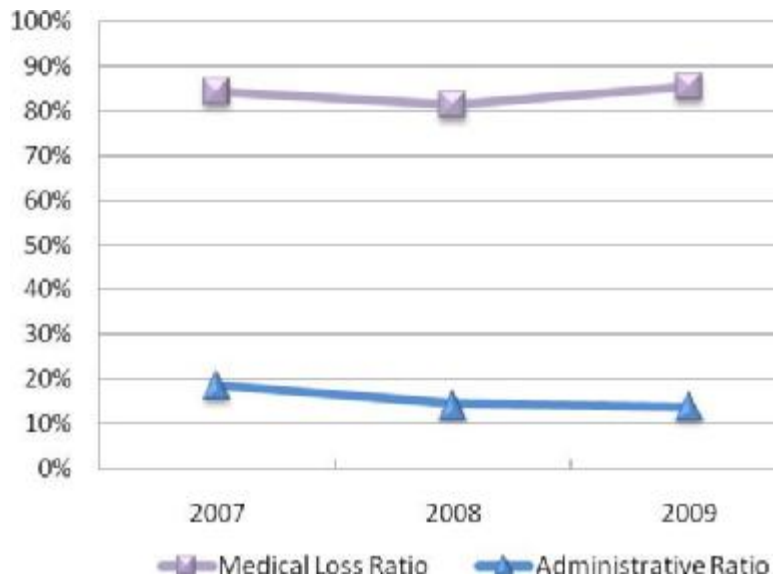
- *Assets to Net Worth*: Reflects the relationship of assets to net worth. For example, a plan with an asset to net worth ratio of 3.0 indicates the plan has \$3 of assets for every \$1 of net worth. The formula is total assets divided by net worth. Assets and net worth are net of intangible assets.
- *Premium Surplus Ratio*: Indicates what percentage of premium dollars goes towards surplus. This ratio is calculated by dividing premium income by total premium revenue. It indicates whether a plan is generating sufficient revenue from its premiums to cover medical and administrative expenses.
- *Medical Loss Ratio*: Indicates what percentage of premium dollars is spent on medical costs. This ratio is calculated by dividing total medical costs by total premium revenue.
- *Administrative Ratio*: Indicates what percentage of premium dollars is spent on administrative costs. This ratio is calculated by dividing total administrative costs by total premium revenue.
- *Current Ratio*: Reflects to what degree current assets cover current liabilities. The formula is current assets divided by current liabilities.

Figure 23a graphically trends selected measures from Figure 23.

Figure 23: Selected Financial Ratios – 2007-2009

	2007		2008		2009	
	WellCare	SWA	WellCare	SWA	WellCare	SWA
PROFITABILITY						
Assets To Net Worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles)	2.0	2.0	2.2	2.2	1.9	2.1
Premium Surplus Ratio = Premium Income/Premium Revenue	-2.9%	-0.6%	4.0%	-0.7%	0.6%	1.6%
Medical Loss Ratio = Medical Expenses/Premium Revenue	84.4%	87.7%	81.5%	88.9%	85.5%	87.4%
Administrative Ratio = Admin Expenses/Premium Revenue	18.5%	13.0%	14.4%	11.8%	13.8%	11.0%
LIQUIDITY						
Current Ratio = Current Assets/Current Liabilities	1.8	1.4	1.6	1.2	1.8	1.1

Figure 23a: Trends for Selected Financial Ratios – 2007-2009



IX. Strengths and Opportunities for Improvement¹

This section summarizes the accessibility, timeliness, and quality of services provided by WellCare to Medicaid recipients based on data presented in the previous sections of this report. The plan's strengths in each of these areas are noted, as well as, opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted. An assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCO's response to the previous year's recommendations, wherein the plan was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve, is appended to this section of the report.

Strengths

- The 2010 HEDIS[®] Audit revealed no significant problems with the Medicaid product line, and the plan was able to report all required Medicaid rates for QARR.
- In regard to the EQRO's 2009 Primary Care Access & Availability Survey, the plan exceeded the 75% threshold for after hours access in Regions 4, and routine and non-urgent "sick" appointments in Region 5.
- As indicated on the EQRO's 2009 HIT Survey, the plan conducts a variety of member and provider activities that rely on HIT. In addition, the plan indicates that it has future plans to implement additional HIT initiatives. Note: HIT Survey responses reported in this version of the Plan-Specific Report were also reported in last year's Plan-Specific Report.)
- The plan performed well in regard to respiratory care as indicated by better than average performance on the HEDIS[®]/QARR *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Spirometry Testing Assessment & Diagnosis of COPD* measures.
- The plan reported better than average performance on the following HEDIS[®]/QARR measures: *Breast Cancer Screening* and *Use of Imaging Studies for Low Back Pain*.

Opportunities for Improvement

- The plan did not receive PQI, compliance, satisfaction or quality scores that qualified it for a percentage of the available financial incentive or for the auto-assignment of new members. (Note: the qualifying score was an opportunity for improvement in the previous year's report.)
- The plan continues to demonstrate an opportunity for improvement in regard to behavioral health and one area of women's health as indicated by continuously poor performance on the HEDIS[®]/QARR *Follow-Up After Hospitalization for Mental Illness -7 Days* and *-30 Days*, and *Chlamydia Screening* measures. Plan rates for these measures have performed below the statewide averages for at least three consecutive reporting periods.
- The plan demonstrates an opportunity for improvement in regard to member satisfaction. The plan reported below average CAHPS[®] scores for the following measures: *Getting Care Needed*, *Customer Service*, *Rating of Healthcare*, *Getting Care Quickly*, *Overall Rating of Health Plan*, *Rating of Specialist*, and *Recommend Plan to Family/Friends*. (Note: *Getting Care Quickly* was an opportunity for improvement in the previous year's report.)
- Despite exceeding the 75% threshold for after hours access in Region 4, and routine and non-urgent "sick" appointments in Region 5 on the 2009 Primary Care Access & Availability Survey, the plan demonstrates an opportunity for improvement as the plan did not meet the 75% threshold for any call type in Region 6.

¹ This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to "Strengths" and "Opportunities for Improvement" rather than "Strengths" and "Weaknesses" as indicated in federal regulations.

- The plan continues to demonstrate an opportunity for improvement in regard to health disparities as indicated by the plan's response to the EQRO's 2010 Health Disparities Survey. Although plan referenced several projects in its response, the response did not indicate that specific activities were conducted during the reporting year to identify or address disparities in health outcomes and/or health care among its Medicaid population. (Note: addressing health disparities was an opportunity for improvement in the previous year's report.)
- In regard to compliance with NYS structure and operation standards, the plan received a total of 22 citations, including 10 Article 44 Review citations in the categories of Quality Assurance and Utilization Review; and 12 focused review citations related to Provider Network, Provider Participation –Directory and Contracts in the following categories: Complaints and Grievances, Disclosure, Organization and Management, Quality Assurance and Service Delivery Network. (Note: compliance with NYS structure and operation standards was an opportunity for improvement in the previous year's report.)

Recommendations

- To ensure that the plan receives a percentage of the available financial incentive and qualifies for the auto-assignment of members, the plan should continue to investigate and work to improve the decline in its qualifying score. The plan should specifically focus on improving member satisfaction and HEDIS[®]/QARR Effectiveness of Care measures as they tie into the State's formula for calculating the qualifying score. The plan should also evaluate the effectiveness of the initiatives described in the plan's response to the previous year's recommendation, and perhaps intensify its efforts. *[Repeat recommendation.]*
- The plan should continue its efforts to address HEDIS[®]/QARR measures that performed below the statewide average, such as *Adult BMI, Childhood Immunization, Chlamydia Screening, Comprehensive Diabetes Care: Diabetes BP <140/90 and Diabetes Dilated Eye Exam, Follow-Up After Hospitalization for Mental Illness*, etc. and implement initiatives to improve their rates to ensure that members are receiving appropriate care. Also, the plan should evaluate the effectiveness of the initiatives described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- The plan should work to address the problems noted in the Article 44 Survey and focused reviews. As nine of the 22 citations received were related to Utilization Review, the plan should review and update its related policies and procedures to ensure compliance to the NYS Medicaid Contract. The plan should also evaluate the effectiveness of the initiatives described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- The plan should allocate resources towards identifying disparities in care and/or health outcomes within its Medicaid population, and implement initiatives to address the identified gaps in order to ensure that its members can access needed care.
- To ensure that members have timely access to primary care, the plan should investigate its low performance on the EQRO's 2009 Primary Care Access & Availability Survey, and implement initiatives to address identified barriers.

Response to Previous Year's Recommendations

- **2008 Recommendation:** To ensure that the plan receives a percentage of the available financial incentive and qualifies for auto-assignment of members, the plan should investigate the decline in its quality and satisfaction scores. The plan should specifically focus on improving member satisfaction and HEDIS[®]/QARR Effectiveness of Care rates as they tie into the State's formula for calculating the qualifying score. The plan should also evaluate the effectiveness of the initiatives described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*

Plan Response:

Follow-up After Hospitalization for Mental Illness

July 2009: WellCare implemented an initiative to coordinate follow-up care for members who are hospitalized with mental health issues before they are discharged. This initiative focused on the coordination of care between a WellCare nurse and the hospital discharge planner. WellCare's case management tracking and reporting system, EMMA, identifies members who are currently hospitalized for mental illness and inform WellCare staff to contact the hospital discharge planner to obtain follow-up appointment and discharge planning details. A database monitors subsequent outreach activity and documents member appointment information and appointment verification.

January 2010: A review of the mental health project indicated that our rates remained unchanged. Since its inception, 720 hospitalizations between July and December 2009 were reviewed with 343 discharges meeting the measure criteria. However, when member enrollment eligibility was applied to the 343 discharges, only 67 discharges were reportable for the measure. It was determined that the initiative did not impact the rates. This initiative was cancelled in January 2010.

Provider Reporting

June 2009: WellCare implemented the use of a database report to identify members (and their PCPs) who should receive quality-of-care services and have not as yet obtained those services. On a monthly basis, the Quality Improvement (QI) Department, in collaboration with the Provider Relations Department, provides each PCP with a list of their non-compliant members. WellCare's PCP outreach stresses the importance of follow-up and preventive care management for our members. Feedback to the plan from our PCPs has initiated revisions to the member non-compliant list and the plan's creation of a "Provider Report Card".

The non-compliant list revisions include:

- A listing of the immunizations already received by WellCare and a list of the immunizations still needed to make the member fully compliant with the approved childhood immunization schedule.
- A listing of the previously received by WellCare off the well child visit encounter/claims data and the number of such visits needed to make the member compliant for the Well Child Visit - age 0-15 months - measure.

The NY QI Department created Provider Report Card is being modified using suggestions from the feedback of our PCPs. This report card gives individual PCPs a comparison view of their 2009 and 2010 HEDIS®/QARR performance scores and their current year-to-date and gap-to-target results. The plan is educating its providers about how and why they should implement processes that will ultimately improve our HEDIS®/QARR scores.

In November 2009, WellCare developed and distributed a provider checklist tool [Well Care Visit Checklist] designed to promote timely health and wellness services for adolescent members by their PCP. The tool provides PCPs with a standardized format to successfully document screening, assessment, counseling, and education regarding the Adolescent Screening and Counseling measure.

Pay-for-Performance 2009

November/December 2009: WellCare developed a Provider Pay-for-Performance (P4P) program designed to promote timely health care services for our members. PCPs were awarded a bonus payment for each qualified claim received and processed by WellCare. Qualified claims for follow-up and preventive care visits were defined using the 2010 HEDIS®/QARR specifications. As indicated in the table below, there was an improvement in

eight (8) of the measures included in the P4P with four (4) meeting the 2010 75th percentile quality benchmark.

2009 P4P Measures	QARR 2008 Rate	QARR 2009 Rate	2010 Quality Benchmark 75P	Improved
Adolescent Well Visits *	62%	61%	60%	
Appropriate Asthma Medications 3 + controller	78%	75%	77%	
Breast Cancer Screening	69%	71%	64%	√
Cervical Cancer Screening **	64%	64%	N/A	
Childhood Immunization Combo 3*	65%	66%	77%	√
Cholesterol Management LDL-C Testing*	91%	92%	N/A	√
Diabetes Dilated Eye Exam*	60%	58%	N/A	
Diabetes HbA1c Testing*	83%	87%	N/A	√
Diabetes LDL-C Testing*	86%	89%	N/A	√
Lead Screening *	86%	91%	90%	√
Mental Health Follow-up 7 Days	35%	41%	66%	√
Testing for Pharyngitis	75%	80%	76%	√
Well Child Visits for 15 months*	81%	81%	87%	
Well Child Visits for 3-6 yrs*	79%	78%	82%	
* Rotated for 2008, QARR 2007 rates reported				
** Rotated for 2009, QARR 2008 rates reported				

Childhood Obesity PIP

In November 2009, WellCare added a member incentive program to our Childhood Obesity Performance Improvement Project. Children and adolescent WellCare members with a diagnosis of overweight or obesity were sent information on this new member incentive initiative program. The program included sending these members a health checklist and an offer to receive a \$25 gift card if they went to their PCP for a well visit check-up prior to December 31, 2009. A gift card was issued to the member once the plan received the PCP's health check-up form which documented that a well visit was completed. The table below indicates an increase in the Adolescent Screening and Counseling measure, suggesting the improvement achieved through this initiative.

Reported Rates	WellCare 2008 Baseline	QARR 2009 SWA	WellCare 2009 Rate
BMI Screening	32	51	53
Nutrition	41	61	41
Exercise	31	48	33

Improving HEDIS/QARR Effectiveness of Care Rates

Provider Outreach: The NY QI Department continues to directly support the Provider Relations Department's site visits with providers, with an educational focus on HEDIS®/QARR results.

Women's Health Initiative: In July 2010, the Corporate QI Department implemented a member focused telephonic outreach program "Women's Health Initiative". The calls provide education and facilitated appointment scheduling to increase the screening rates for Chlamydia infection, cervical cancer and breast cancer detection.

Pay-for-Performance (P4P) 2010: The preventive care measures were included in the 2010 provider Pay-for-Performance Incentive Program. Providers are being offered financial incentives to increase member compliance with specific HEDIS®/QARR related services by December 31, 2010. The P4P program began in April 2010, earlier in the year than previous P4P programs. The P4P measures center around preventive care to encourage the overall health and wellness of our enrollees. The 2010 P4P program is applicable for all currently enrolled NMD, FHP and CHP members, not just HEDIS®-eligible members within those lines of business.

Measures include:

- (1) Comprehensive Diabetes
 - (a) HbA1C Testing
 - (b) LDL-C Screening
 - (c) Nephropathy Screening
- (2) Cholesterol Management
- (3) Lead Screening in Children
- (4) Testing for Pharyngitis
- (5) Childhood Immunization Combo 3
- (6) Well Child Visits During The First 15 Months Of Life, 6 or more visits
- (7) Well Child Visits For Children Ages 3-6 Years
- (8) Adolescent Well Care Visits Ages 12-21 Years

Mammography and Colonoscopy Vendor Agreement

In June 2010, WellCare entered into a business agreement with mammography and colonoscopy providers to facilitate enrollee appointment scheduling, thereby improving compliance with these screening procedures.

Improving Member Satisfaction

CAHPS® Survey: During the first quarter of 2011, the Myers Group will perform a CAHPS® survey with supplemental questions aimed at identifying our enrollees' concerns with the health plan and our providers. The survey results will allow the plan to have provider-level information that can be used to give providers insight into their own quality-of-care and service-level performance.

Focus Groups: In the second quarter of 2011, using a vendor, WellCare will conduct member focus group interviews. These interviews will be used to identify our members' concerns about the plan, and the services rendered by our network of physicians and ancillary providers.

- **2008 Recommendation:** The plan should work to address the problems noted in the focused reviews. The plan should also evaluate the effectiveness of the initiatives implemented to address this area, as described in the plan's response to the previous year's recommendation. [*Repeat recommendation.*]

Plan Response:

Finding: The plan rendered utilization review determinations which were inconsistent with program standards. WellCare conducted training sessions for the Utilization Review Team focused on the use of our updated concurrent review tool and on the requirement to complete a thorough review of all clinical information presented to the Plan. All reviewers will be required to complete this training, stressing the importance of accessing and reviewing all relevant InterQual and/or other applicable clinical review criteria, prior to rendering a determination.

Finding: The plan issued Initial Adverse Determinations (IAD) that was lacking required content. WellCare amended its IAD letter template to include:

- a. The additional information needed by the plan in order to support a reversal of its IAD decision.
- b. The process for filing complaints with the NYS Department of Health.
- c. Updated language to improve overall readability.

Finding: The plan issued appeal acknowledgement letters that were incorrect. WellCare has begun utilizing a daily dashboard report to monitor and track the timeframes within which the acknowledgement letters are mailed. The dashboard will alert the Appeals Department Manager of all appeal cases and the status of each appeal acknowledgement letter. Managers have been instructed to trigger an acknowledgement letter on the same day the case is logged in the dashboard. If an acknowledgement letter is not sent on the same day it was logged, the daily dashboard report will alert the manager who will immediately trigger a letter to the member and re-coach the associate on timeframes for triggering such letters.

The appeal review process was amended so that an Appeals Department Manager is now required to review every appeal acknowledgement letter before it is mailed.

The Appeals Department has begun utilizing new Step Actions and job aids, and providing additional training to its entire staff. The Step Action training includes a review of the appeal intake process and timeframes for member acknowledgement letters.

Finding: Harmony Behavioral Health issued incorrect Retrospective Final Adverse Determination (FAD) letters to providers without the required external appeal rights, instructions and applications and no Final Adverse Determination letters were sent to enrollees. Harmony Behavioral Health Final Adverse Determination letters have been amended to include the required external appeal rights, instructions and application. The Appeals Department began sending a copy of the Final Adverse Determination to the enrollee. The policy and procedure and any related Step Action was updated to reflect the requirement of sending a copy of the Final Adverse Determination to the enrollee. Associate training was conducted upon updating of the policy and procedure.

Finding: The plan issued notices of Final Adverse Determination which were lacking required content. The Clinical Supervisor of the Appeals Department reviews each Final Adverse Determination letter prior to its mailing to ensure that correct language, content, and the appropriate clinical setting for care are captured in the rationale narrative portion of the letter. This review assists the Appeals Department to proactively capture errors prior to mail the letter. Tracking these errors will identify performance concerns that will lead to additional associate training and work performance actions.

- **2008 Recommendation:** The plan should continue its efforts to improve prenatal and postpartum care, and evaluate the effectiveness of the initiatives described in the plan's response to the previous year's recommendation. [*Repeat recommendation.*]

Plan Response:

OB Project

The OB (Obstetrics) Bonus Payment Project showed no improvement in our prenatal and postpartum care related rates due in part to use of a global-billing/payment methodology for WellCare OB providers. In 2010, WellCare enhanced the likelihood of success for our OB Bonus Program by eliminating a global billing/payment methodology and instituting a fee-for-service model.

The NY QI department continues to monitor members who are non-compliant for these measures and we contact the OB providers about these members.

The NY QI department is also conducting OB medical record reviews to identify encounter activity that was not previously submitted to the plan. The effectiveness of finding "missing" encounter data through these medical records reviews will be evaluated during the coming year.

WellCare's Market Medical Director conducted direct OB office outreach visits to encourage the use of the Baby Basics educational guide and pregnancy planner. We are currently evaluating the providers' responsiveness to the plan's offer to supply these educational materials.

Member Incentive Program

The 2010 Postnatal Care Member Incentive Program (MIP) has not yet been launched – this program is currently being re-worked as the new "Mommy and Baby Matters Program" which is currently in the review process by the NYSDOH. This program includes a newly designed member booklet providing pregnant women information on prenatal care, postpartum care, and childhood immunization and lead testing. The MIP will award women a \$50 gift card for completing at least six (6) prenatal care visits and an additional \$25 gift card for completing a timely postpartum visit.

MIP for cervical cancer screening and Chlamydia screening will be launched 4th quarter 2010. This program will award women a \$25 gift card for completing their cervical cancer screen before December 31, 2010. Additionally, a \$25 gift card will be awarded to women who complete a Chlamydia screening before December 31, 2010. Corporate QI Informatics monitors all MIP gift cards awarded to ensure that the NYS \$75 gift card limit is not exceeded.

Alere Case Management:

WellCare has contracted with Alere to provide case management to high-risk OB members. Telephonic outreach is conducted to offer this service. The plan's use of case management efforts are designed to increase compliance with prenatal and postnatal OB care. Members will also be referred to local family planning services and mental health services, if necessary.

- **2008 Recommendation:** The plan should monitor HEDIS[®]/QARR reporting for below average rates for the *Ambulatory Follow-Up After Hospitalization for Mental Illness – 30 Days*, *Antidepressant Medication Management – 180 Days*, *Cervical Cancer Screening*, and *Chlamydia Screening* measures. With regard to Chlamydia screening, the plan should also continue the interventions conducted in the Performance Improvement Project.

Plan Response:

Follow-Up After Hospitalization for Mental Illness – 30 Days

With the recent NYSDOH approval to engage a vendor [Magellan] to assist the plan with mental health service delivery, the plan will be able to increase its efforts to coordinate post-discharge care for these admissions. Scheduling appointments and working on member compliance with appointment follow-up and medication use are included in the service-level agreements with the vendor. WellCare will monitor the progress of this project through monthly reports provided by the vendor.

Antidepressant Management – 180 Days

A new program is under development to identify members currently prescribed the HEDIS®-measure specified antidepressant medications. These members will be contacted telephonically and offered case management services to enhance their compliance with this measure. WellCare will monitor the progress of this project to evaluate the usefulness of this intervention.

Cervical Cancer Screening and Chlamydia Screening

The plan's interventions for these two measures, as well as the plan's new Provider Report Card and non-compliant member list initiatives are described above. WellCare will monitor the progress of these efforts to evaluate the usefulness of the interventions chosen to improve our results.

X. Appendix

References

A. Corporate Profile

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
 - Managed Care Plan Directory, Accessed July 1, 2010
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- Enrollment Status by Aid Category and County as of December 2009
- Auto Assignment Data, 2007 - 2009
- Auto Assignment Quality Algorithm Scores, 2007 - 2009
- Enrollment Status Report, 2009

2) Provider Network

- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, as of December, 2009
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- QARR Measurement Year, 2007 - 2009
- NYSDOH Primary Care Access and Availability Survey, 2009

C. Utilization

1) Encounter Data

- MMC Encounter Data System, 2007 - 2009

2) Health Screening Data

- Medicaid and Family Health Plus Managed Care Enrollee Health Screening, 2007 - 2009

3) QARR Use of Services

- QARR Measurement Year, 2007 - 2009

D. Quality Indicators

- 1) *Summary of HEDIS® Information Systems Audit™ Findings*
 - 2010 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors
- 2) *QARR Data*
 - Performance Category Analysis, Quality Performance Matrix (2009 Measurement Year)
 - QARR Measurement Year, 2007 - 2009
- 3) *CAHPS® 2010 Data*
 - QARR Measurement Year, 2009
- 4) *Quality/Satisfaction Points and Incentive*
 - Quality/Satisfaction Points and Incentive, 2007 - 2009
- 5) *Performance Improvement Project*
 - 2009-2010 PIP Final Report
- 6) *Health Disparities*
 - NYSDOH Health Disparities Survey, 2010

E. Health Information Technology

- NYSDOH Health Information Technology Survey, 2009

F. Deficiencies and Appeals

- 1) *Summary of Deficiencies*
 - MMC Operational Deficiencies by Plan/Category, 2009
 - Focus Deficiencies by Plan/Survey Type/Category, 2009
- 2) *Appeals*
 - MMC External Appeals Data, 2007 - 2009

G. Financial Data

- Medicaid Managed Care Operations Report, 2007 - 2009