Kentucky ICD-10 Site Visit

Training segments to assist the State of Kentucky with ICD-10 Implementation

Segment 2: Analytics, Reporting, and Program Integrity

November 15-16, 2012

Agenda

- **Program Integrity**
  - Background
  - Federal and State Actions
  - Identifying Cases
- **Analytics and Reporting**
  - Background
  - Data Fog
  - Equivalent Grouping
  - Drill-Downs
  - Performance Measurement

Program Integrity

Background

Background

The Scope of the Problem

	Fraud & Abuse	(3-10%)
+	Waste	(15-30%)
	Total Loss	**(25-33%)**

Background

The Villains and Their Targets

- Fraud: an intentional act of deception, misrepresentation, or concealment in order to gain something of value
- Waste: over-utilization of services (not caused by negligent actions) or the misuse of resources
- Abuse: excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices
- Fraud, Waste, and Abuse will be in every phase of every program and will include acts of both commission and omission

Background

The Types of Fraud and Abuse We Know About

- **Providers/suppliers**
  - Billing of unperformed services (DIDN'T DO IT)
  - The deliberate delivery of unnecessary and inappropriate services for the express purpose of receiving the payment (SHOULD NOT HAVE DONE IT)
  - Intentional misrepresentation of services that result in higher payments (DIDN'T DO IT TO THE LEVEL THEY SAID THEY DID)

- **Recipients**
  - Intentional misrepresentation of information in order to gain eligibility and/or enrollment (SHOULD NOT BE ENTITLED)
  - Intentional misrepresentation of information in order to gain access to treatments not medically necessary (SHOULD NOT BE COVERED)

Background

Program Integrity – Sounds Great But What is it?

- **Medicaid Program Integrity - the planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse**

- **HHS OIG's 5 five principles of effective program integrity**
  1. Enrollment: Scrutinize individuals and entities that want to participate
  2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice
  3. Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements
  4. Oversight: Vigilantly monitor programs for fraud, waste, & abuse
  5. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy vulnerabilities

Background

Managed Care Brings New Opportunities and New Challenges

BUSINESS

WellCare finalizes settlement on Medicaid fraud charges

The managed care organization signs what it hopes is the last legal and regulatory agreements stemming from 2008 allegations.

By EMILY BERRY, amednews staff. *Posted May 25, 2011.*

HEALTH CARE BUSINESS

Hospitals Evade Audits, Penalties with Observation Status

The controversial hospital strategy may be a loophole in Medicare cost-containment efforts on admissions. By documenting observation status rather than admissions, hospitals can avoid the Medicare penalties associated with readmissions and the close scrutiny of auditors on admission claims.

By KAREN CHEUNG, FierceHealthcare. *Posted June 5, 2012*

HEALTH CARE BUSINESS

$115 Million in Overpayments Alleged

A subsidiary of UnitedHealth Group was accused by auditors of receiving as much as $115 million in overpayments from the CMS in 2007 by inappropriately using patient diagnosis codes to increase risk-adjusted reimbursements in the population-based insurance program Medicare Advantage.

The company learned it was under investigation in 2008. Law enforcement agencies alleged that the company defrauded Florida's Health Kids program out of $40 million and subsequently made misleading earnings statements based on the ill-gotten gains.

The company entered into a deferred prosecution agreement with the U.S. Attorney General's Office and the Florida Attorney

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

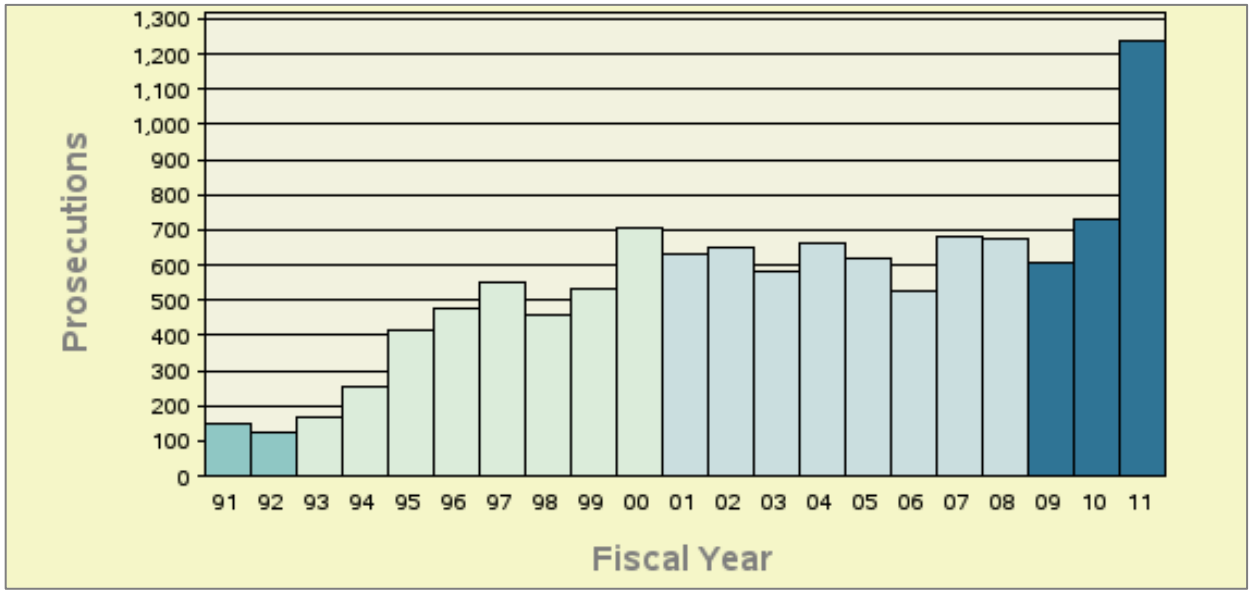
Program Integrity

Federal and State Actions

Federal and State Actions

Working Harder

- "…Good news is there's lots of prosecutions…Bad news is there's lots of prosecutions. The real question is what will CMS do to prevent frauds from taking place in the first place."



- "At the end of the day, we can't enforce our way out of this problem."

Federal and State Actions

Working Smarter in Medicare

- In 2011, CMS began instituting its 'twin pillars' approach using predictive modeling technology to combat fraud
  - Fraud Prevention System (FPS), which uses fraud propensity scores to look for suspicious billing patterns
  - Automated Provider Screening (APS) system, which helps identify ineligible providers and suppliers prior to their enrollment or revalidation
- In June 2012, CMS begins a Recovery Audit Prepayment Demonstration in 11 states, which allows RACs to conduct prepayment claim reviews for Medicare
- In September 2012, CMS begins a Prior Authorization for Certain Medical Equipment Demonstration in 7 states

Federal and State Actions

Working Smarter in Medicaid

- In 2007, HHS Office of Inspector General report found challenges with the reporting of encounter data and found that 15 of 40 applicable States did not report encounters
- Since 2008, HHS has operated the National Medicaid Audit Program (NMAP), which uses Medicaid data from Federal systems and has conducted over 1550 audits but only recovered $20 million after costing over $102 million.
- HHS Regional Inspector General Ann Maxwell stated to a House Committee, much of the data that is mined and analyzed to identify overpayments and fraud in Medicaid is not ‘current, available, complete, [or] accurate.’

Federal and State Actions

Working Smarter in Medicaid (2)

- Better linkage of Federal and State programs - CMS implemented a web-based application that allows States to share and view information regarding terminated providers
- Better use of predictive analytics in Medicaid
  - Analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and CHIP after the third year of the Medicare Fraud Prevention System (FPS)
  - Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015
- In late May 2012, CMS launched the "CMS Provider Screening Innovator Challenge" to develop a multi-State, multi-program provider screening software application

Federal and State Actions

ICD-10 as a tool

With increasing challenges to control cost, the intensity of audits related to fraud, waste, and abuse is increasing. In its "Justification of Estimates for Appropriations Committees," CMS states:

"Reducing health care fraud, waste, and abuse is a major priority of the Administration… Although the ICD-10 code set will not eliminate all fraud, waste, and abuse, CMS believes that its increased specificity will make it much more difficult for fraud, waste and abuse to occur."

Program Integrity

Investments

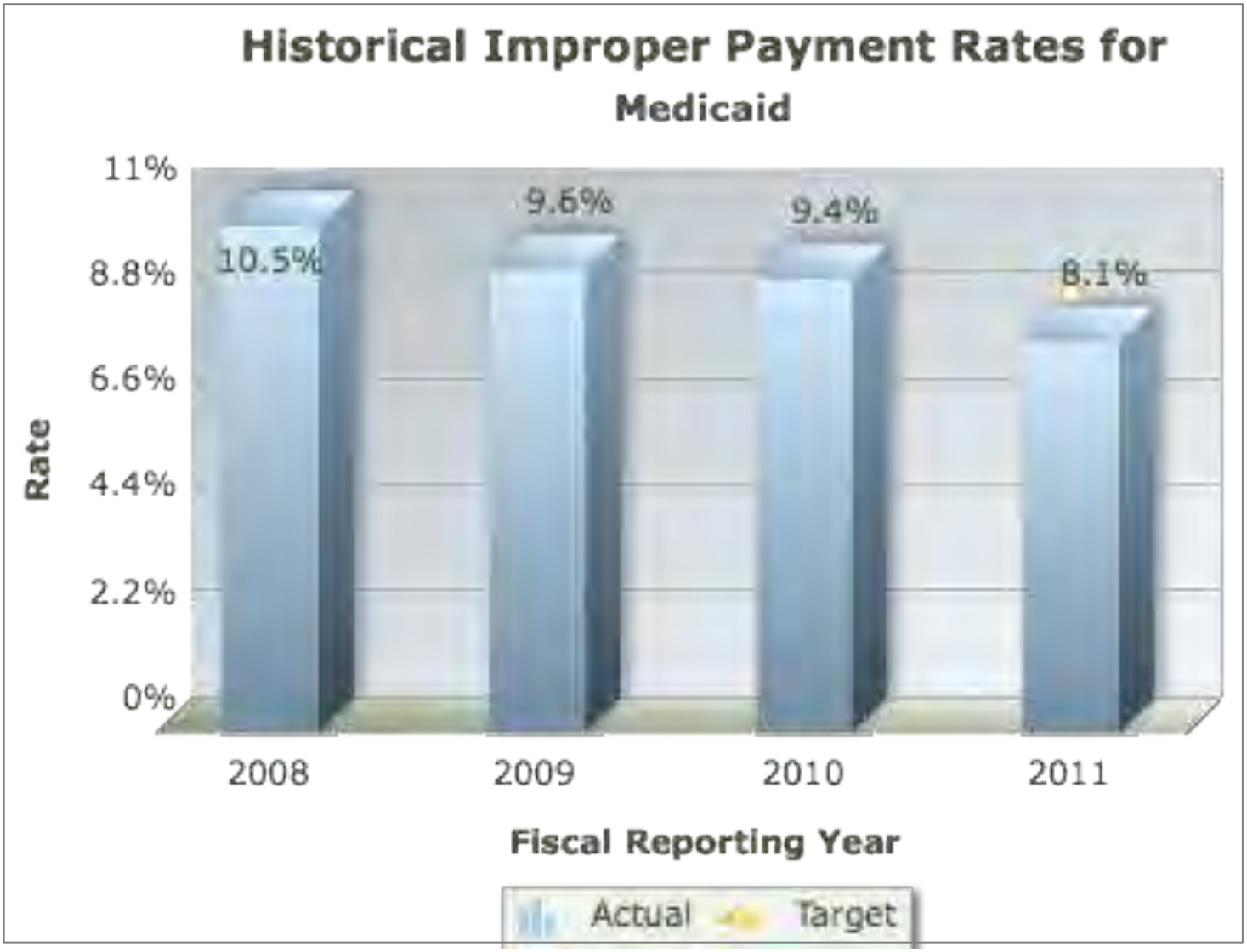
4 Billion Recovered in 2010

Information Technology

Funds Source	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 Request Level
Medicare Operations 1/	$765,648,000	$786,626,000	$860,974,000
Federal Administration	24,240,000	29,240,000	29,353,000
Survey & Certification	3,540,000	3,245,000	5,345,000
Research	5,700,000	5,700,000	5,700,000
Health Care Data Improvement Initiative (HCDII)	-	-	110,000,000
Subtotal, Program			
Management Appropriation	**$799,128,000**	**$824,811,000**	**$1,011,372,000**
Coordination of Benefits (COB) User Fee	26,500,000	26,250,073	27,835,073
CLIA User Fees	2,040,000	2,040,000	$2,965,000
Health Care Fraud & Abuse Account Medicare Integrity Program (HCFAC/MIP) 2/	47,161,199	45,631,165	111,881,198
Quality Improvement Organizations (QIOs) 2/	88,200,000	93,164,285	116,048,824
ESRD Network	-	4,000,000	4,000,000
Medicaid Integrity Program	6,224,750	8,100,000	8,100,000
MIP Discretionary 3/	52,139,940	57,990,817	-
Total, CMS IT Portfolio	$1,021,393,889	$1,061,987,340	$1,282,202,095

enters for Medicare and Medicaid Services

Projections Historical



- Fee-for-Service was 2.7 percent;
- Managed care capitation was 0.3 percent;
- Eligibility was 6.1 percent.

Program Integrity

Ohio Effective Practices

- ***Web-based exclusion database***
  - Ohio maintains a web-based database, called the Sanctioned Provider List, of excluded individuals and entities. It also checks the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) to determine if any individuals are excluded.
- **Enhanced enrollment measures for PCAs / home health aides**
- ***Collaborative relationships and effective communications***
  - Ohio has a close relationship with the MFCU and the Ohio Auditor of State. It has also established program integrity workgroups which bring managed care and home and community-based waiver staff together regularly with State program integrity, auditing and MFCU personnel.

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Program Integrity

Identifying Cases

Identifying Cases

Some Scenarios – Patient Example

- A mother with a criminal history and Ritalin addiction used her child as a means to doctor shop for Ritalin and other similar controlled stimulants used to treat ADHD
- Although the child received overlapping prescriptions of methylphenidate and amphetamine medications during a 2-year period and was banned (along with his mother) from at least three medical practices, the Illinois Medicaid Program never placed the beneficiary in restricted recipient program
- Over the course of 21 months, the Illinois Medicaid Program paid for 83 prescriptions of ADHD controlled stimulants for the beneficiary, which totaled approximately $6,600

Identifying Cases

Some Scenarios – Provider Example

- Licensed physician and owner of medical clinic prescribed controlled substances to patients in quantities and dosages that would cause misuse and abuse without demonstrating sufficient medical necessity
- Use of controlled substances resulted in death of 2 patients
- Evidence showed that significant portion of panel was prescribed controlled substances even though doctor was a family practitioner with no specialty in pain management or psychiatric medications
- Doctor was found guilty and sentenced to 292 months in prison, 3 years probation, and $1M in fines

Identifying Cases

Good Policy and Pattern Analysis

- **Clearly define what service are considered appropriate and under what conditions**
- **Look for Patterns**
  - Improbable service sequences
  - Repetitive condition service pairing
  - Recurring referral patterns
  - Provider reimbursement models that are out of line
  - Outlier referral, diagnostic procedure, or prescribing patterns
  - Recurring patterns of multiple services per patient per condition
  - Recurring and outlier intensity of service and severity of illness

Identifying Cases

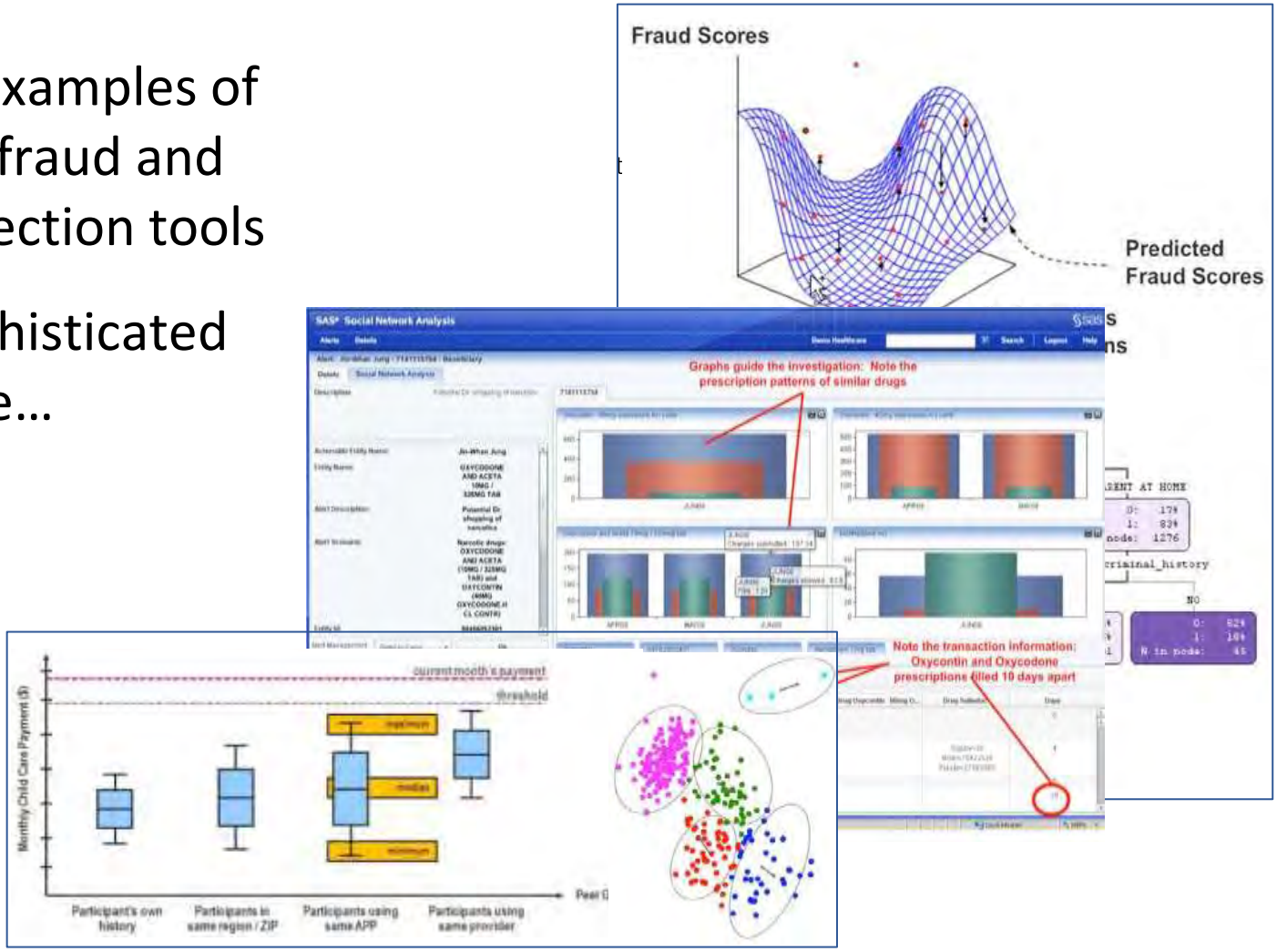
Existing and Emerging Methods of Detection and Prevention

- States apply an increasingly sophisticated set of tools that emphasize pre-payment avoidance (e.g., predictive modeling)
  - Dynamic Rules Engines test a transaction against a predefined set of algorithms. For example, it may target a claim if the claim exceeds a certain amount or involves multiple codes when only one should be used (KNOWN SCHEMES / KNOWN METRICS)
  - Outlier Detection monitors for changes above thresholds (e.g. determination that HIV/AIDS Infusion therapy increased by 25% in one year) (UNKNOWN SCHEMES / KNOWN METRICS)
  - Predictive Modeling uses data mining tools and fraud propensity scores (UNKNOWN SCHEMES / UNKNOWN METRICS)
  - Social Network Analysis identifies organized fraud activities by modeling relationships between entities (UNKNOWN SCHEMES / UNKNOWN METRICS)

Identifying Cases

Technological Toolbox

- Here are examples of advanced fraud and abuse detection tools
- But as sophisticated as they are…



Program Integrity

Summary

- The best tool against fraud, waste, and abuse is good medical policy that answers three basic questions:
  1. Is the service appropriate?
  2. Under what conditions?
  3. How do we deal with inappropriate care?
- The improvements included in ICD-10 with allow States the opportunity to improve the integrity of their programs through better medical policy and fraud & abuse deterrence

Analytics and Reporting

Background

Background

What is Analytics?

- **Analytics** - the application of IT, operations research, and statistics to solve problems. [Huh?]
- **Simple definition of Analytics** - "the science of analysis". [Again, huh?]
- A practical definition, however, would be that analytics is the process of obtaining an optimal or realistic decision based on existing data. [OK]
- Analytics consists of two basic activities – segmentation and prediction

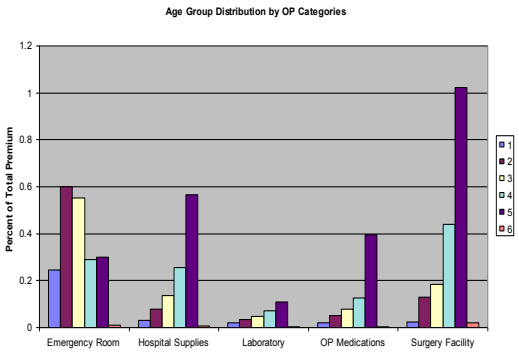
Background

Segmentation and Prediction

- **Segmentation (descriptive statistics) is basically the raw analysis of data across or within a certain time period**
  - Current costs; prevalence of disease; resource usage; performance measurement (e.g., HEDIS); efficiency and effectiveness of policies, procedures, and programs (raw)
- **Prediction (also known as inferential statistics) uses statistical tools to gain further insight from existing data**
  - Health risk and risk stratification; future costs; hypothesis testing and simulations (e.g., what-if analysis); efficiency and effectiveness of policies, procedures, and programs (statistical)
- **ICD-10 impacts all of these types of analytics because**
  - Claims are a primary data source
  - Recipients are characterized and/or categorized by clinical conditions

Background

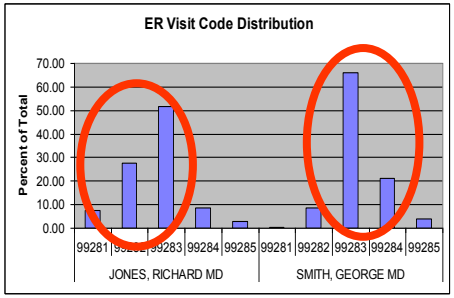
Analytical Examples



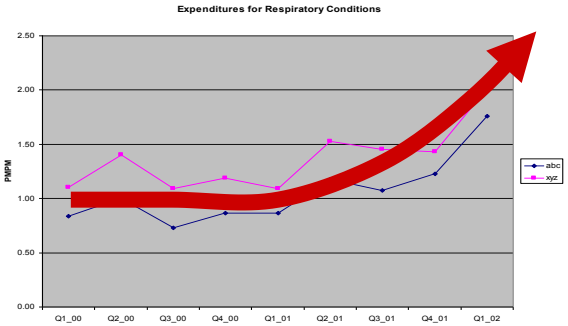
Category Comparisons

Disease Group	Visits
Diseases of the respiratory system	2558
Injury and poisoning	2161
Symptoms, signs & illdefined cond/factors infl health	2107
Diseases of nervous system and sense organs	1549
Diseases of the digestive system	873
Diseases of the genitourinary system	467
Infectious and parasitic diseases	429
Diseases of musculoskeletal system & connective tissue	352
Diseases of the skin and subcutaneous tissue	275
Disease of the circulatory system	265
Complications of pregnancy, childbirth, & puerperium	229
Mental disorders	138
Endocrine, nutritional, metabolic, & immunity disordrs	58
Residual codes, unclassified	55
Certain conditions originating in perinatal period	27
Blood disease	15
Neoplasms	12
Congenital anomalies	1

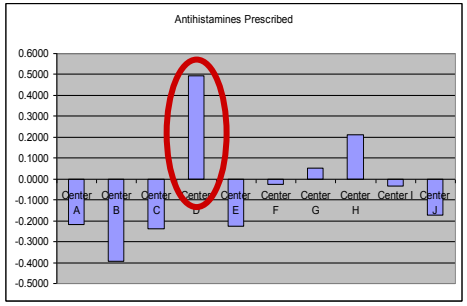
Ranking



Pattern Comparisons



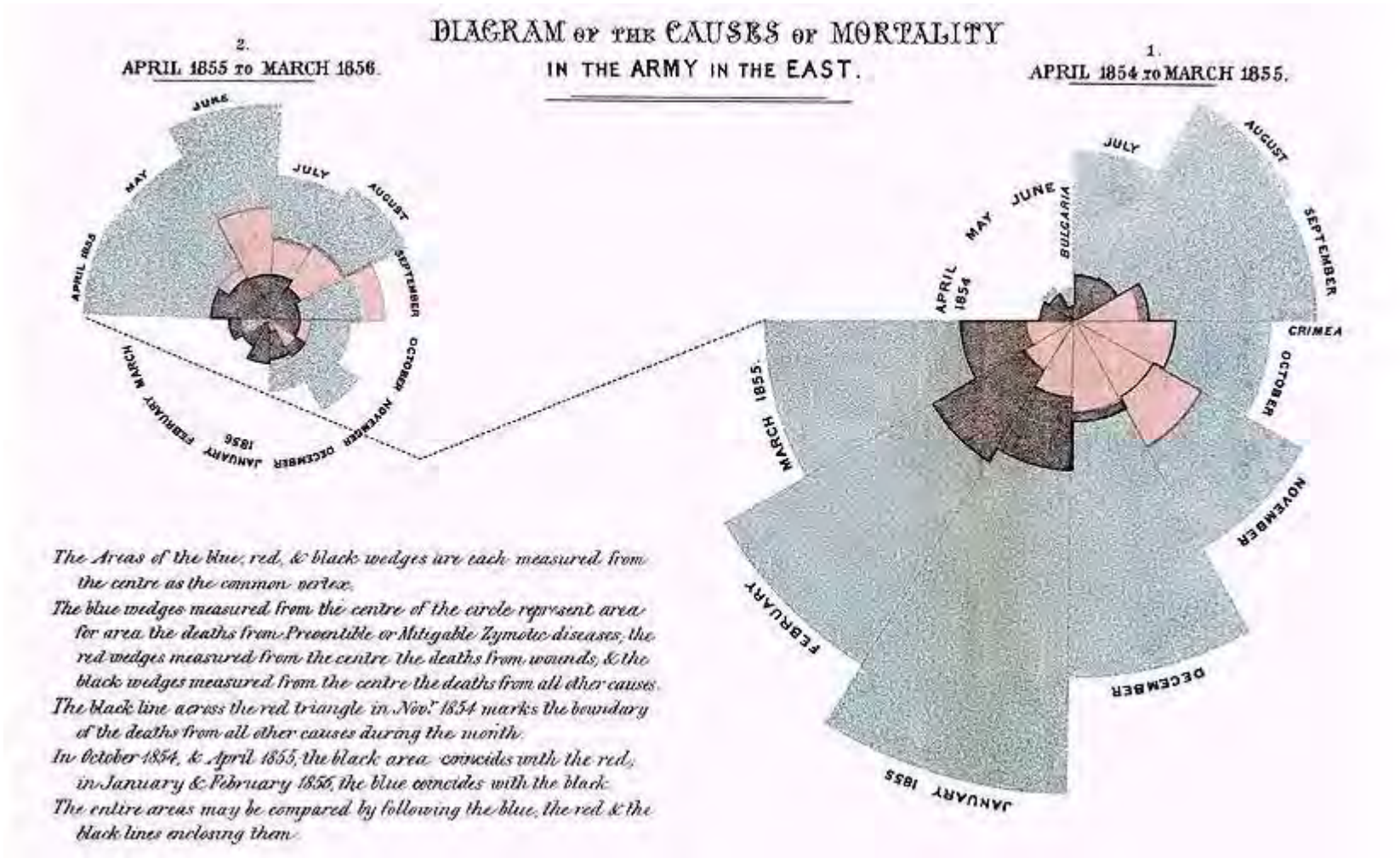
Trends



Variance

Background

Good Example of Analytics



Background

Making it Real for ICD-10

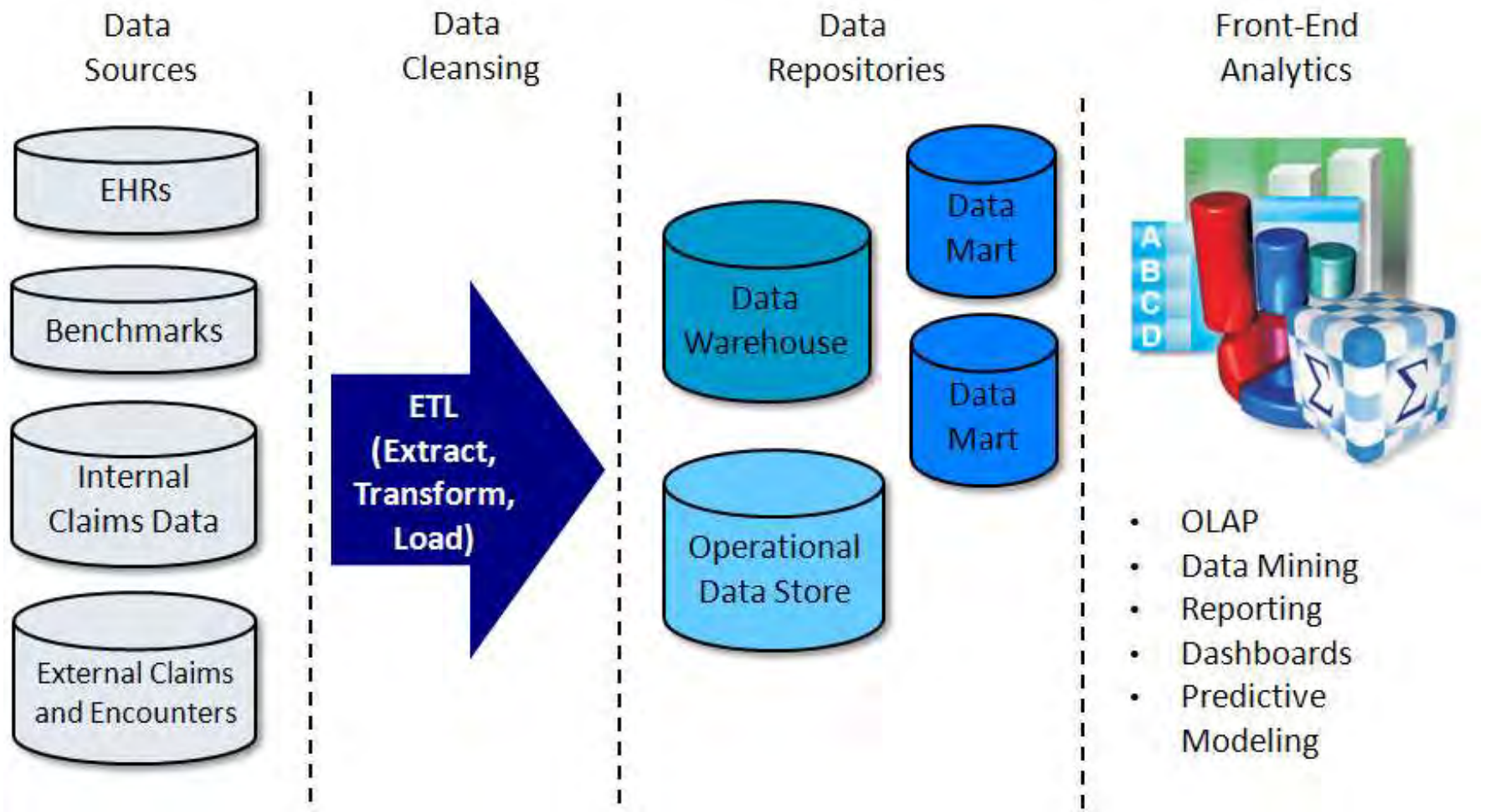
- **Falls Among Elderly Adults**
  - One out of three adults age 65 and older falls each year
  - Of these adults, falls are the leading cause of injury death
  - In 2010, direct medical costs for falls were about $28 billion
- **In a recent journal article, it compared mortality (coded in ICD-10) and morbidity (coded in ICD-9) diagnoses for falls resulting in death and concluded:**
  - Because the reported minor increases in emergency department and hospitalization rates for falls were insignificant [using ICD-9], the almost sevenfold increase in death rates from "other falls on the same level" [using ICD-10] strongly suggests an effect of improved reporting quality

Analytics and Reporting

The “Data Fog”

The Data Fog

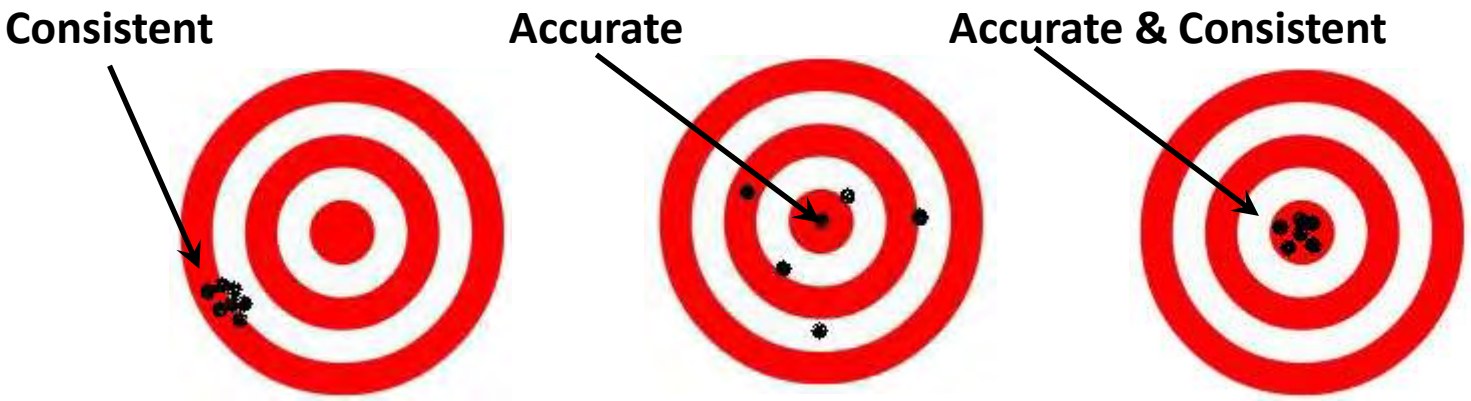
The Data Life Cycle



The Data Fog

A Navigational Challenge

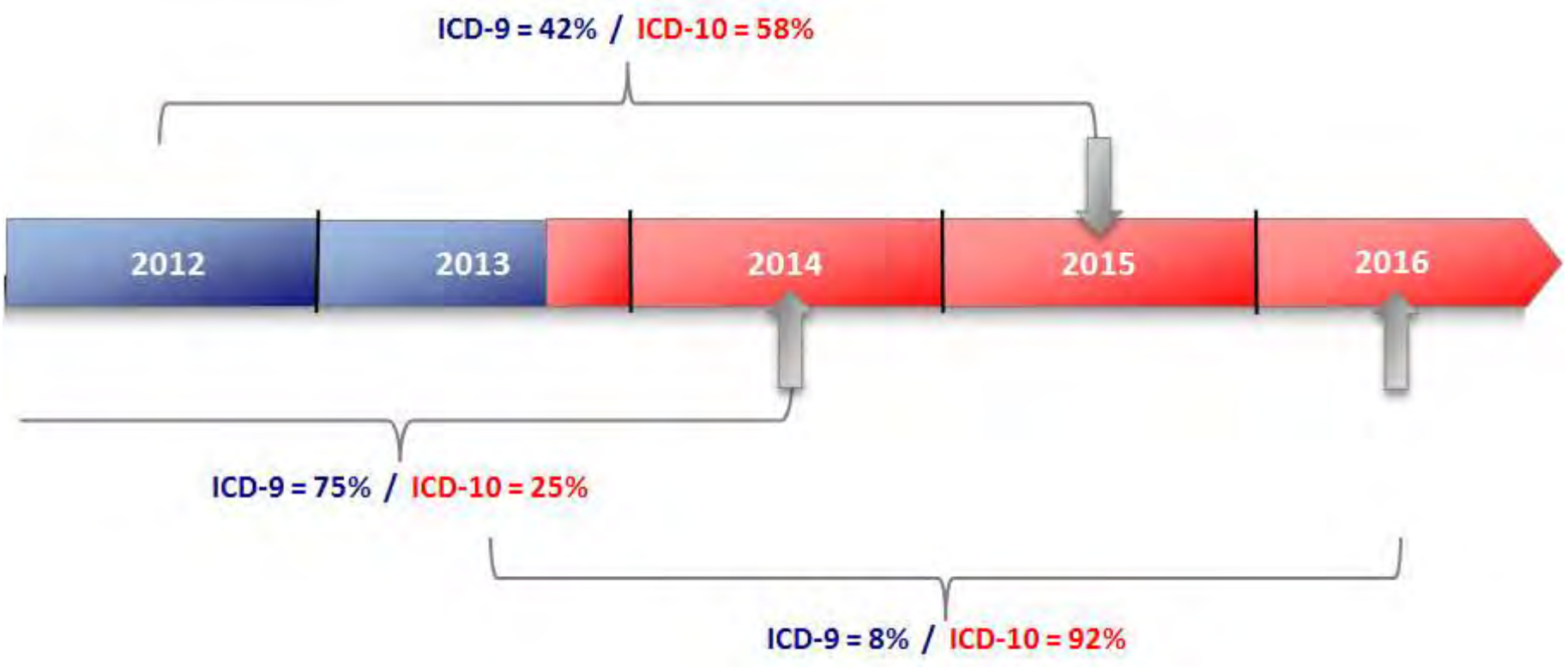
- **A 'Data fog' will challenge analytics during the transition for a number of reasons**
  - A new model with little coding experience
  - Changes in terminology
  - Changes in categorizations
  - The sheer number of codes
  - Complex coding rules
  - Productivity pressures



The Data Fog

Shorter Time Periods are Better

- For example, a 3 year sliding window based on date of service has a 3 year ICD transition period where decision-making will be impacted



The Data Fog

Navigating through the Fog

- **ICD-10 will increase uncertainty in the short run**
- **Since analytics concerns the management of uncertainty, it will increase in importance and workload during the transition:**
  - Remediating existing analytics and reporting
  - Monitoring ICD-10 implementation
  - Building new functionality
  - Evaluating financial neutrality
  - Interpreting trends and benchmarks
  - Validating of aggregation models

Analytics and Reporting

Equivalent Grouping

Equivalent Grouping

Purpose

- **Equivalent Grouping is used to identify an equivalent set of codes that define a medical concept or intent (e.g., diabetes)**
  - Policies that define conditions under which services are considered:
    - Appropriate
    - Not appropriate
    - Require further manual review
  - Rules to define:
    - Coverage
    - Appropriateness
    - COB/TPL
    - Any other criteria that relies on codes to define intent
  - Analytic Categories that attempt to group claims or other data based on types of services or conditions as defined by set of codes

Source: Health Data Consulting 2010

Equivalent Grouping

Methods

- **Bidirectional ICD-9 to ICD-10 code group conversions:**
  - GEM ICD-9 to ICD-10 file (mapped ICD-9 code is the 'Source Code')
  - GEM ICD-10 to ICD-9 file (mapped ICD-9 code is the 'Target Code')
- **Bidirectional ICD-10 to ICD-9 code group conversions:**
  - GEM ICD-10 to ICD-9 file (mapped ICD-10 code is the 'Source Code')
  - GEM ICD-9 to ICD-10 file (mapped ICD-10 code is the 'Target Code')
- **Native Redefinition (independent concept mapping):**
  - Define the concepts associated with the 'intent' of the policy, category, or rule
  - Identify the codes that represent the 'intent' of the policy, category, or rule independent of existing codes

Source: Health Data Consulting 2010

Equivalent Grouping

The Case for Native Redefinition

There are a number of reasons to consider redefining groups of codes to represent the 'intent' of the policy, category, or rule.

- There is an opportunity to be certain that the 'intent' of the original policy, category or rule is clearly defined and articulated so that the proper codes can be selected
- Crosswalking existing codes will reproduce existing errors
- Crosswalking may result in the inclusion or exclusion of codes that don't match to the intent.
- New concepts supported by ICD-10 may result in a refinement or change in the policy, category, or rule
- Reporting on data sets in ICD-9 to data sets in ICD-10 will be comparable if the each data set is aggregated to directly to the same intent

Source: Health Data Consulting 2010

Equivalent Grouping

Example: Pneumonia

Aggregation of codes that represent "Pneumonia"

- Native ICD-9 definition = [56] Codes
- GEM Bidirectional map of the ICD-9 codes = [57] ICD-10 codes
- Native ICD-10 definition = [75] ICD-10 Codes

Source: Health Data Consulting 2010

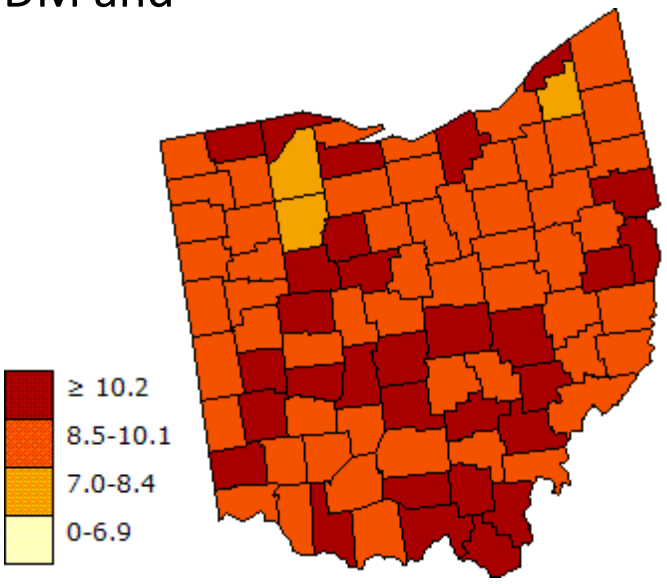
Analytics and Reporting

Drill-Downs

Drill-Downs

Example - Diabetes Mellitus (DM)

- **Chronic disease management is a major opportunity in Medicaid as 5% of recipients account for 50% of costs**
  - ICD-9 codes often define chronic disease only in general terms
  - ICD-10 codes recognize distinctions to help care management
- **For example, let's look at Diabetes Mellitus (DM)**
  - 20% of costs attributable to persons with DM and
  - 10% of costs attributable to DM
- **For example, In ICD-10, DM codes are combination codes that include:**
  - the type of DM,
  - the body system affected, and
  - the complication affecting that body system as part of the code description



Drill-Downs

Clinical Concepts of Diabetes (1 of 3)

Diabetes = 276 ICD-10 Codes / 83 ICD-9 Codes

Unique concepts within in ICD-10 codes = 62

Red = New ICD-10 concepts
Blue = Concepts used by ICD-9&10
Black = Concepts only in ICD-9

Diabetes Type	Pregnancy	Neurologic Complications
Type 1 diabetes	First trimester	Neurological complication
Type 2 diabetes	Second trimester	Neuropathy
Underlying condition	Third trimester	Mononeuropathy
Drug or chemical induced	Childbirth	Polyneuropathy
Pre-existing	Puerperium	Autonomic (poly)neuropathy
Gestational	Antepartum	Amyotrophy
Poisoning by insulin and oral hypoglycemic	Postpartum	Coma
Adverse effect of insulin and oral hypoglycemic		
Underdosing of insulin and oral hypoglycemic		
Neonatal		
Secondary		

Drill-Downs

Clinical Concepts of Diabetes (2 of 3)

Red = New ICD-10 concepts
Blue = Concepts used by ICD-9&10
Black = Concepts only in ICD-9

Lab Findings	Renal Complications	Ophthalmologic Complications
Ketoacidosis	Nephropathy	Retinopathy
Hyperosmolarity	Chronic kidney disease	Macular edema
Hypoglycemia	Kidney complication	Cataract
Hyperglycemia		Ophthalmic complication
		Mild nonproliferative retinopathy
		Moderate nonproliferative retinopathy
		Severe nonproliferative retinopathy
		Proliferative retinopathy
		Background retinopathy

Vascular Complications	Skin Complications	Joint Complications
Circulatory complications	Dermatitis	Neuropathic arthropathy
Peripheral angiopathy	Foot Ulcer	Arthropathy
Gangrene	Skin complications	
	Skin ulcer	

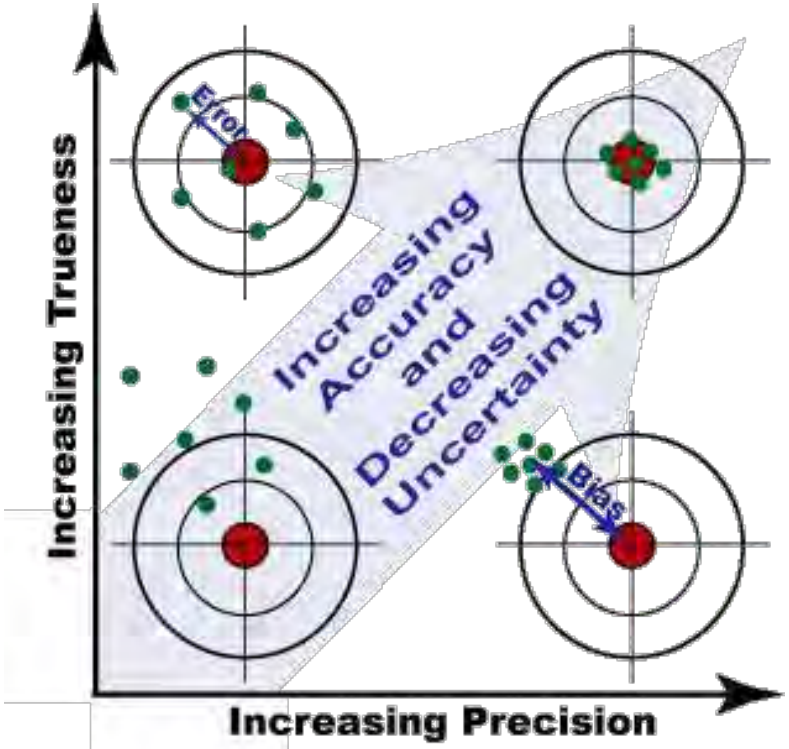
Drill-Downs

Clinical Concepts of Diabetes (3 of 3)

Red = New ICD-10 concepts
Blue = Concepts used by ICD-9&10
Black = Concepts only in ICD-9

Oral Complications	Diabetic Control	Encounter	Other Concepts
Oral complications	Diet-controlled	Initial encounter	Complications
Periodontal disease	Insulin controlled	Subsequent encounter	Right
	Uncontrolled	Sequela	Left
	Controlled		Accidental
			Intentional self-harm
			Assault
			Family history
			Personal history
			Screening

Analytics and Reporting



Performance Measurement

Performance Measurement

Measures

- Measures are a valuable tool to determine health system, contractor, and provider performance for the purposes of contracting, public reporting, and value-based purchasing
- For measures to be valuable, they need to be impactful, transparent, valid, reliable, timely, usable, and feasible – NOT like the following cartoon

© Scott Adams, Inc./Dist. by UFS, Inc, help from n[ate]vw

Performance Measurement

Measure Maintenance

- **Good news is that over time, ICD-10 will improve the accuracy and reliability of population and public health measures**
- **Bad news is that more than 100 national organizations are involved in quality measure maintenance and reporting**
  - Measure maintainers (e.g. including States) need to remediate measures and end-users need to update reporting for ICD-10
  - Measure clearinghouses (e.g. NQF and AHRQ) expect maintainers to remediate measures

Performance Measurement

Changes in Definitions Used in Diagnoses

- **During the ICD-10 transition, it may be difficult to determine if changes in quality measurements are an actual change in performance or simply due to the change in the code sets**
- **For example, the definition of AMI has changed**
  - ICD-9: Eight weeks from initial onset
  - ICD-10: Four weeks from initial onset
- **Subsequent vs. Initial episode of care**
  - ICD-9: Fifth character defines initial vs. subsequent episode of care
  - ICD-10: No ability to distinguish initial vs. subsequent episode of care
- **Subsequent (MI)**
  - ICD-9 – No ability to relate a subsequent MI to an initial MI
  - ICD-10 – Separate category to define a subsequent MI occurring within 4 weeks of an initial MI

Performance Measurement

Example: Comprehensive Diabetes Care (CDC)

- Added azilsartan to "Angiotensin II inhibitors" description in Table CDC-L.
- Added aliskiren-hydrochlorothiazide-amlodipine to the "Antihypertensive combinations" description in Table CDC-L.
- Clarified BP control criteria for the Administrative Specification.
- Clarified that members who meet the Optional Exclusion criteria must be excluded from the denominator for all rates, if optional exclusions are applied.
- Clarified reduction in sample size in the *HEDIS Specification*.
- Clarified that "Documentation of a renal transplant" meets criteria for the *Medical attention for nephropathy* indicator.

- The Comprehensive Diabetes Care measures are often used by State Medicaid Agencies to determine performance

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following.

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) for a selected population*
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- BP control (<140/80 mm Hg)
- BP control (<140/90 mm Hg)

**Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.*

- Diagnosis and procedure codes are used to determine both the denominators and numerators

Source: National Committee for Quality Assurance (NCQA). HEDIS 2012 Volume 2: Technical Specifications.

Performance Measurement

Remediation

- The National Committee for Quality Assurance (NCQA) is remediating approximately one-third of their measures each year so that they are complete by 10/1/2013
- On 3/15/2012, NCQA will post ICD-10 codes applicable to a second set of measures, including Comprehensive Diabetes Care, for 30-day review and comment
- "HEDIS will begin the phase-out of ICD-9 codes in HEDIS 2015. Codes will be removed from a measure when the look-back period for the measure, plus one additional year, has been exhausted. This is consistent with NCQA's current policy for removing obsolete codes from measure specifications"

Source: NCQA. http://www.ncqa.org/tabid/1260/Default.aspx

BadgerCare Plus HMO Report Card
Health Care Measures (2009 Data)

HMO	Asthma Care	Breast Cancer	Diabetes 1	Diabetes 2	Pap Tests	STD	Vaccines	Blood Lead*	Smoking*	Overall Grade
Abri Health Plan	C	B	D	D	B	A	C	A	D	C
Children's Community Health Plan	B	A	C	D	B	B	B	A	C	B
CompCare	C	B	B	C	B	D	B	A	A	B
Dean Health Plan	B	B	B	D	C	C	A	B	A	B
Group Health Cooperative - Eau Claire	C	B	A	B	B	D	A	B	A	B
Group Health Cooperative - South Central	A	B	C	D	A	A	A	C	A	B
Gunderson Lutheran Health Plan	N/A	N/A	C	C	A	C	N/A	N/A	A	B
Health Tradition Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	C	A	N/A	B
Managed Health Services	B	C	C	D	A	B	D	B	D	C
MercyCare HMO	B	B	B	C	A	D	C	B	B	B
Network Health Plan	C	C	C	C	A	B	B	C	C	C
Physicians Plus	N/A	N/A	N/A	N/A	D	A	N/A	N/A	A	B
Security Health Plan	B	A	B	C	A	D	A	A	A	B
United Healthcare	B	B	C	D	A	B	B	B	C	B
Unity Health Plan	B	A	C	D	B	D	A	B	A	B
Wisconsin Medicaid Average	**B**	**B**	**B**	**C**	**A**	**C**	**B**	**60.4% = B**	**58.8% = B**	**B**
National Medicaid Average	***88.6% = B***	***52.4% = B***	***80.6% = B***	***74.2% = B***	***65.8% = B***	***56.7% = B***	***74.3% = B***	**--**	**--**	

Health Care grades show how each HMO compares to the **National Medicaid Average**.
* = National Medicaid Average is not available for this measure. Grades are based on how the HMOs compare to the Wisconsin Medicaid Average.
N/A = Complete data are not available for that measure.

Performance Measurement

Example – The Wisconsin Collaborative

TABLE 2: Group Means, HEDIS® Comprehensive Diabetes Care Measures (care provided in 1999-2009)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
HbA1c Poor Control (>9.0%)*	---	---	---	---	22%	21%	21%	21%	21%	21%	22%
HbA1c Control (<8.0%)	---	---	---	---	---	---	---	---	---	70%	67%
HbA1c Good Control (<7.0%)	---	---	---	---	---	---	---	44%	48%	44%	47%
HbA1c Testing Performed	84%	88%	89%	90%	91%	92%	92%	92%	93%	93%	92%
Eye Exam Performed	63%	66%	63%	66%	63%▽	64%	69%	69%	67%	68%	68%
LDL-Cholesterol Screening Performed	70%	78%	81%	88%	90%	92%	94%	84%▽	85%	86%	87%
LDL-Cholesterol Control <100 mg/dL	---	---	---	---	---	47%	51%	48%▽	51%	51%	52%
Blood Pressure Control <140/90 mmHg	---	---	---	---	---	---	---	69%	70%	71%	72%
Blood Pressure Control <130/80 mmHg	---	---	---	---	---	---	---	38%	40%	41%	42%
Medical Attention for Nephropathy	---	---	---	---	---	---	---	85%	87%	88%	88%

Analytics and Reporting

Summary

- **Analytics concerns the management of uncertainty. It is the process of obtaining an optimal or realistic decisions based on existing data, which often includes claims data**
- **Analytics will be key to the transition**
  - Remediating existing analytics
  - Monitoring ICD-10 implementation
  - Building new functionality
  - Evaluating financial neutrality
  - Interpreting trends and benchmarks
  - Validating of aggregation models

- **ICD-10 provides an opportunity to improve knowledge**

Questions