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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Senate
(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

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June 8, 2009

The Honorable Jon B. Erpenbach
Chairman, Committee on Health, Health Insurance,
Privacy, Property Tax Relief, and Revenue
8 South, State Capitol
Madison, WI 53702

The Honorable Tim Carpenter
Chairman, Committee on Public Health, Senior Issues,
Long-Term Care, and Job Creation
306 South, State Capitol
Madison, WI 53702

Dear Senators Erpenbach and Carpenter:

Wis. Stat. § 153.05 (2s) directs the Department of Health Services and the Department of Employee Trust Funds to jointly prepare an annual report on the activities of the Wisconsin Health Information Organization (WHIO). The Departments are required to submit this report to the standing committees of the Legislature with jurisdiction over health issues.

At both the national and state levels, efforts are under way to transform health care through the use of health information technology. The American Recovery and Reinvestment Act of 2009 appropriated over $35 billion to advance the adoption of electronic health records and to create standardized electronic health information exchange. Wisconsin is uniquely positioned to participate in these federal efforts to transform the health care delivery system because of its technical resources and strong industry partners in the technology and health care sectors, and the commitment and intellectual capacity across the public and private sectors brought to this work.

As a result of the ground-breaking work done by the Wisconsin Health Information Organization, both public and private sector health care purchasers will have the ability to measure the quality and price of health care services and use that information to increase the value of future purchases. Health care providers will have information available to them that will help them identify where quality and cost variation exists and answer the question, "What care provides the most value to patients?"

WHIO is an excellent example of a collaborative public-private partnership and an extremely important initiative for Wisconsin to achieve transparency in health care and promote better health care outcomes for the people of Wisconsin. We are fully committed to working in partnership with the other health care stakeholders across the state through WHIO.

Please find enclosed the first annual report on the activities of WHIO, as well as a fact sheet on WHIO and a WHIO Board Membership Roster. If you have any questions, please contact Denise Webb, eHealth Program Manager, at (608) 267-6767.

Sincerely,

David Stella, Secretary
Department of Employee Trust Funds

Sincerely,

Karen E. Timberlake, Secretary
Department of Health Services

Enclosures

Annual Report to the Wisconsin Legislature
on
the Wisconsin Health Information Organization (WHIO)

Submitted by the Department of Health Services and the Department of Employee Trust Funds

June 1, 2009

Background

In 2008, the Department of Health Services (DHS) and the Department of Employee Trust Funds (ETF) entered into a contract with the Wisconsin Health Information Organization (WHIO) to serve as the data organization defined in Wis. Stat. § 153.01 (3g). WHIO was formed to collect and aggregate health care claims data into a centralized repository ("Data Mart"), and subsequently analyze and report on the delivery of health care in Wisconsin.

WHIO is a collaborative, public-private partnership established in 2005 to drive improvements in the quality, safety, efficiency, and cost of health care in Wisconsin. WHIO is governed by a multi-stakeholder Board that includes providers, purchasers, and insurance payers. Board members include representatives from the following organizations:

- DHS
- ETF
- Anthem Blue Cross Blue Shield of Wisconsin (Anthem)
- Dean Health System
- Greater Milwaukee Business Foundation on Health
- Humana
- The Alliance
- UnitedHealthcare of Wisconsin
- WEA Trust
- WPS Health Insurance (WPS)
- Wisconsin Collaborative for Healthcare Quality (WCHQ)
- Wisconsin Hospital Association (WHA)
- Wisconsin Medical Society (WMS)

WHIO's initial goal is to create a centralized repository of aggregated administrative medical and pharmacy claims data for Wisconsin. This data will be used by member organizations to generate comparative performance reports for providers, evaluate population health, and perform additional analysis on the delivery of health care. The longer term goal is for WHIO to develop and disseminate public reports on health care quality, safety, and efficiency.

WHIO Operations

WHIO and its founding members signed a three-year, $4.8 million contract with Ingenix Consulting (Ingenix) on March 31, 2008. This contract tasks Ingenix with responsibilities for constructing and hosting the Data Mart, and developing the data analysis and reporting tools. Ingenix is a health and human services consulting organization with significant experience working with hospitals, physicians, health plans, employers, government agencies, and pharmaceutical companies.

Wis. Stat. § 153.05 (2r) specifies requirements that needed to be met before DHS and ETF could formally enter into a contract with WHIO as the official data organization. The service contract with Ingenix for the Data Mart work was a necessary precursor to fulfill the applicable statutory requirements. Likewise, WHIO had to commit matching funds, which could include in-kind contributions, to complete the health care claims aggregation, analysis, and reporting work.

WHIO met all statutory requirements; and DHS and ETF subsequently negotiated and executed a three-year service contract with WHIO, effective April 25, 2008. The total State contribution through this contract is $1.65 million ($904,900 PR,[1] $595,100 FED,[2] and $150,000 SEG[3]).

DHS is responsible for $1.5 million of the contract, paid in six semi-annual payments of $250,000. ETF will pay up to $150,000—$50,000 for every 25% of ETF's covered members included in the WHIO Data Mart.

Ingenix delivered the first version of the Data Mart to WHIO on December 2, 2008. This version of the repository included claims data submitted by Anthem, Humana, UnitedHealthcare, WEA Trust, and WPS. To create a flexible and accurate data mart, the health insurers had to comply with a rigorous, standard data submission process. The Wisconsin health insurers voluntarily agreed to submit their data and made a significant resource investment to prepare their data to meet the WHIO data mart standards. The aggregated data represents:

- 1.5 million members
- 55 million medical and pharmacy claims
- $11.8 billion in billed charges
- $6.7 billion in standardized costs
- 5.9 million episodes of care
- 122,000 Wisconsin-based medical professional, facility, and allied providers
- A 27-month period (January 1, 2006 – March 31, 2008)

To improve the ability to produce comprehensive comparative performance reports for health care providers throughout the State, WHIO's long term goal is to capture health care claims data

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[1] Program revenue from the annual Physician Fee Assessment in accordance with Wis. Stat. § 153.

[2] Federal financial participation (administrative federal matching funds) for the percentage of Medicaid members to be represented in the data mart relative to the total insured members expected to be in the data mart at the completion of the project.

[3] ETF segregated trust fund.

from as many sources as possible. WHIO recognizes it will be impossible to capture all medical care activity through insurance claims.

To assure compliance with federal and state patient privacy, confidentiality, and anti-trust laws and regulations, Ingenix removed all patient, commercial payer, and employer identifiers from the WHIO Data Mart in the claims data aggregation process. Additionally, the WHIO Board developed and approved a "data use agreement" on December 1, 2008, which will guide the appropriate use of the Data Mart by WHIO and all member organizations.

On January 1, 2009, WHIO initiated a 90-day study period for member organizations to access and become familiar with the Data Mart and the Ingenix "Impact Intelligence" analysis and reporting tool. WHIO also coordinated a physician engagement pilot program to share performance reports with participating group practices and/or individual practicing physicians for feedback and reaction.

The study period participants evaluated the usability of the reporting tool as well as the breadth and depth of data for analyzing health care quality, cost, and efficiency. They also conducted extensive testing in collaboration with Ingenix staff during the study to document any data gaps or reporting system limitations and to allow any defects to surface.

The study period was a success and revealed no major system flaws, and participants were very pleased with the Data Mart and the analysis tools. The study did identify some minor defects and data gaps, as well as recommendations to improve the data quality, usability, and functionality of the Data Mart. The next version of the Data Mart—which will be produced in August 2009—will include improvements based on the study period findings.

The complete study period report is attached for your reference.

Medicaid Data Submission to WHIO

DHS staff from the Division of Health Care Access and Accountability, the Division of Public Health, and the eHealth program participated in the 90-day study. DHS will begin to submit Medicaid claims data for the third version of the Data Mart, which will be released by April 1, 2010. WHIO and DHS mutually agreed to delay the submission of Medicaid data due to resource constraints related to the implementation of the State's new Medicaid Management Information System (MMIS)—Wisconsin InterChange.

DHS is currently working with EDS Information Systems, the State's Medicaid fiscal agent and MMIS administrator, to develop the technical specifications and queries necessary to extract Medicaid data for inclusion in the Data Mart.

WHIO also decided to delay the addition of any new data contributors until the third version of the Data Mart to give Ingenix the ability to focus on technical corrections, functional upgrades to the data aggregation methodology and reporting system, and refreshed data from the existing data contributors for the second version of the Data Mart. Ingenix is expected to include the

Medicaid data along with data from at least two additional commercial data submitters for the third version of the Data Mart.

Future Operations

WHIO is continually working to expand its membership and the number of data contributors. MercyCare Health Plans, Group Health Cooperative–South Central Wisconsin, and Health Tradition Health Plan joined WHIO in 2008 and have committed to contribute their data in the future. Dean Health Plan and Gundersen Lutheran Health Plan became WHIO members in 2009 and have committed to submit data to WHIO for the third Data Mart version. These additions will bring the number of individuals included in the Data Mart to nearly 3 million.

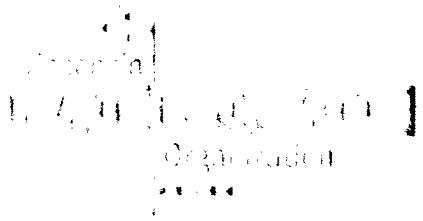
Current analysis and reporting is limited to WHIO's member organizations and provider groups. As the Data Mart expands and improves, WHIO will be able to generate reports for public distribution to inform and assist consumers in their health care purchasing decisions. The goal is to produce such reports by April 2011. At this point, WHIO will continue to focus on improving the reliability and usefulness of the reports being provided to physician practices to foster and further provider-based health care quality improvement initiatives.

To date, WHIO has depended exclusively on the contributions of member organizations and the State contract for revenue, and funding is a challenge. Going forward, WHIO will aim to fully develop its business plan and generate revenue through the sale of subscriptions to the Data Mart to supplement the contributions and service fees. Marketing efforts will begin in the summer of 2009.

Medical systems, benefit managers, brokers, and consultants will be able to purchase a subscription to the WHIO Data Mart for an annual fee and use the data to generate their own analysis. As part of the marketing plan, WHIO will develop a website to help keep interested parties informed on the membership, the Data Mart, and the information to be shared.

WHIO will also investigate opportunities that may be available through federal stimulus funding for health care quality and technology.

Attachment
WHIO Data Study Period Findings and Recommendations, April 23, 2009



WHIO Data Study Period Findings and Recommendations

Presented to and Approved by WHIO Board of Directors:
April 23, 2009

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Background

The first version of the WHIO Data Mart delivered in December of 2008 and contained 1.5 million members, 55 million medical and pharmacy claims lines totaling $11.8 B in billed charges and $6.7 Billion in standardized costs, 5.9 million episodes of care and 122,000 Wisconsin based medical professional, facility and allied providers. The breadth and depth of data captured in the data mart was more expansive than any data source previously available for population health and provider performance reporting. This was both exciting and intimidating - the foremost need was to evaluate the aggregated data. That is, to confirm that the data in the data mart was as expected, that the aggregation and matching processes had produced satisfactory results and to build confidence that the accuracy and completeness of the data was of reasonable quality to be used for physician performance measurement and other business analytics.

The data set was composed of claims and member information submitted from five (5) commercial health insurance companies operating in the State of Wisconsin: Anthem Blue Cross Blue Shield, Humana, United Health Care of Wisconsin, Wisconsin Education Association Trust and Wisconsin Physicians Service, Incorporated.

WHIO members agreed to declare a period of study during which members and other invited parties would participate in varied and numerous activities to explore the data set and purposely seek data gaps and defects in pursuit of quantifying the usability of the data mart for provider measurement and other internal business purposes. During this time, no one with access to the data would use the data or any reports produced from the data for any purpose than to become proficient with the software, knowledgeable about the reporting capabilities and familiar with the data. The WHIO Data Study Period was from January 2, 2009 through March 31, 2009. This report documents the process, findings, and recommendations of that exercise.

To provide context for the Data Study period, Ingenix noted that for their clients, the initial deliverable is the first opportunity for users to view and assess the results of the collective data produced by the Impact Intelligence data processing. The dynamics of the initial input data and the business objectives drove many of the business decisions during the initial implementation. Once the data processing occurs and the value-added results evaluated, it is very common that opportunities to improve upon the presentation of information become identifiable. The recommendations of the study period are consistent with the experience of many other clients who are long term successful users of the Impact Intelligence tool.

Turning patient encounter records into actionable information is a multistep process:

1. Providers must record the encounter data
2. Providers must accurately transmit the data to payers
3. Payers must accurately aggregate and transmit data to Ingenix
4. Ingenix must properly further aggregate and process the data
5. Data and analyses need to be presented in clear, understandable reports
6. Providers need education about how to use the data and analyses to improve their practices

While the data study period was first envisioned to only address the third and fourth steps above, it evolved into a common effort to improve all steps in the process.

Executive Summary

Study Period Overview

The purpose of the Study Period was to assess the quality and completeness of the Data mart, as well as its suitability for tracking, analysis, and measurement of entire episodes of care used in evaluating health care value based on quality and cost/efficiency measures. The Study Period was comprised of three components, the physician pilot, the paired member data study, and individual member analytics. An overview of each is immediately below, with further detail later in this report.

The intent of the Pilot Program was share the performance reports produced from the Data Mart with the participating group practices and/or individual physicians and to collect feedback on the content, format, and usability of the information in a clinical setting. In conjunction with this effort, an assessment of the educational and ongoing support needs of providers receiving the performance reports was included. Five practice sites volunteered to participate in the pilot. Each varied significantly from the other in terms of geographic service area, medical specialty, and clinical setting. Performance Reports, produced from the Impact Intelligence Reporting System, included 17 quality measures selected by the Clinical Advisory Group, as well as standard cost and utilization metrics. Reports were hand delivered to pilot participants by the Pilot Leadership team that included Dr Tom Knabel and Rita Long (Ingenix), Dr Tim Bartholow (Wisconsin Medical Society) and Julie Bartels (WHIO). One clear ground rule was a prohibition on report sharing with any other entity, unless the practice group provided specific direction to do so. Two of the five practice groups received measures and reports that reflected the aggregate performance of the practice group. The other three received measures and reports for individual providers in the practice group. By varying the level of reporting, we hoped to ascertain where the greatest value of the information resides and what is most useful in the clinical environment.

To create the Paired Member Study Teams, WHIO member organizations who were also data contributors to the data mart matched up with Wisconsin based medical systems who agreed to participate in the evaluation process. By pairing the medical systems' knowledge and data about its own physicians and patients with the WHIO member organization knowledge of the data mart and reporting tools the team could create and conduct data reasonability tests. Teams performed data comparisons between the medical system's data and WHIO data for the purpose of uncovering gaps or defects in the data, providing explanation for their occurrence and defining possible workarounds. Because the data in the data mart did not comprise the entire universe of claims data in Wisconsin, the WHIO data mart was by definition incomplete. Understanding that the teams would not find an exact match between systems, they were able to create subsets of the data that were reasonably comparable and express an opinion based on those tests. Descriptive details of the nature and extent of these tests are in the following sections of the report

All WHIO members not participating in either the Pilot Program or the Paired Member Study Teams were encouraged to conduct their own internal business studies. In some cases, they were able to compare the WHIO data to an internal data source for comparative purposes. In other cases, they were able to explore the Impact Intelligence Reporting Tool to comment on its ease of use and functionality. It was valuable to have the distinct viewpoints and specialized knowledge of all the members who participated.

While the initial intention was for the Member Paired Study Teams and for the Independent Member studies to be separate processes, the two converged during the course of the Study Period. By sharing information and lessons learned during the process, each group benefitted from the questions, observations, and findings of the other.

Summary Findings

In general and overall, feedback from Study Period participants about the data, the software tool, and the resulting performance reports was positive. Data comparisons revealed that the data was reasonably complete and accurate. Pilot participants indicated that performance reports were reflective of individual and clinic practice patterns and that the tool was generally easy-to-use. Feedback regarding training was also positive. There were no material defects found during the study however, there are several opportunities to increase the utility of the data set for future use. Ingenix can perform some of these improvements in the aggregation and matching of the data or software enhancements, while others require coding or processing change by providers and/or payors.

Key areas for improvement include:

- Enhance the reporting system to support for both clinic level and individual level reporting.
- Expand the data collection process to include new payors, plus ASO and other clients of existing data contributors in order to minimize data gaps
- Improve the content of data submitted - especially servicing provider information - - to improve the accuracy of aggregation and reporting
- Enhance provider matching process to include Institutional providers
- Expand the number of quality measures for primary care physicians
- Add specialty peer groups for reporting
- Develop tools to assist providers in understanding how to make the performance reports actionable in their clinical settings

Action is already underway on several of these items and data mart users will see significant improvement in Data Mart Version 2 (DMV2) scheduled for delivery in August 2009. Specifically:

- Ability to report at both the clinic and individual provider level
- Approximately 100,000 additional members (this will be an ongoing improvement process)
- Improved servicing provider information
- Addition of quality measures and specialty peer groups for reporting

Recommendations to address other areas for improvement, along with a plan for extending performance reporting to an increasing number of provider clinic sites are included in more detail later in the report. A presentation of the study period results and recommendations contained in this report highlight achievements to date and seeks to gain consensus on the priority and sequence of the recommended next steps, as well as a commitment of the resources to achieve them.

Report Detail

Pilot Study

The pilot program portion of the data study evaluated the performance-reporting segment of the software tool in combination with the aggregated data in the data mart. It also sought to gain understanding of the pre- and post-delivery education and support needs of providers who were included in the measurement process.

The pilot process included selection / qualification of provider sites for participation identification and orientation of the internal staff contact person at the clinic site, introduction / personalized-drop off of performance reports with clinical staff, and bi-weekly round table conference calls to focus on specific sections of the report and a subset of measures. WCHQ and WMS were highly involved with the selection process.

A 2-hour webinar jumpstarted the orientation and acquainted the participants and designated contacts with the measures / methods and basic information about the data and the Impact Intelligence reporting methodology. This webinar placed extra emphasis on peer grouping, episode grouping, confidence intervals, and attribution. A face-to-face meeting with clinic staff to review their specific performance results followed this. Participant reactions, impressions, questions, and advice were captured in meeting minutes and via an electronic survey administered at the end of the pilot period. Throughout the pilot study period, WHIO expressed interest in in not only participant observations and recommendations based on personal experience in the Pilot, but also their guidance and comment about things relating to a full rollout of these reports / measures to the broader Wisconsin provider community.

Prior to the initiation of the pilot program, members of the Clinical Advisory Group (CAG) and Physicians Cabinet (PC) had been consulted about what level (aggregation) of reporting would be most beneficial in the clinical practice setting. There was a significant difference of opinion on whether clinic-level performance reports by specialty or individual physician reports would generate the greatest value. To investigate this issue further pilot sites were broken into two groups; one received performance results based on aggregate group practice data and the other received reports at the individual physician level:

Individual Physician Performance Report Group:

- Prevea Health, Green Bay, East Mason Health Center; Specialty: Internal Medicine
- Froedtert & Community Health West Bend Clinic – received individual reports
- Dr. John Barkmeier, Menasha ThedaCare; Specialty Family Practice – received an individual report

Group Practice Site Performance Report Group:

- Bellin Health Family Medicine Center Ashwaubenon ; Specialty: Family Practice
- ProCare Medical Group, Milwaukee, Kilbourne St Clinic; Specialty: Internal Medicine

In response to receiving Individual Performance Reports, the first group said they wanted to get Group Practice Performance data too. Similarly, the groups who received Group

Practice Performance Reports immediately requested drill down to individual performance data. In the end, in order for the data to be maximally useful in the clinical setting both group practice and individual performance reporting will be required.

Pilot Observations and Findings

Data

1. Pilot members were generally impressed by breadth and depth of data – even if data is incomplete, they felt there was enough data and information to be actionable (with the exception of Prevea Clinic see #5 below)

2. De-identification of the patient was a difficult issue at first, but there has been some movement toward appreciation of the usefulness of data to take action on processes within their practices

3. The age of the data was of initial concern to some participants. Claims data from 2006-2007 and Q1 2008 for some clinics is now a "couple of improvement projects ago." However, by decreasing the lag between claims adjudication and submission for WHIO and reducing the amount of time between raw data submission and the final deliverable, data will be more current in future deliverables.

4. The Quality of Care measures included in were only those that are non-controversial and proved too basic for many participants. Additional measures are requested, both in terms of more measures for primary care physicians and specialists.

5. Prevea Health East was chosen as a pilot because a high percentage of their patient volume is derived from current data contributors and because they were very enthusiastic about the opportunity to participate. They reported that over 38% of their bills were invoiced to the five data contributing organizations so we had reason to believe that there would be plenty of data to generate the performance measures at an individual physician level. Unfortunately, the bulk of patients served at this clinic were self funded (Administrative Services Only) clients and/or patients of certain non-integrated subsidiaries who were not included in the data submission. It is essential to get all data sources submitting data from all systems and sub-systems as quickly as possible.

6. While it was not possible to create an exact match between WHIO data to the EMR data or other internal systems of the pilot sites as a result of patient de-identification and/or missing ASO data participants felt that the performance results correctly reflected individual and clinic patterns.

7. "Claims data notoriously inaccurate" was an assumption by some of the pilot groups as a starting point; however, this prove problematic enough to discredit the results of the performance reports, as some would have expected.

8. Endocrinology needs to be added as a specialty

9. Facility provider matching was inadequate (clinic, lab, outpatient, hospital) This issue is discussed further in the member section, since it was a much more significant issue for the Member study

10. The historical and prevalent focus on quality measures and quality improvement make conversations about cost more difficult. Cost control often has punitive connotations. Some providers questioned, "What is a cost measure, anyway?"

11. Currently, many clinics have quality managers and even full departments focused on quality measurement and improvement but no one has value (quality +cost) managers. The perception is that cost tends to be the province of contracting staff. This requires a significant paradigm shift and presents an enormous challenge to WHIO in affecting change.

Reports

Paper copies of performance reports supported the Pilot participant reviews, since assurance of direct access to the underlying data or software was not possible. While they might have found this additional level of detail of value in understanding the performance results, we wanted to match the situation providers will experience when WHIO reports are rolled out to a larger population. Access to the underlying data or software presents a revenue opportunity to WHIO and a planned discussion in a more detailed is being scheduled (WHIO Data Sales/Marketing).

1. In general, providers found they needed someone to "walk through" the reports the first time, but otherwise considered the reports well laid-out and understandable.

2. Explanation of the data source and reporting methodology is necessary for physicians to understand reports and see value in them

3. The starter performance measures in the reports were considered too rudimentary for most pilot locations (see comments under data)

4. Review of reports provided at the group level resulted in pilot study participants wanting to drill down to the individual physician level. Conversely, those who received individual reports wanted to aggregate to the group level

5. More graphics and visual representations would enhance the reports

Training

Pilot participants had highly customized training, well outside of the normal scope of conventional Ingenix training programs. Therefore, there were no specific observations on their own training however they did comment that an investment of time and effort to educate the general provider population on the methodologies and measures would be required in order to 'move the ball' in the Wisconsin health care marketplace.

Other Comments

There have been many opportunities for WHIO and delegates to have conversations with physicians outside the formal pilot process. Many WHIO board members and committee members are physicians. In the normal course of business, WHIO members such as WMS and WCHQ actively interact with physicians. Physician observations arising from outside the formal pilot include:

1. There was a high level of concern within the physician population regarding how the data will be used by WHIO members and potential buyers, particularly that it might be used against physicians

2. Some who have worked successfully in quality have difficulty in approaching a conversation about what is actionable in improving "cost" experience - there is a gap or lack of ownership about the cost issue

3. In most institutions quality management and provider contracting functions operate in completely different silos. Contracting staff is typically not at the table for the type of discussions that WHIO is holding, and perhaps this should change.

4. In the past, "value" has been defined as "quality" but now needs to be both quality and cost

5. The science behind quality and efficiency measures is rapidly growing. The process by which standards achieve 'national standard' status is slow and laborious. As a result, some measures and the value they offer are ignored even when there is general agreement that there is significant benefit to be derived by sharing the results with providers. WHIO made a policy decision to move forward with public reporting of national standards in order to avoid any conflict or controversy about the appropriateness of the measures. However, the data and reporting capabilities of the Ingenix Impact Intelligence tool in terms of quality measures are not being leveraged fully because of this decision.

6. There is no "gold standard" for aggregating all types of providers.

7. The Pilot demonstrated that certain historic assumptions are no longer true. "Claims data is inaccurate" is one of those faulty assumptions

8. There are questions about how the findings will be rolled out to the larger physician community, and the options that will be available for training/education.

Provider Study Suggestions for Improvement

Improvements in process and scheduled for DMV2 (August 09)

1. Expand quality measures used in WHIO reports to include ALL NCQA standard measures.
2. Expand quality measures available in the reporting system to include available measures so that system users are able to leverage the full range of measures built into the software.
3. Support both clinic and individual reporting. Clinic profiling in DMV2 will be configured such that episodes are assigned to practice groups first and then to the most responsible individual within that group
4. Including confidence intervals in profile reports using 90% CI, conforming to NCQA standards
5. Add Endocrinology as a specialty

Suggestions for future improvements:

6. Develop tools to assist participants in understanding how to make the process reports actionable (potentially in conjunction with other clinical data systems)
7. Expand number of Specialties in future versions of reporting software.

Suggestions for Rollout

1. The first five clinics will continue participation, should they choose to do so.
2. 25 new clinics (note, not medical systems with 'all clinics')will be added after the release of DMV2 (August 2009) . Assuming that this further rollout is successful, additional rounds of 25 to 50 new clinics each will follow, probably beginning in January 2010
3. For these next groups of participants we will employ an "Opt in" selection process, where WHIO will send a broad invitation for new individuals and clinics to participate, and individuals/clinics will volunteer. The next 25 will be on a first come first serve basis
4. Requirements to participate include:
    - Agreement to commit time and resource necessary to Participate in initial training/education program
    - Agreement to commit to time and resource necessary to Participate in Roundtable meetings (to be established)

5. Create an educational/feedback program to replace the calls the occurred during the pilot period. This is necessary due to the scope of the rollout. While this requires further development, components are expected to include:

    a. Recorded webinars of basic concepts and report methodology

    b. Educational tools focused on methodology to support self-learning

    c. Periodic conference calls

    d. Education regarding why it is important for providers to submit servicing information on claims, and why it is in providers own best interest to submit claims completely and accurately

    e. Assuming WHIO expands measures used for physician measurement, physician education is needed to explain that the Overall Quality Index presented in the report is based on all rules, not the subset selected for display in the report..

Member Study

Where the Pilot Program focused on the performance measurement and attribution methodology by evaluating the Performance Reports, the member study portion of the Data Study focused on evaluation of the data.

Member Study Process

Paired Member Study Teams performed comparative analyses using WHIO data and comparing that data to an outside source such as a medical system EMR or billing system; Individual Member Analytics reviewed the data in light of how they expected to access and use the data for their internal business purposes. In all cases, the organizations were invited to participate in first weekly, and then bi-weekly round table calls throughout the Study Period where ideas and information was shared.

The paired study teams were:

- WEA Trust/Aurora Health
- WPS/ThedaCare
- Humana/ProHealth
- UHC/Bellin Health
- Anthem/ Medical College of Wisconsin

The members performing independent analysis were:

- Group Health Cooperative of South Central Wisconsin
- Mercy Health Care Plans
- Wisconsin Hospital Association
- Wisconsin Department of Health Services
- Wisconsin ETF
- Milliman, on behalf of Greater Milwaukee Business Foundation
- WCHQ
- Wisconsin Medical Society

As mentioned above, the Paired Member Study Teams reports and Individual data study reports are summarized together, because they addressed similar issues. One distinctive study that deserves particular mention is the study conducted by the Wisconsin Hospital Association. Prior to the study period, it was known that institutional provider matching would be a challenge. Institutional provider matching affects WHA in particular, so their observations, findings and recommendations have a different focus than other data study participants.

Both the paired member study teams and the members pursuing independent studies were supported by a variety of resources. A new section of the WHIO Hub was created to assist the study. Using the hub as an open forum, users could submit questions and present

findings at their convenience. Additionally, a number of training and reference documents were posted to the hub, and others were added as requested. A Q&A log was established in order to have a central area for members to submit questions, and for all participants to review the answers. Ingenix researched the questions, and posted answers as quickly as possible. There were also bi-weekly calls with the following standard agenda:

- Highlight of a specific Data Study team
- Review of the newly posted questions & answers on the WHIO Hub
- Success Stories
- Open Forum

At the end of the study period, a questionnaire was filled out by all participants to capture the specifics of what studies they conducted, their findings, and any recommendations. The result of this process follows. For the member responses in their entirety, see exhibit X.

Member Observations and Findings

Data

1. In general and in aggregate, data meets expectations. There were some individual claims line, member or provider data elements found in the data study that required investigation and explanation and in some cases, correction.

2. The data reflects the billing practices of the providers and the adjudication processors of the payors. While it is not perfect from a reporting perspective, no material defects were found in the data that would disqualify it from being used for performance reporting.

3. Cost and use, quality compliance, and aggregate measures were consistent with expectations and benchmarks. The Milliman/GMBFH team, in particular, performed a thorough benchmark comparison of aggregated measures.

4. Member matching was highly successful, using methodology referenced in the contract Physician matching and institutional matching are discussed below

5. Provider data minor issues included:

    a. Claims for two providers were inaccurately combined into one provider. Note that eliminating all overmatching results in an unacceptable level of under-matching,

    b. Provider billing practice does not always mirror provider practice (e.g., providers may have more claims attributed to them as appropriate because NP or BA bills under their number

6. When servicing provider data was missing, the billing provider was substituted. This leads to inaccuracies, particularly when billing occurs at the practice level. For example, the Anthem / Medical College of WI team found that claims were missing for a Dr. Nattinger and one of the reasons is believed to be that claims were rolled up under a group TIN.

7. In some instances when servicing provider is found on claims, the servicing provider indicated is a practice group rather than an individual. This occurs because data contributors contract with practices, not individuals, and would need to be addressed at the contract level

8. Matching of institutional non-physicians is a significant issue, and is summarized in the report of the Wisconsin Hospital Association submitted by Joe Kachelski. It would be beneficial to have additional filtering at the provider level, particularly to indicate hospital vs. non-hospital providers to help with the development of the crosswalk being pursued by WHA and Ingenix.

9. In certain limited situations, study participants reported seeing more claims than they would have expected. Far more common was an experience of missing claims, generally due to missing ASO customers, noncommercial data, or subsidiaries not reported by data contributors (acquisitions not integrated into core systems).

10. Overall, there are a significantly higher number of provider records than participants expected to see, but fewer members than they expected to see. This is explainable in that there were no filters applied to the provider record submission so out of state and old provider data was included in the files and because ASO members or members from acquisitions who are managed on alternate systems were not submitted. Enhancements to the provider matching process will also reduce the number of provider records. The addition of members with only partial claims activity represented in the data (e.g., supplemental or non-WI members) will also increase the number of members.

11. Missing pharmacy claims and/or an inaccurate eligibility flag for pharmacy claims is perceived as a significant issue because it affects compliance results for those quality measures that rely on drug information. However, it is statistically less significant than might first appear, other than for the Medicare population from UHC and ETF. 55-60% of members have pharmacy claims, similar to national averages, and there is consistency across DCs, - therefore WHIO is probably receiving a typical level of pharmacy data. One suggested enhancement was receiving data from PBMs, but this would not be effective due to the lack of a corresponding eligibility file. Note that WHIO discussions of pharmacy relate to retail, but not hospital etc, because the latter are covered under medical inpatient benefit and are fully received as medical claims.

12. Vision, mental health and dental are still potential gaps, particularly due to the practice of "carving out" these services

13. There is a desire to be able to perform additional analyses based on geography. This appears to be partially resolvable through additional training; however, to use geography in the manner desired, WI geographic regions should be defined before the data is processed.

14. Lab test results were discussed as desirable several times during the data study. However, the Lab Test Results table in the output is a LOINC based table. Lab results often cannot be submitted in LOINC format, only members who show at least one result are evaluated. and Lab Test Results only impact a small subset of rules in Impact Intelligence.

15. It would be helpful to integrate WIR data

Software

1. All member responses indicated that the web based application is easy to use
2. The Impact Intelligence Reporting System has proven robust and diverse enough in meeting member access and reporting information needs that only one member requested a full copy of the physical data mart, and that member requested it before the deliverable to meet special needs. A few payers are still evaluating the need for a physical data mart. Wherever the software tool meets the data access and reporting flexibility requirements of the members, they will incur lower hardware and support costs than may initially have been anticipated
3. Both providers and payers saw fewer coding inaccuracies or gaps appear in the data than was anticipated.
4. Some members are more familiar with the MS-DRG grouper than the APS-DRG grouper used by Ingenix. APS has some advantages because MS-DRG was developed for the Medicare population, while APS was created to address all payors and all ages. After some discussion, the APS grouper was chosen as best for WHIO, but additional education is required. An issue was raised that the wording of certain groupers is not correct - this will be corrected in DMV2.
5. DRG descriptions should be updated
6. Clinic level reporting is needed
7. Provider Tax ID reporting is needed to links to their proprietary contracts
8. Documentation is generally helpful, with certain exceptions. While the electronic documentation provided is highly searchable, several respondents mentioned the desire for an online help function, Ingenix has found that as clients become more familiar with the documentation over time, the desire for online help decreases. However, online help is on the product roadmap, because of the value it should add.
9. Members did not find all quality measures that they had hoped to find. Some wanted HEDIS measures that are not part of EBM Connect. Additional quality rules are needed, particularly for provider specialties.
10. Exporting to excel needs to improve both in terms of issues for certain software systems and in terms of the quantity of data that can be exported to Excel
11. Enabling the capability to write SQL queries was requested
12. Providers should be able to be filtered by last name instead of first name

Training

1. The training presentations given in December assumed that member data study participants would focus on cost and use measures, rather than the Provider Needs

Assessment (PNA) module. During the study period, it became clear that understanding the PNA module is very important

2. Quality Confidence intervals will also be generated based on all rules.

3. While the tool is easy to use, most questions were about content, not software problems. "Help me understand what I see," "where do I find underlying methodology," rather than not "this tool doesn't work as described."

4. In addition to core training on PNA, training is needed to understand why certain things are seen in cost and use, but are not seen in PNA.

5. More documentation about where to look for answers is needed, or else more Ingenix staff support is needed. An online help functionality would help significantly

6. Certain specific areas such as ER visits not counting in inpatient confinements are areas that need more emphasis

7. SQL Training would be beneficial to a limited segment of members

Paired Member Study Team and Member Study Suggestions for Improvement:

Improvements in process and scheduled for DMV2 (August 09)

Data

1. Non-Wisconsin providers with fewer than 10 medical claim lines will be removed from the data mart and Wisconsin Providers included only if have at least one medical claim line. This will remove approximately 80% of facilities from the database

2. Ongoing Ingenix improvement in provider matching methodology, including improvement in facility and non-professional group entity matching

    a. Developing a gold standard with WMS for physicians

    b. Beginning development of a gold standard with WHA for hospitals

    c. Still seeking other gold standards for other providers

    d. Providers with exact name matches will be matched

    e. Facility providers with NPI2 plus first three letters of name matching will be matched.

3. Other improvements in physician provider matching have been implemented. The preliminary match rate for DMV2 is 95%

4. Provider name will be searchable by last name instead of first

5. Provider city will be included as a custom field

6. Partial claims data, such as Medicare supplemental, or non-WI members from member perspective – will be included in the data mart, but excluded from provider analysis

7. Members who do not have a pharmacy benefit will be excluded from provider measurement (about 9% of members)

8. To integrate with WIR, we suggest that DHS send WIR claims

9. Billing Provider ID will continue to be used on medical claims when Servicing Provider ID is missing, or if Servicing Provider ID is included but not found on the Provider file

10. Ingenix will de-identify the data contributor Claim Header and Claim Line information such that the link among records from the same claim is retained and included in the deliverable

Software

1. A software issue inhibiting exporting to Excel has been corrected. The number of lines which can be exported to Excel will be significantly increased in DMV2

2. All rules for the peer definitions will be turned on in the software in order to maximize options in the tool for member etc use in the web-based reporting system, but limit their use in reports provided to physicians.

3. Providers will be able to be filtered by last name instead of first name

4. DRG grouper wording has been corrected

Training

1. Training will highlight certain focused items that are related to output that differs from general expectations of the overall user community, such as:

    a. ER data not being included in admissions,

    b. Partial data members, and others scenarios where data may be in one reporting functionality (i.e., cost and use) but not another, such as PNA

    c. A limited amount of Physician overmatching will occur

    d. Why missing pharmacy claims/pharmacy flag may be less significant than first appears

2. Provider matching and PNA education are needed as a separate class, probably after newly trained users have had a chance to practice using the tool

3. Create / conduct advanced analytics on DMV2 possibly in mid October

4. Ensure that anyone considering receiving a physical data mart has received training sufficient to determine/evaluate whether their needs can be met using the existing reporting system

5. While not strictly a training issue, it is probably advisable to convene a user group for mutual education and to address issues such as "what constitutes a geographic region for analysis"

Suggestions for future improvements

Data:

1. Data contributors should be encouraged to also filter out defunct providers, and rename providers as appropriate.
2. The individual servicing provider needs to be identified on all submitted claims, and all servicing providers found on claims also need to be included in the provider file.
3. Data Contributors are also encouraged to invest time and effort to create cleaner accurate and complete provider data, including all requested fields for provider matching. Adding a field to distinguish between individual and institutional providers would be beneficial.
4. Data Contributors are specifically encouraged to improve fill rates for NPI, especially for facilities
5. The amount of ASO plus unreported subsidiary data as well as noncommercial data needs to be addressed. The data mart contents must closely reflect market activity in order to be considered credible.
6. The following structural changes are to submitted files from data contributors are recommended starting with DMV3
    a. One record per provider id, instead of one record for each provider id and tax id combination (note – if there is a desire to re-investigate matching by tax id, this will need to be removed)
    b. Including only providers found in 36 months of data (all provider types)
    c. Including flag indicating whether provider record is for an individual vs. group entity
    d. Include NPI and Tax ID as a custom field on the provider table
    e. Include three new fields plus layouts related to an upcoming software upgrade
7. Include NPI and Tax ID as a custom field on the provider table visible in the Reporting System
8. Include Secondary ID of NPI and/or tax id included in the data mart would be helpful so individual providers are identifiable and linkable to other data. For this to carry through to the group level, WMS would need to add tax id for clinics
9. If analysis by geographic region is desirable, regions need to be defined. Alternatively, Explore feasibility of building regional or other geographic subsets of peer grouping for provider reporting.

10. Include lab test results on submitted claims. Since the benefits of including this data are outweighed by the difficulty in collecting it and properly evaluating results, Ingenix does not recommend including lab test results

Software

1. Activate the 19 additional rules that will be available in the tool once the tool is expanded to include 36 months of data. (Expected in DMV3 or DMV4)
2. The issue of how physicians are grouped to parents and specialties needs to be thoroughly revisited
3. Enabling the capability to write SQL queries should be considered

Final Report Conclusions and Recommendations:

Conclusions

1. WHIO data is imperfect and incomplete in terms of representing the universe of health care in Wisconsin; this is expected and does not render the data set unusable.

    a. The imperfections are a result of data created by providers for the purpose of invoicing payors for payment and by payors processing payment of those claims. These are not errors. It highlights the importance that users of the data become educated about how to properly access the data, produce reports, and interpret the results.

        - Both providers and payors can reduce the amount and impact of imperfections by changing the way they generate and/or submit data.

        - Sometimes aggregating data across payors magnifies the imperfections. Member matching, provider matching, servicing provider identification/attribution will automatically improve as the data submitted improves.

    b. The imperfections found during the Data Study were attributable to specific provider level coding or processing - there were no material defects found on an aggregate scale that would render the data mart unusable for any purpose, even in its' current state. That said, education, education, education is required.

    c. The incompleteness of the data was/is anticipated. Aggregate claims data will only include insured participant data. Even so, until we have data feeds coming from all claims processors and Medicaid/Medicare it will be a partial representation. Further, we are missing a significant portion of ASO data and feeds from non-integrated systems from current data contributors. This is and will remain a continuous data quality improvement challenge for WHIO as we recruit and include more data contributing organizations over the next couple of years.

    d. Incomplete data can and often is used to generate statistically significant and actionable results. Again, it is important that users of the data become educated about how to properly access the data, produce reports, and interpret the results.

2. Providers' acceptance of WHIO measures will take an investment of time and effort on the part of the provider and WHIO/WHIO Members.

    a. Providers:

        - need to accept the data as credible, WHIO must 'prove' it to them by sample/example

- must be educated about the reporting methodology(s) and have opportunity to challenge/ask questions etc before WHIO reports will accepted as a legitimate business tool for them to use
- require both practice group and individual performance data reports in order to buy that the data/results are credible and to take action based on them that will improve their practice patterns/patient outcomes.

b. WHIO/WMS/WCHQ and other Members :

- Must create roll out strategy and on going support programs that address needs of providers listed above

3. Provider matching is an incredibly complex process

a. Results of matching individual physicians across multiple payors was successful.

b. Results of matching those individual physicians to primary practice groups for practice group reporting requires improved data. WMS is working on creating it.

c. It is important to be able to access hospital/facility performance as well as physician/medical professional performance. Facility provider matching will be required in order to allow WHIO data and the Ingenix reporting tool to support this.

- There's a lot of junk coming in -- we can filter most of it out
- Payors/providers need to change and standardize billing and processing processes to reduce variation and allow for higher quality matching -- an essential piece to facility performance reporting

Recommendations

1. **WHIO members should continue to observe limited use of DMV1.**

Members should continue to explore the Data Mart with the intent to become familiar with the data and proficient with the software but refrain from using the results for any production purpose.

Rationale: The number and scope of improvements scheduled for DMV2 will address a significant portion of the findings and suggestions uncovered during the Pilot Program and Data Study activities. These improvements will make the data more accurate and accessible and assure a higher quality reporting result.

2. **DMV2, anticipated delivery in August 2009 should be considered the first 'production' version of the WHIO data mart.**

Following a 30-day 'curing' period during which all members will access the data to assure improvements have been properly installed in the data and software, all use restrictions should be removed and the data mart considered production ready. At this point member access is governed only by the provisions of the Founder or Member Agreement, the Ingenix Master Agreement and Product Schedule and the

Data Use Agreement and WHIO will be positioned to implement its data marketing strategy.

Rationale: Improvements in the data, data access, and reporting software accompanied with advanced training for users will support broad distribution and use of the data for multiple business purposes.

3. **Create and implement Provider Rollout Plan to include more sites in each reporting cycle.**

   This plan must address the selection and qualification of provider sites, the creation and delivery of performance reports, and initial and ongoing support requirements of providers in the program. It must build provider awareness about WHIO and the data mart, reporting methodology and the utility of the data. Awareness, education, and support are key deliverables.

   Rationale: The Pilot Program provided an opportunity to learn about provider resistance/acceptance of measures and data and to understand the challenges of transforming the measures into actionable work plans that will result in improved care. We must use what we've learned to develop a 'mass delivery model' and put it into action in a manner that will promote broad buy in and acceptance in the provider community without being unreasonably difficult or resource intensive.

4. **Build and implement a plan to address facility/institutional matching.**

   This will be an incremental process in which hospital provider records will be matched first and other types of institution may follow depending on need and ability for data to support it.

   Rationale: Payors and Purchasers have expressed a need to aggregate and report on facility performance in addition to physician performance. This level of matching will also increase the utility of the data to other outside entities who may become purchasers or subscribers to the WHIO Data Mart.

5. **Build a plan to address extended provider identification.**

   This should include:

   - Tax Identification Number
   - Provider Affiliation Parent Organization

   Rationale: These enhancements will support matching of WHIO provider results to Payor or Medical System internal reporting systems. This is important as contracts are frequently built on tax id as the source for delivery and payment.

6. **Explore the potential for and the implications of geographic peer group reporting.**

   Rationale: Member health plans have suggested that this capability would offer great value.

All of the recommendations above were accepted unanimously by the WHIO Board of Directors on April 23, 2009


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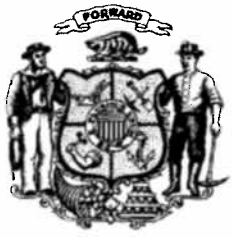

FORWARD

State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

August 5, 2009

Senator Jon Erpenbach
Committee on Health and Health Care Reform
Room 8 South State Capitol
Madison, WI 53702

Senator Tim Carpenter
Committee on Health and Health Care Reform
Room 306 South State Capitol
Madison, WI 53702

Dear Senators Erpenbach and Carpenter:

The Department of Health Services is pleased to submit to you, as required by s.253.115 of the Wisconsin Statutes, the annual report on the status of Universal Newborn Hearing Screening (UNHS) in Wisconsin. I am especially pleased to report that in 2008, all of the State's birthing hospitals had implemented a hearing screening program.

In 2008, 98 percent of babies born in Wisconsin were born in a facility that offers UNHS and 2 percent were born at home. Currently 96 percent of babies are screened prior to hospital discharge, with a 0.2 percent rate of refusal. The statewide average rate of infants who did not pass the inpatient hearing screen in 2008 was 2.1 percent, which falls within the American Academy of Pediatrics recommendation of less than 4 percent.

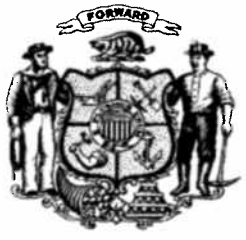
The Department's early hearing detection and intervention program, Wisconsin Sound Beginnings (WSB), continues to provide support to screening and diagnostic organizations and to the county Birth to 3 programs, working with identified infants with hearing loss and their families. With federal funds, WSB has implemented an early hearing loss data collection and tracking system in 94 birthing units, 18 neo-natal intensive care units, and 61 audiology clinics. WSB also has developed a parent-to-parent support system which has received national attention, called the Guide By Your Side program. The program provides services for families of children who are deaf or hard of hearing, including those who are Spanish- and Hmong-speaking only.

Hearing loss is the most common congenital birth defect, affecting an estimated 200 Wisconsin infants annually. Undetected hearing loss impedes speech, language, and cognitive and social development. The Department is dedicated to helping children and families cope with the effect of hearing loss through its early detection and intervention programs, so that all Wisconsin children can have a sound beginning.

Sincerely,

Karen E. Timberlake
Secretary

WISCONSIN STATE LEGISLATURE



State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

September 1, 2009

Mr. Robert J. Marchant
Senate Chief Clerk
Room B20 Southeast, State Capitol
Madison, WI 53702

Mr. Patrick E. Fuller
Assembly Chief Clerk
17 West Main, Suite 401
Madison WI 53703

Dear Mr. Marchant and Mr. Fuller:

Section 227.485(9) of the Wis. Stats. requires the Department to submit a report concerning decisions and resulting payments of attorney fees and related legal costs. Attorney fees and other legal costs are to be paid whenever the opposing party to an agency's Chapter 227 hearing prevails and it is determined the agency's position was not substantially justified. As indicated in the attached chart, two payments totaling $7,679.14 were made during SFY 2009.

In addition, under 814.245(10) of the Wis. Stats., the Department is required to report any awards granted to the Department regarding frivolous motions brought against this Department. In SFY 2009, no motions of opposing parties were found to be frivolous. Consequently, the Department has no awards to report.

Sincerely,

Karen E Timberlake

Karen E. Timberlake
Secretary

Enclosure

Referred to committee on Health, Health Insurance, Privacy, Property Tax Relief & Revenue.

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone 608-266-9622 •
dhs.wisconsin.gov

1985 WISCONSIN ACT 52
Claims Under Sections 814.245 and 227.485, Wis. Stats.
Fiscal Year: July 1, 2008 to June 30, 2009

CASE NAME	CASE No.	AGENCY	ASSISTANT ATTORNEY GENERAL/ DHS ATTORNEY	OPPOSING COUNSEL	NATURE OF CASE/CLAIM	COSTS/FEES REQUESTED	AWARDED/DENIED	AMOUNT AWARDED	DATE OF ORDER	APPEAL
Paiga, Joseph	09-CV-1215	DHS	Neil Gebhart/ Robert Hunter	Mitchell Hagopian	Medicaid Prior Authorization for Speech Therapy	$2,135.82	Awarded	$2,135.82	05/20/2009	No
Hottovy, Joshua	08-CV-1387	DHS	Neil Gebhart/ Robert Hunter	Mitchell Hagopian	Medicaid Eligibility	$5,543.32	Awarded	$5,543.32	04/23/2009	No