NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
OFFICE OF QUALITY AND PATIENT SAFETY

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

WELLCARE OF NEW YORK, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

Table of Contents

List of Tables

List of Figures

Acronyms Used in This Report

ALOS:	*Average Length of Stay*
AO:	*Area Office*
CFR:	*Code of Federal Regulations*
CHP:	*Child Health Plus*
CMS:	*Centers for Medicare and Medicaid Services*
COM:	*Commercial*
DBA:	*Doing Business As*
EQR:	*External Quality Review*
EQRO:	*External Quality Review Organization*
F/A:	*Failed Audit*
FAR:	*Final Audit Report*
FFS:	*Fee-For-Service*
FIDA:	*Fully Integrated Duals Advantage*
FTE:	*Full Time Equivalent*
HARP:	*Health and Recovery Plan*
HCS:	*Health Commerce System*
HEDIS:	*Healthcare Effectiveness Data and Information Set*
HIE:	*Health Information Exchange*
HIT:	*Health Information Technology*
HMO:	*Health Maintenance Organization*
HPN:	*Health Provider Network*
MAP:	*Medicaid Advantage Plus*
MCD:	*Medicaid*
MCO:	*Managed Care Organization*
MLTC:	*Managed Long-Term Care*
MMC:	*Medicaid Managed Care*
MMCOR:	*Medicaid Managed Care Operating Report*
MRT:	*Medicaid Redesign Team*
MY:	*Measurement Year*
N:	*Denominator*
N/A:	*Not Available*
NCQA:	*National Committee for Quality Assurance*
NP:	*Not Provided*
NR:	*Not Reported*
NV:	*Not Valid*
NYC:	*New York City*
NYCRR:	*New York Code of Rules and Regulations*
NYS:	*New York State*
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*
OQPS:	*Office of Quality and Patient Safety*
PCP:	*Primary Care Practitioner/Provider*
PHSP:	*Prepaid Health Services Plan*
PIP:	*Performance Improvement Project*
PIHP:	*Prepaid Inpatient Health Plan*
PNDS:	*Provider Network Data System*
POC:	*Plan of Corrective Action*
PMPY:	*Per Member Per Year*
PTMY:	*Per Thousand Member Years*
PQI:	*Prevention Quality Indicator*
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*
ROS:	*Rest of State*
RY:	*Reporting Year*
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*
TR:	*Technical Report*
UR:	*Utilization Review*

I. About This Report

Purpose of This Report

In order to comply with federal regulations, the New York State Department of Health (NYSDOH) contracts with Island Peer Review Organization (IPRO) to conduct the annual External Quality Review (EQR) of the MCOs certified to provide Medicaid coverage in New York State (NYS). NYS is dedicated to providing and maintaining the highest quality of care for enrollees in managed care organizations. The NYSDOH's Office of Health Insurance Programs (OHIP), and Office of Quality and Patient Safety (OQPS) collaboratively employ 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.

Structure of This Report

This report is organized into the following domains: MCO Corporate Profile, Enrollment and Provider Network, Utilization, Performance Indicators, Health Information Technology, and Structure and Operation Standards . Although the technical reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP) and Commercial product lines. The CHP product line is the NYS version of the federal Child Health Insurance Program (CHIP), which provides health coverage to eligible children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. CHP data are part of the Medicaid managed care data sets used in this report. For some measures, including QARR 2019 (MY 2018), aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' 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 VIII of this report 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 MCO 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 effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's report. The MCO was given the opportunity to describe current or proposed interventions that address areas of concern, as well as an opportunity to explain areas 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 technical reports are prepared based on data for the most current calendar year available. Where trending is desirable, data for prior years may also be included. This report includes data for Reporting Year 2018.

II. MCO Corporate Profile

WellCare of New York, Inc. (WellCare) is a regional, for-profit health plan that serves Medicaid (MCD) and Child Health Plus (CHP) 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 CHP product line.

Wellcare Web Page: https://www.wellcare.com/New-York

*Participating Regions and Products			
Hudson Valley[1]:	MCD	CHP	
Long Island[2]:	MCD	CHP	
Northeast[3]:	MCD	CHP	
New York City[4]:	MCD	CHP	
Western[5]:	MCD	CHP	

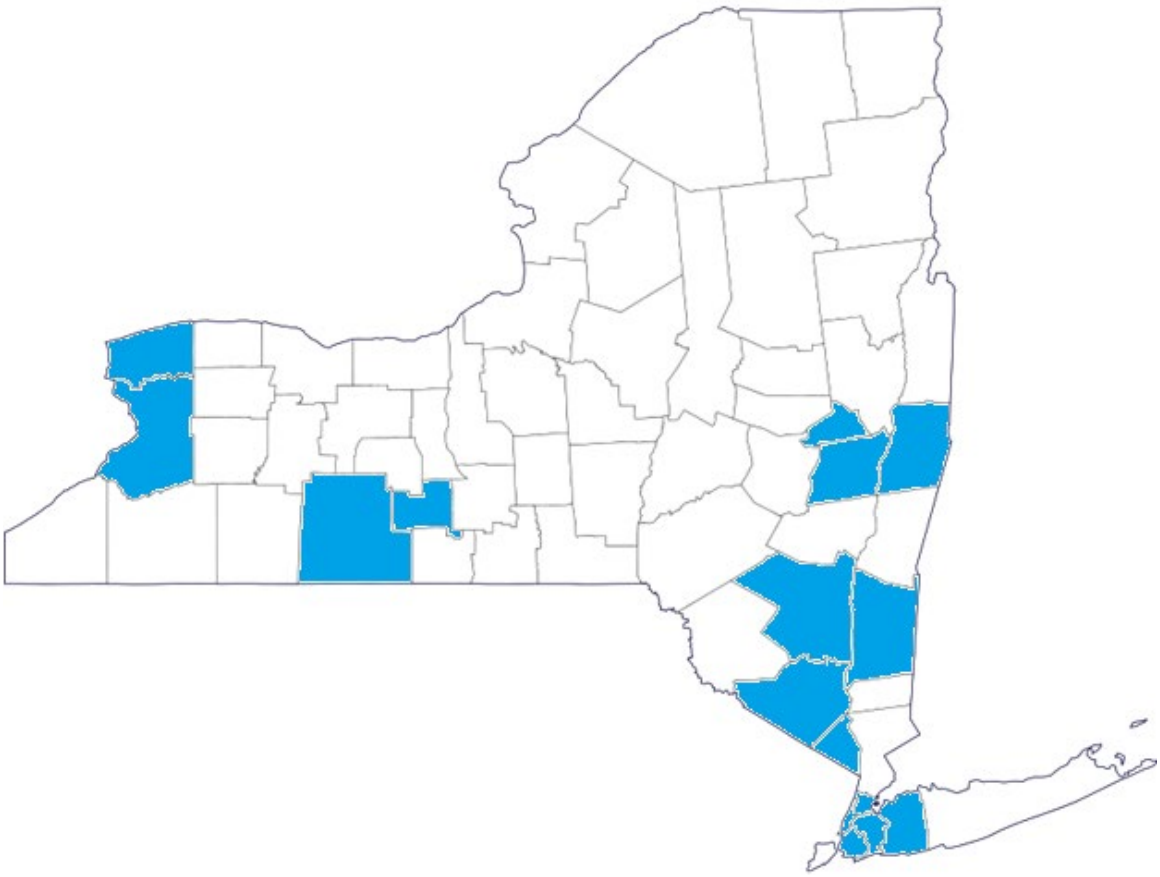
* Please contact the plan directly to confirm the plan participation counties.

Region Definitions

Region	Counties
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tomkins
Hudson Valley	Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Long Island	Nassau, Suffolk
Northeast	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
New York City	Bronx, Kings, New York, Queens, Richmond
Western	Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates

[1] Wellcare participates in Duchess, Orange, Rockland, and Ulster counties.
[2] Wellcare participates in Nassau County only.
[3] Wellcare participates in Albany, Rensselaer, and Schenectady counties.
[4] Wellcare participates in the Bronx, Kings, New York, and Queens counties.
[5] Wellcare participates in Erie, Niagara, Schuyler, and Steuben counties only.

Figure 1: WellCare Map of Participating Counties



III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has increased from 2017 to 2018 by a rate of 4.5%. WellCare's membership represents 2.4% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	98,565	101,568	106,304
% Change from Previous Year	-8.5%	3.0%	4.5%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	2.3%	2.3%	2.4%

Data Source: NYS OHIP Medicaid DataMart

[1] The statewide totals include MCOs that were operational during the measurement year, but did not have enough members to report sufficient data.

Table 2: Enrollment in Other Product Lines—2016-2018

	2016	2017	2018
CHP	3,900	4,509	5,326

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: WellCare Enrollment Trends—All Product Lines

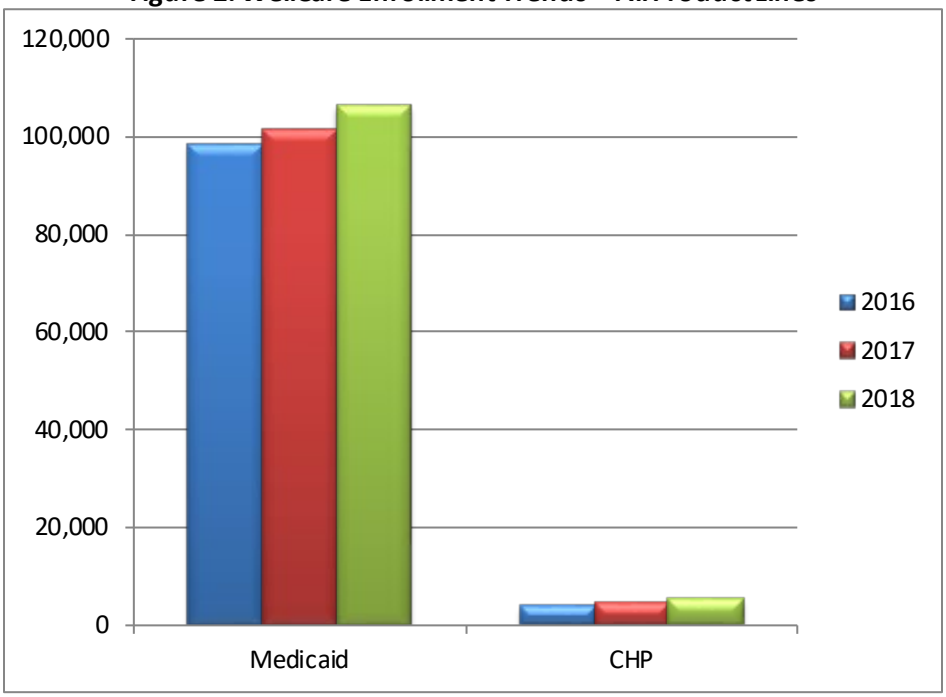


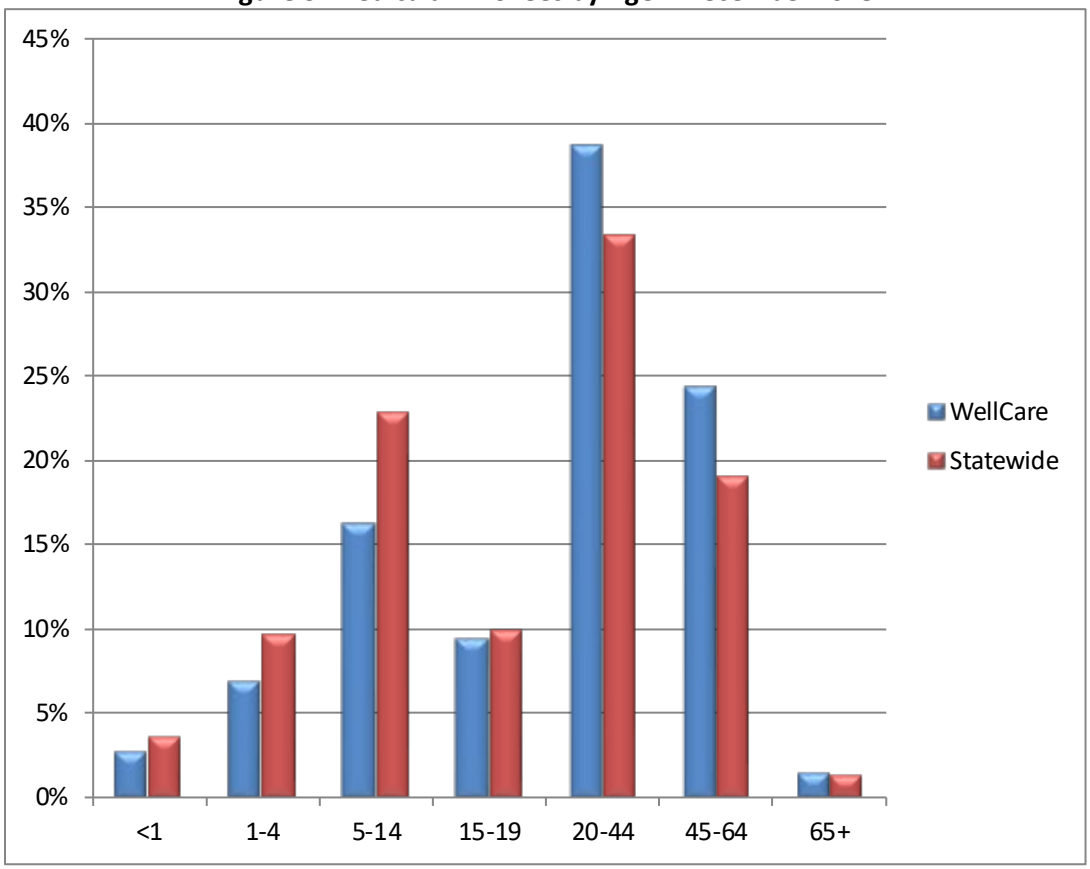
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average (SWA). The MCO's rates of members aged 20-44 years old and 45-64 years old were above the SWA in 2018.

Table 3: Medicaid Membership Age and Gender Distribution—December 2018

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	1,502	1,394	2,896	2.7% ▼	3.6%
1-4	3,698	3,629	7,327	6.9% ▼	9.7%
5-14	8,771	8,510	17,281	16.3% ▼	22.8%
15-19	5,233	4,752	9,985	9.4%	9.9%
20-44	22,489	18,460	40,949	38.7% ▲	33.3%
45-64	13,964	11,806	25,770	24.4% ▲	19.1%
65 and Over	669	868	1,537	1.5%	1.4%
Total	56,326	49,419	105,745		
Under 20	19,204	18,285	37,489	35.5% ▼	46.1%
Females 15-64		35,018		33.1%	34.7%

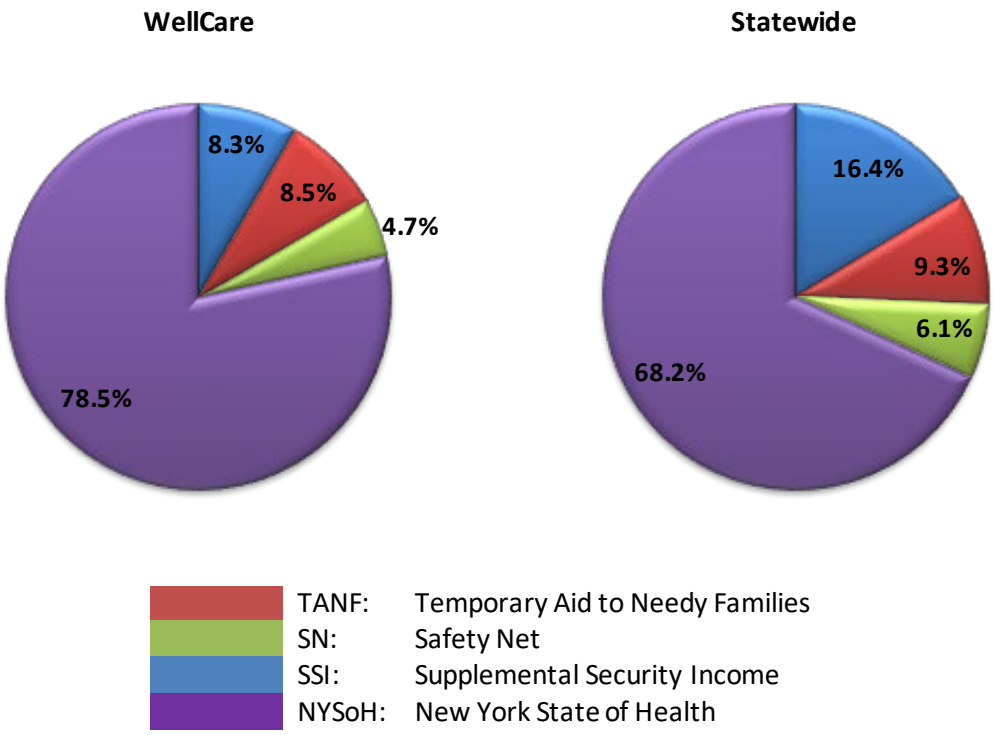
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



A breakdown of MCO membership by aid category, as reported by the NYSDOH for December 31, 2018, is shown in **Figure 4**.

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

This section of the report examines the MCO's provider network through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey. This section also includes an overview of network adequacy standards.

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. In 2018, the MCO's rates showed an improvement for 5 out of 6 measures. For detailed information regarding board certification of providers, please see *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[6].

Table 4: HEDIS®/QARR Board Certification Rates—2016-2018

Provider Type	2016		2017		2018	
	WellCare	Statewide Average	WellCare	Statewide Average	WellCare[1]	Statewide Average
			Medicaid/CHP			
Family Medicine	69%	71%	73%	72%	76%	74%
Internal Medicine	71% ▼	75%	73% ▼	76%	73%	76%
Pediatricians	73% ▼	78%	76%	79%	77%	80%
OB/GYN	62% ▼	75%	66% ▼	77%	70%	80%
Geriatricians	68%	63%	62%	63%	73%	63%
Other Physician Specialists	63% ▼	75%	63% ▼	76%	65%	77%

[1]Level of significance was unaudited.

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. The MCO had rates above the statewide average for the Dentistry specialty.

Table 5: Medicaid Providers by Specialty—2018 (4th Quarter)

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	4,403	20.9%	19.5%
Pediatrics	956	4.5%	3.8%
Family Practice	933	4.4%	3.5%
Internal Medicine	1,806	8.6%	8.4%
Other PCPs	708	3.4%	3.8%
OB/GYN Specialty[1]	791	3.8%	3.8%
Behavioral Health	2,261	10.7%	17.2%
Other Specialties	9,510	45.2%	46.0%
Non-PCP Nurse Practitioners	1,082	5.1%	8.7%
Dentistry	3,002	14.3% ▲	4.9%
Total	21,049		

Data Source: NYS Provider Network Data System (PNDS).

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

[6] *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations* https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/

Table 6 displays the ratio of enrollees to providers, as well as the number of Full Time Equivalents (FTEs), and the ratio of enrollees to FTEs for the fourth quarter of 2018. Statewide data are also included. For this table, 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.

Table 6: Ratio of Enrollees to Medicaid Providers—2018 (4th Quarter)

Specialty Type	Wellcare			Statewide		
	Ratio of Enrollees to Providers	Total Number of FTEs	Ratio of Enrollees to FTEs	Median Ratio of Enrollees to Providers[1]	Total Number of FTEs	Median Ratio of Enrollees to FTEs
Medicaid						
Primary Care Providers	24:1	4,476	24:1	42:1	80,986	42:1
Pediatrics (Under age 20):	39:1			70:1		
OB/GYN (Females age 15-64)	44:1			59:1		
Behavioral Health	47:1			73:1		

Data Source: Derived ratios calculated from NYS OHIP Medicaid DataMart and NYS Provider Network Data System (PNDS).

[1] The statewide median was used for this table, 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 **Table 7** for the fourth quarters of 2016 through 2018. Panels are considered "open" if a provider has fewer than 1,500 Medicaid members. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼. In 2018, the MCO's rate for Medicaid PCPs with an Open Panel was below the statewide average.

Table 7: Medicaid PCPs with an Open Panel—2016-2018 (4th Quarter)

	2016			2017			2018		
	Wellcare		Statewide	Wellcare		Statewide	Wellcare		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Medicaid									
Providers with Open Panel	2,750	81.1	85.0	2,640	94.9	95.7	983	22.5 ▼	90.8

Data Source: NYS Provider Network Data System (PNDS)

Primary Care and OB/GYN Access and Availability Survey—2018

On behalf of the NYSDOH's Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Primary Care and OB/GYN Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid Managed Care Contract. The survey evaluates 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.

Section 15.2 of the Medicaid Managed Care Contract outlines the timeliness standards for various types of services. For routine office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(vi) states *"Routine, non-urgent, preventive appointments…within four (4) weeks of request."* For non-urgent "sick" office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(v) states that appointments must be scheduled *"…within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated."* Note that the timeliness standard for these types of appointments excludes weekends and holidays. The timeliness standard for prenatal appointments with OB/GYN providers is stated in Section 15.2(a)(ix) as follows: *"…within three (3) weeks during the first trimester, within two (2) weeks during the second trimester, and within one (1) week during the third trimester."*

As noted previously, the Survey also assesses MCO compliance with standards for after-hours access. Section 15.3 of the Contract outlines requirements for providers for 24-hour access to care for members. Section 15.3(a) states *"The Contractor must provide access to medical services and coverage to Enrollees, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour, seven (7) days a week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends."* The Contract also states, in Section 15.3(b), that MCOs can satisfy this requirement *"…by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after-hours "on-call" telephone resources to members with medical problems."* For the purposes of the Survey, after-hours access is considered compliant if a "live voice" representing the named provider is reached or if the provider's beeper number is reached.

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

Table 8: displays the Wellcare provider participation rate. The total number of providers surveyed (or sample size) is based on MCO Medicaid enrollment size and provider network size. The total number of compliant providers is the number of providers that will be included in the Appointment Availability and After-Hours Access-Survey.

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
50	35	**70.0%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 35 providers (total number of providers who were compliant for participation). There were no providers with closed panels. The MCO performed above the threshold for all call types.

Table 9: Appointment Availability and After-Hours Access Rates—2018

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	6	6	100.0%
	Pediatrician	4	4	100.0%
	OB/GYN	3	2	66.7%
	Total Routine	**13**	**12**	**92.3%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	6	4	66.7%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**12**	**9**	**75.0%**
After-Hours Access	Internist/Family Practitioner	2	2	100.0%
	Pediatrician	5	5	100.0%
	OB/GYN	3	1	33.3%
	Total After-Hours	**10**	**8**	**80.0%**

[1] Timeliness was not considered when determining appointment availability rates.

IV. Utilization

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

Encounter Data

Table 10 depicts selected Medicaid encounter data for 2016 through 2018. Rates for this period are also compared to the statewide averages. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼. Wellcare's rates for Specialty and Dental providers were below the SWA in 2018.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	WellCare	Statewide Average	WellCare	Statewide Average	WellCare	Statewide Average
PCPs and OB/GYNs	0.81 ▼	3.85	3.22	3.56	3.14	3.50
Specialty	3.42 ▲	2.45	1.89	2.30	1.87 ▼	2.33
Emergency Room	0.48	0.54	0.57	0.55	0.58	0.53
Inpatient Admissions	0.10	0.14	0.13	0.14	0.13	0.13
Dental	0.00 ▼	1.03	0.00 ▼	1.02	0.00 ▼	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a) (ii) of the Medicaid Managed Care and Family Health Plus Model Contract, MCOs 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. MCOs are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the MCO was able to complete health screenings. **Table 11** summarizes the percentage of Medicaid enrollees receiving health screenings within 30 days of enrollment from 2016 through 2018, in addition to displaying the statewide averages for these years. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. The MCO's rates improved from 2016 to 2018.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	Wellcare	SWA	Wellcare	SWA	Wellcare	SWA
	Medicaid					
Enrollee Health Screenings	3.4%	12.5%	4.7%	12.7%	6.1%	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). In 2018, the MCO had 1 out of 10 measures with a rate above the SWA.

Table 12: QARR Use of Services Rates—2016-2018

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	4,593	4,907	4,446	5,317
ER Visits	438	452	458	492
Inpatient ALOS				
Medicine	3.7 ▼	4.2	3.9	4.5
Surgery	6.8	7.6 ▲	7.3	7.0
Maternity	2.7	3.1	3.0	2.9
Total	3.9	4.4	4.2	4.4
Inpatient Utilization (PTMY)				
Medicine Cases	38	40	39 ▲	30
Surgery Cases	12	12	11	12
Maternity Cases	22	25	25 ▼	32
Total Cases	67	72	69	66

PTMY: Per Thousand Member Years
ER: Emergency Room
ALOS: Average Length of Stay. These rates are measured in days.

V. Performance Indicators

To measure the quality, accessibility, and timeliness of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of performance indicators. This section is a summary of findings from those reports, including HEDIS®/QARR 2019 audit findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

The NYS EQRO provided technical assistance to MCOs throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new MCOs, 3) serving as a liaison between the MCOs and NCQA to clarify questions regarding measure specifications, and 4) clarifications to MCO questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® Final Audit Report prepared for Wellcare indicated that the MCO had no significant issues in any areas related to reporting. Wellcare demonstrated compliance with all areas of Information Systems and Measure Determination. The MCO was able to report rates for all measures for all applicable product lines. The MCO passed Medical Record Review for the five measures validated, as well.

Wellcare used NCQA-certified software to produce its HEDIS® rates. Supplemental databases that were 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 required for reporting.

HEDIS®/QARR Performance Measures

For Reporting Year (RY) 2018, performance measures were organized into the following domains:

- Effectiveness of Care
  - Prevention and Screening
  - Acute and Chronic Care
  - Behavioral Health
- Utilization
- Access to Care

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH. [7]

Quality Indicators

This section of the report explores the quality of health care services provided by the MCOs. Performance in the Effectiveness of Care domain is examined.

[7] Additional information on the Performance Indicators/Measures is reported in the *2018 External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*.

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was significantly better than the SWA (indicated by ▲) or whether the MCO's rate was significantly worse than the SWA (indicated by ▼). In 2018, the MCO had rates above the SWA for 3 out of 14 measures.

Table 13a: HEDIS®/QARR MCO Performance Rates 2016-2018—Effectiveness of Care: Prevention and Screening[1]

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	90	94 ▲	97 ▲	**89**
WCC—BMI Percentile	80	84	90 ▲	**86**
WCC—Counseling for Nutrition	78	81	82	**83**
WCC—Counseling for Physical Activity	60 ▼	70	74	**74**
Childhood Immunizations—Combo 3	73	75	72	**73**
Lead Screening in Children	88	85	84 ▼	**89**
Adolescent Immunizations—Combo 2[2]		37	39	**43**
Adolescents—Alcohol and Other Drug Use[3]	49 ▼	67	68	**70**
Adolescents—Depression[3]	52 ▼	57	60	**67**
Adolescents—Sexual Activity[3]	46 ▼	62	62	**67**
Adolescents—Tobacco Use[3]	45 ▼	73	71	**74**
Breast Cancer Screening	68 ▼	67 ▼	67 ▼	**71**
Colorectal Cancer Screening	57	57	63	**63**
Chlamydia Screening (Ages 16-24)	80 ▲	80 ▲	81 ▲	**76**

Note: Rows shaded in grey indicate that the measure is not required to be reported

BMI: Body Mass Index; WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; COPD: Chronic Obstructive Pulmonary Disease

[1] All measures included in this table are HEDIS® measures, unless noted otherwise.

[2] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2017, *Combination 2* is reported, as it includes the HPV component.

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had rates above the SWA for 3 out of 20 measures.

Table 13b: HEDIS®/QARR MCO Performance Rates 2016-2018-Effectiveness of Care: Acute and Chronic Care[1]

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	86 ▼	89	87 ▼	**91**
Spirometry Testing for COPD	55	54	53	**56**
Use of Imaging Studies for Low Back Pain	91 ▲	80	81 ▲	**77**
Pharmacotherapy Management for COPD—Bronchodilators	86	85	88	**89**
Pharmacotherapy Management for COPD—Corticosteroids	68	72	72	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	70	69	68	**71**
Medication Management for People with Asthma 50% (Ages 5-18)	57	44 ▼	53	**59**
Asthma Medication Ratio (Ages 19-64)	63 ▲	65 ▲	63	**60**
Asthma Medication Ratio (Ages 5-18)	63	67	64	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	84	79	75	**80**
CDC—HbA1c Testing	92	92	92	**92**
CDC—HbA1c Control (<8%)	55	59	53 ▼	**60**
CDC—Eye Exam Performed	61	59 ▼	62 ▼	**67**
CDC—Nephropathy Monitor	96 ▲	93	91	**92**
CDC—BP Controlled (<140/90 mm Hg)	61	63	60 ▼	**66**
Drug Therapy for Rheumatoid Arthritis	77	81	75	**83**
Monitor Patients on Persistent Medications—Total Rate	93 ▲	93	93 ▲	**92**
Appropriate Treatment for URI	95 ▲	95	96	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	46 ▲	46 ▲	53 ▲	**36**
HIV Viral Load Suppression[2,3]	71	66 ▼	70 ▼	**77**
Flu Shots for Adults (Ages 18-64)[4]	42	39		
Advising Smokers to Quit[4]	81	79		
Smoking Cessation Medications[4]	58	63		
Smoking Cessation Strategies[4]	51	63		

Note: Rows shaded in grey indicate that the measure is not required to be reported.

COPD: Chronic Obstructive Pulmonary Disease; CDC: Comprehensive Diabetes Care; BP: Blood Pressure; URI: Upper Respiratory Infection

[1] All measures included in this table are HEDIS® measures, unless otherwise noted.

[2] NYS-specific measure.

[3] The *HIV Viral Load Suppression* measure was introduced in Reporting Year 2016.

[4] CAHPS® measure.

Behavioral Health

This section examines the health care services the MCO provided to members with behavioral health conditions through performance on several HEDIS®/QARR Behavioral Health measures. The table below describes the measures included in this domain.

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had rates below the SWA for 1 out of 9 measures.

Table 13c: HEDIS®/QARR MCO Performance Rates 2016-2018—Behavioral Health[1]

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	48	54	52	**53**
Antidepressant Medication Management—Effective Continuation Phase	34	35	39	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	66	59	55	**59**
Follow-Up Care for Children on ADHD Medication—Continue	*SS*	*SS*	*SS*	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	64 ▼	62 ▼	67 ▼	**74**
Follow-Up After Hospitalization for Mental Illness—7 Days	45 ▼	39 ▼	59	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	83	80	81	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	83	79	73	**80**
Antipsychotic Medications for Schizophrenia	68	65	63	**63**

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
ADHD: Attention Deficit/Hyperactivity Disorder
[1] All measures included in this table are HEDIS® measures.

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as *"the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."* Performance indicators related to Utilization and Access to Care are included in this section.[8]

Table 14a displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Utilization domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). The MCO has rates below the SWA for all measures.

Table 14a: HEDIS®/QARR MCO Performance Rates 2016-2018—Utilization[1]

Measure	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	58 ▼	61 ▼	64 ▼	**81**
Well-Child Visits—3 to 6 Year Olds	79 ▼	78 ▼	79 ▼	**86**
Adolescent Well-Care Visits	65 ▼	64 ▼	64 ▼	**68**

[1] All measures included in this table are HEDIS® measures.

[8] Additional information on Access/Timeliness indicators are reported in the *2018 External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*.

Access to Care

The HEDIS®/QARR Access to Care measures examine the percentage of children and adults who access certain services, including preventive services, prenatal and postpartum care, and dental services.

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). In 2018, the MCO had rates below the SWA for 80% of the measures.

Table 14b: HEDIS®/QARR MCO Performance Rates 2016-2018—Access to Care[1]

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	91 ▼	92 ▼	93 ▼	**97**
25 Months-6 Years	89 ▼	87 ▼	88 ▼	**94**
7-11 Years	95 ▼	93 ▼	92 ▼	**97**
12-19 Years	93 ▼	92 ▼	91 ▼	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)				
20-44 Years	73 ▼	69 ▼	69 ▼	**81**
45-64 Years	85 ▼	83 ▼	83 ▼	**89**
65+ Years	89	88 ▼	87 ▼	**91**
Access to Other Services				
Timeliness of Prenatal Care	89	88	89	**88**
Postpartum Care	69	71	69	**70**
Annual Dental Visit[2]	55 ▼	49 ▼	50 ▼	**61**

[1] All measures included in this table are HEDIS® measures.

[2] For the Annual Dental Visit measure, the Medicaid age group is 2-20 years, while the Child Health Plus age group is 2-18 years.

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and 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 MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. Vital statistics data are used in the risk adjustment. **Table 15** presents prenatal care rates calculated by the NYSDOH for QARR 2015 through 2017 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates—2017-2019

Measure	2015		2016		2017	
	WellCare	Regional Average	WellCare	Regional Average	WellCare	Regional Average
NYC						
Risk-Adjusted Low Birth Weight[1]	8%	6%	8%	6%	-	-
Prenatal Care in the First Trimester	71%	75%	73%	76%	73%	75%
Risk-Adjusted Primary Cesarean Delivery[1]	14%	14%	19%	14%	-	-
Vaginal Birth After Cesarean	10%	18%	10%	18%	-	-
ROS						
Risk-Adjusted Low Birth Weight[1]	6%	7%	6%	7%	-	-
Prenatal Care in the First Trimester	68%	74%	69%	74%	68%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	12%	14%	14%	13%	-	-
Vaginal Birth After Cesarean	6%	14%	6%	14%	-	-

Note: Some of the 2017 rates were not available at the time of the report.

NYC: New York City; ROS: Rest of State

[1] A low rate is desirable for this measure.

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). In 2018, the MCO had rates below the statewide average for 2 out of 12 measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	2014		2016		2018	
	WellCare	Statewide Average	WellCare	Statewide Average	WellCare	Statewide Average
			Medicaid			
Getting Care Needed[1]	83	**83**	85	**85**	74 ▼	**84**
Getting Care Quickly[1]	80 ▼	**87**	80 ▼	**88**	81 ▼	**88**
Customer Service[1]	75 ▼	**82**	83	**86**	86	**86**
Coordination of Care[1]	68	**74**	70	**74**	78	**75**
Collaborative Decision Making[1]	56	**53**	69	**74**	74	**76**
Rating of Personal Doctor[1]	88	**89**	90	**89**	87	**90**
Rating of Specialist	72	**81**	90	**83**	84	**84**
Rating of Healthcare	81 ▼	**85**	82	**86**	83	**87**
Satisfaction with Provider Communication[1]	90 ▼	**93**	93	**93**	91	**93**
Rating of Counseling/Treatment	71	**64**	65	**68**	*SS*	**69**
Rating of Health Plan—High Users	84	**84**	76 ▼	**85**	79	**84**
Overall Rating of Health Plan	76 ▼	**83**	78 ▼	**85**	82	**85**

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

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

Table 17 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Utilization and Access to Care measures reported annually in the New York State Managed Care Plan Performance Report. Thirty-nine measures were included for the Measurement Year (MY) 2018 Medicaid Quality Performance Matrix, which include combined measures for the Medicaid and CHP product lines. The matrix diagrams the MCO's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid MCOs through a percentile ranking.

The Quality Performance Matrix is partitioned into cell categories (A-F). The cell category in which the measures are placed is determined by year-over-year performance on the horizontal axis and an evaluation of the MCO's performance based on a percentile ranking on the vertical axis. The percentile ranking is partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. For MY 2018, the MCO was required to follow up on no more than three measures from the D and F categories of the Matrix. If the 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.

Table 17: Quality Performance Matrix—Measurement Year 2018

Trend*	Percentile Ranking 0 to 49%	50% to 89%	90 to 100%
	**C**	**B** Weight Assessment for Children and Adolescents - BMI Percentile	**A**
No Change	**D** Annual Dental Visits (Ages 2-18) Antidepressant Medication Management-Effective Acute Phase Treatment Asthma Medication Ratio (Ages 5-64) Breast Cancer Screening Cervical Cancer Screening Childhood Immunization Status (Combo 3) Controlling High Blood Pressure Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement of AOD - Total Medication Management for People with Asthma 50% Days Covered (Ages 5-64) Medication Management for People with Asthma 75% Days Covered (Ages 5-64) Monitoring Diabetes - Eye Exams Statin Therapy for Patients with Cardiovascular Disease - Adherent Weight Assessment for Children and Adolescents - Counseling for Nutrition Weight Assessment for Children and Adolescents - Counseling for Physical Activity Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	**C** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Chlamydia Screening (Ages 21-24) Colon Cancer Screening Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD - Total Metabolic Monitoring for Children and Adolescents on Antipsychotics Use of Spirometry Testing in the Assessment and Diagnosis of COPD Postpartum Care Timeliness of Prenatal Care	**B** Antidepressant Medication Management-Effective Continuation Phase Treatment Chlamydia Screening (Ages 16-20)

	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits) Initiation of Pharmacotherapy upon New Episode of Opioid Dependence Viral Load Suppression		
	**F** **Managing Diabetes Outcomes - Poor HbA1C Control**	**D**	**C**

Performance Improvement Project

As part of the external quality review responsibilities, IPRO assists the MCOs through many steps of the Performance Improvement Project (PIP) process. The contract between the NYSDOH and the MCOs instructs the MCOs to conduct at least one PIP each year. The PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: 1) measurement of performance using objective quality indicators, 2) implementation of interventions to achieve improvement in the access to and quality of care, and 3) evaluation of the effectiveness of interventions based on the performance measures.

The purpose of a PIP is to assess and improve the processes and outcomes of the health care provided by an MCO. Protocol 3 of CMS' Federal Regulation 42 CFR §438, subpart E specifies procedures for EQROs to use in assessing the validity and reliability of a PIP. Protocol 3 describes how to conduct the following activities: assessment of study methodology, verification of study findings, and evaluation of overall reliability and validity of study results. The results of the PIPs are available on the CMS Medicaid website and in the EQR technical report. States may incorporate specific PIPs as part of their State quality strategy, required by Section 1932(c)(1) of the Social Security Act, to align with the HHS National Quality Strategy for Quality Improvement in Health Care.

The PIP should target improvement in either clinical or non-clinical services delivered by the MCOs. Study topics must reflect MCO enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over- or under-utilization that present a clear threat to health or functional status, as well. The topic should address a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may be categorized as infrequent conditions or services, and also exist for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special needs place them at high risk. The State may select the MCO's study topic(s), or topics may be selected based on enrollee input. While MCOs have the option to select a study topic of their choosing, they are encouraged to participate collaboratively with other MCOs in conducting their PIPs. In Report Year 2018, the common-themed two-year PIP that was chosen was Perinatal Care and Pre-term Births.

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

In addition, the NYS EQRO validated the MCO'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 MCO's improvement strategies, the likelihood that the reported improvement is "real" improvement, and whether the MCO 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 the validation teams. The validation process concluded with a summary of strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of PIP results was at risk.

WellCare's 2017-2018 PIP topic was *"Improving Perinatal and Post-Partum Health Outcomes".* During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- The Mommy and Baby Matters Program and the high-risk pregnancy programs provided member education to improve health and birth outcomes.
- Healthy Rewards program offered members incentives for completing their prenatal and post-partum visits.
- Wellcare assisted members with various social services, such as assistance with housing, WIC services, nutrition workshops, financial and life planning.

MCO-Focused Interventions:

- Continue to enroll members in Optum's Mommy and Baby Matters Program.
- Community advocacy department guided members to appropriate social services.

Table 18 presents a summary of WellCare's 2017-2018 PIP. The MCO demonstrated an improvement in 9 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	89%	89%	5% increase	Performance level was maintained
Postpartum Care	69%	69%	5% increase	Performance level was maintained
Received at least one 17P injection	5%	8%	5% increase	Demonstrated improvement
Depression Screening*	62%	65%	5% increase	Demonstrated improvement
Tobacco Screening*	84%	87%	5% increase	Demonstrated improvement
Tobacco Screening Follow-Up*	0%	0%	5% increase	Not measurable due to small sample size
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	1%	4%	5% increase	Demonstrated improvement
Age 15-20 years; within 60 days	30%	24%	5% increase	Performance declined
Age 21-44 years; within 3 days	7%	8%	5% increase	Demonstrated improvement
Age 21-44 years; within 60 days	29%	16%	5% increase	Performance declined
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	1%	4%	5% increase	Demonstrated improvement
Age 15-20 years; within 60 days	9%	11%	5% increase	Demonstrated improvement
Age 21-44 years; within 3 days	1%	4%	5% increase	Demonstrated improvement
Age 21-44 years; within 60 days	5%	7%	5% increase	Demonstrated improvement

*Medical record review was not completed for the interim measurements.

Health Disparities

For this year's technical report, the NYS 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 MCO's Medicaid population according to at-risk characteristics.
2. Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
3. Identification of gaps in quality of care for the MCO'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 MCO members with at-risk characteristics.

Wellcare reported that there were no activities performed in 2018 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 health care.

In 2018, the NYS EQRO surveyed Medicaid MCOs regarding the use of HIT to improve the care of its Medicaid members. Specifically, MCOs were asked to report on:

- Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
- Use of telecommunications technologies
- Use of Electronic Health Records (EHR)
- Use of electronic internal registries
- Use of clinical risk group (CRG) or similar software
- Secure electronic transfer of member data between the MCO, its vendors, and network providers
- Electronic communication with providers
- Electronic communication with members
- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)[9]
- Participation in State, Federal, or privately funded HIT initiatives
- Participation in a medical home pilot or program
- Future plans to implement HIT

Table 19 displays the statewide results of the HIT survey. Of the thirteen MCOs who responded to the survey, 100% utilized secure electronic transfer of member data between the MCO, its vendors, and/or network providers. Additionally, 100% of MCOs utilized electronic communication with providers and secure electronic transfer of PHI to patients and/or providers. Some of the other forms of HIT utilized by the majority of MCOs include telecommunications technologies, Electronic Health Records (EHR), and use of clinical risk group (CRG) or similar software. In addition, 77% of MCOs reported future plans to implement HIT.

Table 19: MCO Use of Health Information Technology—2018 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%
Electronic communication with providers	100%
Secure electronic transfer of protected health information to patients and/or providers	100%
Future plans to implement HIT	77%
Use of clinical risk group (CRG) or similar software	100%
Use of telecommunications technologies	100%
Use of Electronic Health Records (EHR)	92%

[9] 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.

Health Information Technology	% of MCOs Reporting Use
Electronic communication with members	100%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	69%
Participation in a medical home pilot or program	46%
Use of electronic internal registries	46%
Participation in State, Federal or privately funded HIT initiatives	46%

Note: IHA and Affinity did not provide responses to the 2018 HIT questionnaire and therefore are not included in results.

Wellcare has indicated that it performs the following HIT-related activities:

- Secure electronic transfer of protected health information to patients and/or providers:
  - Use of secure email.

- Use of telecommunications technologies:
  - Use of vendor AbleTo and GoMo to send text messages to members with reminders and general health information.

- Use of Electronic Health Records (EHR):
  - Utilizes EMR files from providers to update HEDIS/QARR data.

- Use of clinical risk group (CRG) or similar software:
  - Use of predictive modeling tool, Decisionpoint, to identify and risk stratify members for Care Management.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Utilize secure FTP sites.
  - Use of secure email.

- Electronic communication with providers:
  - Utilize secure FTP sites.
  - Use of secure email.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Wellcare does not participate in a RHIO.

- Participation in a medical home pilot or program:
  - Wellcare does not participate in a medical home pilot of program.

- Future plans to implement HIT:
  - No plans at this time to implement any new forms of HIT.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

To assess the compliance of an MCO 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 MCO's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories listed in **Table 21**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO was 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/ re-credentialing, 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 MCO after the monitoring review, and the MCO 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 MCOs are required to resubmit. Ultimately, all MCOs 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 MCOs 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 compliance with structure and operation standards. The focused review types are summarized in **Table 20**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 21 reflects the total number of citations for the most current operational survey of the MCO, if applicable, as well as from focused reviews conducted in 2018. WellCare was in compliance with all operational and focused review categories in 2018.

Table 20: Focused Review Types

Review Name	Review Description
Access and 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%.
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 HCS to ensure providers that have been identified as having their licenses revoked or surrendered, or otherwise sanctioned, are not listed as participating with the MCO.
MEDS	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.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information—Web	Review of MCOs' web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listings of primary, specialty, and ancillary providers for the enrolled population.
Provider Participation—Directory	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	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 PCPs 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.
Other	Used for issues that does not correspond with the available focused review types.

AO: Area Office; HCS: Health Commerce System; MEDS: Medicaid Encounter Data Set; SOD: Statement of Deficiency; QARR: Quality Assurance Reporting Requirements

Table 21: Summary of Citations

Category	Operational Citation	Focused Review Citations
Complaints and Grievances	0	0
Credentialing	0	0
Disclosure	0	0
Family Planning	0	0
HIV	0	0
Management Information Systems	0	0
Medicaid Contract	0	0
Medical Records	0	0
Member Services	0	0
Organization and Management	0	0
Prenatal Care	0	0
Quality Assurance	0	0
Service Delivery Network	0	0
Utilization Review	0	0
Total	**0**	**0**

Note: No operational and focused review deficiencies issued to the MCO in 2018.

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, the MCO had 30% of external appeals overturned.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	39	32	19
Overturned in Part	7	9	5
Upheld	61	38	41
Medicaid Total	**107**	**79**	**65**
		CHP	
Overturned	0	0	0
Overturned in Part	0	0	0
Upheld	0	0	1
CHP Total	**0**	**0**	**1**

VIII. Strengths and Opportunities for Improvement[10]

One of the purposes of this report is to identify strengths and opportunities for improvement, and make recommendations to help each MCO improve care delivery and health services. Understanding these strengths and weaknesses helps assess an organization's readiness to take on new tasks, identify initiatives that match the MCO's skills, and recognize areas where additional training or resources are necessary. IPRO references both current and past performance, trends, benchmarks, and comparisons, along with specific DOH goals and targets to make these determinations. Based on this evaluation, IPRO presents the DOH with a high-level commentary on the direction of each MCO's quality improvement programs and offers advice on facilitating positive change and further improving the care and services provided to enrollees of NYS Medicaid Managed Care. 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 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, is appended to this section of the report.

Strengths

An MCO's strengths are the valuable resources and capabilities it has developed or acquired over time, which are seen as distinguishing characteristics. An MCO significantly exceeding the national average for a measure would be considered a strength.

Strengths:

- In regards to the number of Medicaid providers in the MCO's provider network, the MCO's rates for Dentists was above the statewide average.
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO performed at or above the 75% threshold for Routine, Non-Urgent "sick", and After-Hours Access call types.
- The MCO's rate of new enrollees receiving a health screening has improved from 2016 to 2018.
- In the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for *Chlamydia Screening in Women (Ages 16-24)*, while the MCO's rates for *Adult BMI Assessment, Weight Assessement* and *Counseling – BMI Percentile* were reported above the statewide average for 2018.
- In the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain, the MCO has reported rates above the statewide average for at least three consecutive reporting years for *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, while the MCO's rates for *Use of Imaging Studies for Low Back Pain* and *Annual Monitoring of Patients on Persistent Medications – Total Rate* were reported above the statewide average for 2018.

Opportunities for Improvement

An MCO's weaknesses are those resources or capabilities of an organization that are deficient and viewed as shortcomings in its ability or performance. IPRO identifies an organization's resource or capability as a weakness when that entity is not compliant with provisions of the NYS Medicaid Managed Care Contract, federal and State regulations, or it performs substantially below both the DOHs' and/or enrollees' expectations of quality care and service. An example of a weakness is a HEDIS PM rate below the national average.

[10] 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.

Opportunities for Improvement:

- The MCO has reported rates below the statewide average for Medicaid encounters with Specialty and Dental providers.
- The MCO has reported rates below the statewide average in regards to the number of Medicaid PCPs with an open panel.
- In the HEDIS®/QARR Effectiveness of Care domain, the MCO has reported a rate below the statewide average for at least three consecutive reporting years for *Breast Cancer Screening*. The MCO also had rates below the statewide average in 2018 for the *Lead Screening in Children* measure. *(Note: Breast Cancer Screening was an opportunity for improvement in the previous year's report.)*
- In the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain, the MCO's rates for *Comprehensive Diabetes Care – (HbA1c Control (<8%), Eye Exam [Retina] Performed, and Blood Pressure Controlled [<140/90 mm Hg]), HIV Viral Load Suppression* and *Testing for Children with Pharyngitis* were reported below the statewide average.
- The MCO continues to demonstrate an opportunity for improvement in the HEDIS®/QARR Behavioral Health domain. The MCO's rates for *Follow-Up After Hospitalization for Mental Illness—30 Days* has been reported below the statewide average for at least three consecutive reporting years. *(Note: Follow-Up After Hospitalization for Mental Illness was an opportunity for improvement in the previous year's report.)*
- The MCO continues to demonstrate an opportunity for improvement in regard to access to primary and preventive care for children and adults. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Well-Child Visits in the First 15 Months, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits;* and *Annual Dental Visit (Ages 2-20)*, as well as for the following age groups of the *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* measures: *12-24 Months, 25 Months-6 Years, 7-11 Years, 12-19 Years, 20-44 Years,* and *45-64 Years*. Additionally, the MCO's rates for *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* were reported below the statewide average for 2018. *(Note: Well-Child Visits in the First 15 Months of Life—6+ Visits; Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Children and Adolescents' Access to Primary Care Practitioners; Adults' Access to Preventive/Ambulatory Health Services; and Annual Dental Visits (Ages 2-20) were opportunities for improvement in the previous year's report.)*
- The MCO reported a rate below the statewide average for the CAHPS® measures *Getting Care Needed* and *Getting Care Quickly.*

Recommendations:

- The MCO should continue to investigate reasons behind its continued poor performance in regard to measures related to access to primary and preventive care for children and adults. The MCO should conduct thorough, population-specific barrier analyses to determine factors preventing members from seeking or receiving care, such as transportation issues, lack of child care during appointment times, or any accessibility issues. Additionally, the MCO should consider examining these measures in terms of geographic areas, such as by county or zip code, to determine if some areas have more significant issues in order to target initiatives to drive improvement. Additionally, the MCO should investigate if the low performance on measures is related to the low performance for the Child CAHPS® measures *Getting Care Needed* and *Getting Care Quickly.*
- The MCO should continue to work to improve those HEDIS®/QARR measures that consistently perform below average. The MCO should conduct a root cause analysis to determine the key factors for poor performance in regards to preventative screenings, chronic disease management and follow-up care with mental health practitioners after an inpatient discharge. The MCO should consider offering an evidence

based chronic disease self-management program to members. Self-management programs improve health behaviors, disease-related symptoms, communications with providers, and overall health status.[11]

Response to Previous Year's Recommendations:

The BBA, Section 42 CFR section 438.364(a)(5), states that the EQRO (IPRO) "must provide an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each MCO describe how its organization addressed MCO-specific recommendations from the RY2017 technical report. The following responses are taken directly from the MCO and are not edited for content.

- **2017 Recommendation:** The MCO should continue to work to improve those HEDIS®/QARR measures that consistently perform below average through thorough barrier analyses and evaluation of current interventions targeting these measures. The MCO should continue to evaluate and monitor the effects of its Predictive Behavior Analytics model for targeted outreach to ensure positive outcomes. Additionally, the MCO should consider implementing more active interventions for care gap closures in addition to its current outreach program. *[Repeat recommendation.]*
  MCO Response: HEDIS/QARR: In 2017 & 2018, WellCare instituted a more focused approach to identify and address the areas of poor performance related to preventive care, chronic care and access to primary care HEDIS and QARR measures. We focused on improvement in 3 areas of activities: Data Analytics, Provider Engagement and Member Engagement. Within each of these areas, we developed new ways to enhance our Quality Improvement performance. First, we developed an improved Data Analytics approach. This involved 4 keys areas of enhanced analytic capabilities:
  - Member Care Gap analytics that use "Heat-Mapping" abilities to identify providers by zip code with the greatest number of members with open care gaps/un met medical needs. This data is used by our QPAs (Quality Practice Advisors see below under Provider Engagement) to prioritize which provider PCPs they focus on first. They start with PCPs that have the largest number of members with the greatest number of Member specific open Care Gaps.
  - Measure specific barriers analysis to identify member challenges preventing compliance with needed care. Examples of identified barriers preventing our Medicaid members from receiving appropriate care include lack of transportation to the provider's office, lack of appointment access and timeliness of care related activities such as immunizations.
  - Member HEDIS compliance /future behavior predictive analytics that allows for member –centric outreach programs based upon the results of the predictive analytics. These analytics assess the likelihood that a member will be compliant in the future for each HEDIS Measure. It risk stratifies each member into 1 of 4 categories ranging from very likely to comply with Care Gap closure to never be complaint. Member outreach is then tailored to the best way to engage the member to achieve HEDIS Care Gap closure by identifying the types of outreach interventions that an individual member is most likely to respond. This approach was used for all Medicare members in Calendar year 2017 resulting in significant improvement in Care Gap closure and improved trends in all HEDIS results. This analytic approach has been applied to all Medicaid Members as of January 2018.
  - In 2017, we continued conducting Mock *CAHPS* Surveys for the majority of our members. Using this information, we create provider specific Mock CAHPS survey results that we then have our QPAs review with each provider who scores below the 75th percentile. Sharing this type of satisfaction survey results allows us to educate our providers on the member specific issues identified within

[11] Ahn S, Basu R, Smith ML, et al. The impact of chronic disease self-management programs: healthcare savings through a community-based intervention. *BMC Public Health*. 2013;13:1141. Published 2013 Dec 6. doi:10.1186/1471-2458-13-1141

their practice. This approach was implemented in our FL Medicaid market resulting in significant improvement tin their CAHPS survey results. In addition, we conducted CAHPS specific data predictive analytics to identify members who have had access issues. We reach out to them proactively to schedule appointments/resolve their access issues.

With our improved Data analytics, we have enhanced Provider Engagement Activities in to improve our QAR scores several areas: We have expanded the number and the activities of our QPAs (Quality Practice Advisor). These trained clinicians disseminate the provider specific member care gap data. They teach the providers and their office staff about proper coding allowing us to capture all HEDIS related Quality data. In addition; they are working with our providers using the result of the provider specific Mock CAHPs surveys to improve member appointment access and member satisfaction with care received.

- For larger group practices with significant numbers of WellCare members, we have created the role of the PCA (Patient Car Advocate). Their activities are similar to the QPA, but they are not clinicians. Each is assigned to work with an individual practice. They reside within the individual PCP group's office and work with the PCP group's staff and members to schedule the necessary appointments need to close member Care Gaps.
- We reinstituted a P4Q (Pay for Quality) Program in 2016 & 2017. PCPs are given financial incentives to close member care gaps and code properly to assist in WellCare data capture of measure related to Quality HEDIS & QARR measures. Preliminary results suggest the program has had a positive effect on some of our QARR related HEDIS scores.

In addition, we have used our new analytic capabilities to enhance our Member Engagement Activities:

- As mentioned above, we use Predicative Behavior analytics in the area of HEDIS measure compliance to risk stratify the members into 1 of 4 categories then tailor our telephonic outreach approach based upon those analytics:
  - Level 1 – most likely to be complaint. They receive a simple phone call reminder to have a care gap service performed and are provided assistance with making the appointment
  - Level 2 – usually compliant but not always. They received a more sophisticated telephonic outreach call from a highly trained customer service representative focused on motivating them to close a specific care gap
  - Level 3 – usually very resistant to receiving care gap closure. These member receive an outreach call from a clinician, usually an LPN or SW, using a different script focused that focuses on overcoming barriers identified using the Predictive analytics tools
  - Level 4 – our most complex members who rarely engage in closing HEIDS Care gaps and have a Case Manager. They received a personalized call from their Case Manager with whom they already have a relationship and who uses another different script focused that focuses on overcoming barriers identified using the Predictive analytics tools

In 2017, we have rolled out a Member reward payment incentives plan to improve compliance with HEDIS/QARR Care Gap closure. We have found Health Literacy to be a significant barrier in educating our members regarding the care that they should receive. We have evaluated our entire member written care educational materials and have worked with an expert in Health Literacy to simplify and improve our materials. Here is an example of such work:

As discussed above, we conducted CAHPS specific data predictive analytics to identify members who have had access issues and are reaching out to them proactively to schedule appointments/resolve their access issues.

The above-described activities that took place in 2016 led to an improved NCQA Health Plan Rating for Medicaid from 3.5 to 4.0. This rating system includes Clinical measures in the areas of Prevention & Treatment as well as CAHPS scores. In addition, the NY Medicaid plan raised its NCQA accreditation to the "Commendable" level.

To improve our QARR scores in the area of Well Child visits and Immunization, we focused our efforts on improved member outreach and appointment scheduling. To accomplish this we created the role of the PCA (described above) to reach out to our Medicaid members needing Well-Child visits and assist them in scheduling appointments. During these outreach calls, our PCAs spoke with the member about their transportation needs and arranged for the members' when transportation was deemed to be a barrier in making and keeping their appointment. In 2018, we believe the additional use of our Predictive Analytics capabilities will enhance our abilities to do effective member telephonic outreach (described above).

We carefully monitor each of our HEDIS/QARR measures using a monthly tracker. This allows us to determine the impact of our outreach activities and make improvements during the calendar year without waiting for the final results to be determined.

- **2017 Recommendation:** The MCO should conduct barrier analyses to determine factors that are preventing members, both children and adults, from seeking or receiving primary and preventive care, as the MCO continues to struggle to improve measures related to this area. The MCO should implement a targeted intervention strategy to alleviate barriers to accessing care, and should consider conducting regional analyses to determine if there are any places within the MCO's service area that are under-performing compared with the rest of the service area.

MCO Response: To improving performance related to primary and preventive care a barrier analysis was conducted and the following intervention strategies were put into place:

- WellCare has implemented the "MyWellCare mobile app". The app features allow members to find providers and urgent care centers based on geo location, access their ID card image, receive reminders of their unique care gaps, and allow them to schedule and track appointments for care. General health educational messages are also featured as relevant to current season or 'health focus of the month.' The mobile app downloads and features are tracked monthly to measure the total number of app downloads and the most utilized app feature.
- WellCare also has partnered with vendor NOVU to launch a member incentive program to reward members for completing their annual preventative health activities. Members activate their reward accounts and submit attestations for each eligible service via website, mail or phone. Members may choose from a selection of merchant gift cards for their rewards.
- WellCare has implemented the Inbound Care Gap Program for members calling into the Customer Service line. The program is designed to increase member compliance with preventive care screenings and improve experience with care. When a Member calls Custer service for whatever reason, their individual care gaps are identified by the Customer Service Associate. The Associate educates the member particular to their outstanding care gaps. The Customer Service associate then assists the member in scheduling the appointment and arranging for transportation. Automated telephonic reminders are completed 24 hours prior to the appointment.

- **2017 Recommendation:** The MCO should work to address the issues identified in the operational and focused review surveys. First, the MCO should review its policies, procedures, and documentation related to Complaints and Grievances and Utilization Review to ensure all materials correctly include all required information and ensure that MCO staff in these areas are properly trained. Next, the MCO should review Customer Service procedures and ensure all staff are trained appropriately for responding to members' requests for information. Last, the MCO should continue its efforts to improve the accuracy of provider information included in the directories and evaluate the impact of the MCO's partnership with LexisNexis for data scrubbing. *[Repeat recommendation.]*

MCO Response: WellCare takes all audit findings seriously. In response to the operational survey findings around Complaints, Grievances and UR WellCare made updates to all relevant materials and

retrained the employees responsible for these areas. In response to the member services finding the plan updated the necessary call tools and retrained the member services team on how to appropriately handle these situations. Finally, WellCare continues to work diligently to ensure provider data is accurate and is closely monitoring the ongoing updates provided by our partnership with LexisNexis.

IX. Appendix

References

A. MCO Corporate Profiles

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory
- NCQA Accreditation website, https://reportcards.ncqa.org

B. Enrollment and Provider Network

- *Enrollment:*
  - NYS OHIP Medicaid DataMart, 2018
  - NYSDOH OHIP Child Health Plus Program, 2018
- *Provider Network:*
  - NYS Provider Network Data System (PNDS), 2018
  - QARR Measurement Year 2018

C. Utilization

- *Encounter Data:*
  - NYS OHIP Medicaid DataMart, 2018
- *QARR Use of Services:*
  - QARR Measurement Year 2018

D. Performance Indicators

- *HEDIS®/QARR Performance Measures:*
  - QARR Measurement Year 2018
- *CAHPS® 2018:*
  - QARR Measurement Year 2018
- *Performance Improvement Project:*
  - 2018-2019 PIP Reports

E. Structure and Operations

- MMC Operational Deficiencies by Plan/Category, 2018
- Focused Deficiencies by Plan/Survey Type/Category, 2018