



**ONPOINT**  
Health Data

# Proposal

---

**Research, Analytical, and Reporting Services for the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)**

SUBMITTED: September 23, 2010

**TABLE OF CONTENTS**

**Introduction.....1**

**5.1 Technical Bid ..... 2**

**5.2 Organizational Experience .....32**

**5.3 Cost Proposals .....51**

**Appendices.....57**

**Appendix A – Project Timeline .....58**

**Appendix B – Work Samples – Standard Analysis & Reporting.....59**

**Appendix C – Work Samples – Health Insurance Rate Reviews .....92**

**Appendix D – Work Samples – Special Studies & Ad Hoc Reporting.....96**

**Appendix E – Work Samples – In-House Reporting Training.....101**

**Appendix F – Work Samples – Custom Medicaid Studies.....104**

**Appendix G – Work Samples – Custom Blueprint Studies..... 114**

**Appendix H – Work Samples – Special Reports & Studies ..... 131**

**Appendix I – Staff & Subcontractor Experience & Responsibilities ..... 134**

**Appendix J – Onpoint’s FY 2009 Audited Financial Statement..... 135**

**Appendix K – Onpoint’s Certificate of Liability Insurance .....146**

# BID CERTIFICATION FORM

## REQUEST FOR PROPOSAL

**THIS FORM MUST BE COMPLETED AND SUBMITTED AS PART OF THE BID FOR IT TO BE CONSIDERED VALID.**

### THIS IS A SEALED BID

**BIDS MUST BE RECEIVED ON OR BEFORE September 24, 2010, 4:00 p.m. EDST**

**Date:** September 23, 2010  
**Bidder Name:** Onpoint Health Data  
**FEIN#:** 01-0349706  
**Business Address:** 16 Association Drive, Manchester, ME 04351  
**Contact Telephone #:** 207-430-0682  
**Contact E-mail Address:** [jharrison@onpointhealthdata.org](mailto:jharrison@onpointhealthdata.org)

The undersigned has read, understood, and accepted all provisions, terms, and conditions of this bid.

### Chapter 2 VERMONT TAX CERTIFICATE

---

To meet the requirements of Vermont Statute 32 V.S.A. § 3113, by law, no agency of the State may enter into, extend or renew any contract for the provision of goods, services or real estate space with any person unless such person first certifies, under the pains and penalties of perjury, that he or she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes. 32 V.S.A. § 3113.

In signing this bid, the bidder certifies under the pains and penalties of perjury that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due the State of Vermont as of the date this statement is made.

---

(Bid Not Valid Unless Signed)

**Quotation Valid for** 60 **Days Date:** September 23, 2010

**By:** \_\_\_\_\_ **Name:** James H. Harrison  
Bidder Officer Signature (Type or Print)  
**Title:** President/CEO



## INTRODUCTION

Onpoint Health Data, an independent, nonprofit health data organization based in Manchester, Maine, has assembled a highly capable team to provide Vermont's Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) and Department of Vermont Health Access (DVHA) (collectively the State) with the services described in the "Research, Analytical, and Reporting Services for the Vermont Healthcare Claims Uniform Reporting and Evaluation System" Request for Proposals (RFP).

Our team brings together a clear understanding of Vermont's objectives, the necessary technical and analytic skills, the established relationships with key stakeholder organizations, and a track record of effectively delivering the results that our clients seek.

Onpoint developed and deployed Vermont's all payer claims database (APCD) and, for more than two years, has collaborated successfully with BISHCA and Blueprint colleagues to develop and deliver a robust set of customized reporting to support the State's health reform and operational needs. We leveraged our expertise in claims data analysis (as well as our relationships in Maine and New Hampshire) to create a first-of-its-kind, tri-state analysis spotlighting regional variation in utilization and cost of care across health service areas in Vermont, New Hampshire, and Maine. And we have demonstrated our skills in the planning and design of a matched cohort evaluation of the advanced medical home project (Blueprint), which will be completed soon.

Onpoint takes great pride in this ongoing partnership with the state of Vermont. With this proposal, we look to expand this relationship, bringing together the diversity of experience and the expertise needed to achieve the goals outlined in the State's RFP.

For this proposal, Onpoint has expanded our resource base and broadened our skills by partnering with two highly capable organizations with similar, successful track records in Vermont:

- **Burns & Associates** — The Burns & Associates team, based in Phoenix, Arizona, specializes in Medicaid-focused analytic services and will work closely with Onpoint on the Medicaid-related deliverables. They contribute an intimate knowledge of the Vermont Medicaid data set and years of experience in providing analytic services on behalf of DVHA personnel.
- **Compass Health Analytics** — Compass Health Analytics is a Maine-based financial and actuarial consulting firm with the specific experience required to meet the State's health insurance rate review deliverables. Compass has provided BISHCA with actuarial consulting services in the past and is currently assisting other states with very similar rate review initiatives.

We attribute Onpoint's growth and success over the years to an exceptionally skilled staff, well-developed systems, and a track record of excellent service. We, along with our partners on the project, look forward to building on our past success as we undertake the interesting and challenging work set forth in the State's RFP.



## 5.1 TECHNICAL BID

**5.1.1.** A brief introduction outlining the bidder's overall technical approach to completing the requirements. The narrative must demonstrate to the State an understanding of the process that is to be implemented, and must persuade the State that the bidder understands the objectives the project is designed to meet, the nature of the required work, and the level of effort required. The bidder must demonstrate depth of knowledge and proven experience in research and statistical methods related to research in health services, health care administration, health policy and/or public health using claims and eligibility data from both commercial and government insurers to measure expenditures, utilization, and performance for commercial and government insurers and different insured populations. (RFP/p.8)

### Understanding Vermont's Research, Reporting, & Analytic Needs

Onpoint Health Data understands this project's primary objective: to enhance the State's understanding of health status, access, quality, utilization, and cost of care for Vermont residents through the production of reports and analyses using Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) claims data. The project will be based initially on VHCURES commercial claims data with rapid integration of Medicaid claims data and eventual incorporation of Medicare claims data.

Vermont State government has taken a lead nationally in healthcare reform, with several progressive health policy initiatives under way that require careful planning, execution, and evaluation. The State takes its healthcare access and regulatory oversight roles seriously and each requires ongoing monitoring and effective management. Meeting each of these important responsibilities relies on timely and reliable information and a capable analytic partner. Onpoint brings several core strengths that are key to effectively meeting the State's needs and distinguish it from other potential vendors:

- Knowledgeable guidance and intelligent design of analysis and reporting deliverables
- Customized studies and reporting resulting from a collaborative process seeking input from key stakeholder organizations
- An analytic partner that clearly understands Vermont's past and future goals, knows the data, and has a track record of responsive solutions
- Clear, concise presentation and effective communication tools to convey the State's findings to the public

Onpoint is pleased to submit this proposal to meet the analytic needs of BISHCA, DVHA, and other state agencies. We have assembled an experienced team of health services research staff, systems and data analysts, and expert consultants to advance the State's overall goals. This proposal's team includes:

- **Onpoint Health Data** — Onpoint brings the breadth of skills and experience necessary to effectively deliver the multiple and varied requirements in the RFP. We bring a long history, now 35 years, of providing reliable data and innovative analytic solutions. Our experience working with all payer claims databases, in both a data management and analytic capacity, spans 15 years. Our analytic services are led by Karl Finison, Director of Health Services Research, who alone brings more than 25 years' experience working with claims data and has unparalleled experience working with statewide claims databases. We will bring together an exceptional group of researchers, analysts, programmers, and health data specialists to team with Karl on the project, ensuring the depth to deliver quality

work in a timely fashion. We are partnering with two accomplished firms, below, that contribute the specialized knowledge and skills needed to most effectively address the State's requirements in some areas.

- **Burns & Associates** — Our colleagues at Burns & Associates, led by principal consultant Mark Podrazik, will help address the needs of Vermont's Medicaid program. Burns' knowledge of the Medicaid data and successful track record meeting DVHA needs in the past will ensure a seamless transition under this agreement.
- **Compass Health Analytics** — Compass Health Analytics' team will be led by its president, Jim Highland, who brings the quantitative skills required to accomplish BISHCA's rate-setting deliverables. Compass brings many years of experience in assisting state insurance departments across the country address their needs for robust actuarial and financial analysis.

Our assembled team stands apart from other potential analytic vendors in several important respects, including Onpoint's unmatched knowledge of the VHCURES data set. As the current claims data aggregator for BISHCA, Onpoint has a deep and fundamental understanding of the primary data source, its inherent strengths, and its limitations. Other key advantages include extensive market knowledge, proven results, and the service excellence the State has come to expect. Each major deliverable under the project will be well managed and carefully executed with the following commitments:

- **A collaborative approach** — BISHCA and DVHA staff will be integral to the project team and involved in up-front and ongoing communications about both the project as a whole and individual deliverables. We will schedule project kickoffs with both BISHCA and DVHA teams in January 2011, implementing twice-monthly project status calls to review and ensure steady progress.
- **Clarity in roles, scope of work, cost, and timeline** — Onpoint's project lead will be responsible for ensuring that the State's expectations are met, including the critical, initial step of scope development and approval (often formalized in the form of a report description or concept paper). Staff and other resource requirements will be assessed, project timelines and budgets will be confirmed, and attention will be given to regular project updates.
- **Regular communications** — Beyond project kickoff meetings and regular twice-monthly project status calls, Onpoint will follow up regularly with BISHCA and DVHA staff to resolve open issues quickly and effectively. Our experience with Vermont has been characterized by timely, responsive communications; this same standard will apply for this proposal's deliverables. Our project lead will review analytic results and interpretations with BISHCA, DVHA, and other Vermont staff, making necessary modifications before final distribution.
- **Committed resources** — Onpoint's team has the experience to hit the ground running. With more than two years' experience in the development and use of VHCURES, our team has specific experience and valuable insight regarding the deliverables outlined in the RFP. In our state-level work, we have delivered reporting and analysis of member demographics, health status, quality of care, utilization, and cost. We have supported health reform initiatives and other needs that require population-based, episode-based, and provider- and procedure-specific reporting capabilities.
- **Reliable results** — Onpoint recognizes the fundamental importance of data reliability. We are committed to ensuring the quality of the underlying data and its preparation to support analytics as we are to the follow-on analysis and reporting. Our role as Vermont's data aggregator gives us unique insights into the data's integrity. Onpoint's own Health Services Research staff are internal customers

of Vermont’s database and, in that role, are able to put the data through its paces. They provide invaluable feedback on process improvements and identify enhancements to core data processing systems.

- **Responsive service** — As BISHCA’s primary analytic partner for the past two years, we have developed the relationships, market knowledge, and track record of responsive service that create a foundation for success in an expanded role.

Onpoint will work with BISHCA and DVHA to ensure that reporting is well documented, transparently developed, and robustly deployed. The research and analytic products delivered to the State will incorporate a variety of value-added tools and groupers, risk-adjusted rates, and confidence intervals, and will employ multivariate statistical methods and matched-control study designs when needed. Onpoint also will incorporate both national and regional data for comparisons by acquiring NCQA Quality Compass and by using claims data from other states (e.g., New Hampshire and Maine). Key dimensions of available Onpoint reporting are identified in [Table 1](#).

**Table 1.** Onpoint Report Stratification and Measurement Capabilities for VHCURES

METRIC	POPULATION-BASED	EPISODE-BASED	PROVIDER & PROCEDURE SPECIFIC
<b>Member Stratification</b>			
Demographics (e.g., age, gender)	✓	✓	
Location of residence (HSA)	✓	✓	
Health status - disease specific (e.g., diabetes)	✓	✓	
Health status score (episode risk group score)	✓	✓	
Insurer (e.g., BCBS, CIGNA)	✓	✓	
Product (e.g., indemnity, PPO, POS, HMO)	✓	✓	
Medicaid Category (dual, low-income, disabled)	✓	✓	
Blueprint Participant	✓	✓	
Provider attribution (primary care practice)	✓	✓	
Provider attribution (hospital/specialist)	✓	✓	
<b>Provider Stratification</b>			
Location (HSA and out-of-state)	✓	✓	
Type (hospital, primary care, specialist, RX)	✓	✓	
MPI (primary care practice, hospital, specialist)			✓
<b>Claim Measurement and Classification</b>			
Inpatient care (MSDRG, APR-DRG)	✓	✓	✓
Outpatient hospital services (APG, APC)	✓	✓	✓
Professional services (BETOS*)	✓	✓	✓
Professional services (physician and other specialty)	✓	✓	✓
Pharmacy (Red Book*)	✓	✓	✓

METRIC	POPULATION-BASED	EPISODE-BASED	PROVIDER & PROCEDURE SPECIFIC
Non-medical services unique to Medicaid	✓	✓	✓
Relative Value Unit composite utilization measure	✓	✓	✓
HEDIS effective care measures	✓		✓
HEDIS access and preventive visit measures	✓		✓
HEDIS use of services measures	✓	✓	✓
AHRQ Quality Indicators (PQI, IQI, PSI, PDI)	✓	✓	✓
Cost (plan and member)	✓	✓	✓
Cost (standardized)	✓	✓	✓

\* Berenson-Eggers Type of Service (BETOS) is a classification of CPT and HCPCS coding publically available from CMS.

**5.1.2.** A description of how the work will be accomplished. Simple statements that a task will be completed or a reiteration of the RFP will not be considered adequate responses for this technical bid section. Using Exhibits A and B as a guides, the bidder must describe in specific detail how it will fulfill responsibilities related to every specified deliverable in the exhibits. The work anticipated to fulfill the requirements outlined in Exhibits A and B should be described separately. (RFP/p.9)

The following section provides in-depth detail regarding Onpoint’s background and experience in relevant research, analysis, and reporting. This proposal offers separate responses — subsections 5.1.2.A and 5.1.2.B — to the demands and deliverables outlined in the RFP’s exhibits A (for BISHCA) and B (for DVHA), respectively. To ensure a comprehensive response, these two subsections are mapped to the RFP’s exhibits and employ their numbering systems (in green) for facilitated look-up.

### 5.1.2.A. BISHCA Deliverables (Exhibit A)

#### STANDARD ANALYTICAL & REPORTING SERIES

**EXHIBIT A: 3.1.1.** Contractor shall consult with the State and provide an Annual Expenditure & Utilization Report for the commercially insured population for comprehensive major medical insurance and benefit plans. Contractor shall consult with State regarding incremental report improvements based on prior reports published by the State per the following Internet [link](#). Contractor shall consult with the State to keep the reporting categories in close alignment with the [Vermont Annual Health Care Expenditure Analysis and Forecast](#). In the annual reports, Contractor shall trend the data from base years identified by the State and from the prior year. Contractor shall include an executive summary in each annual report that identifies major findings in narrative and graphical formats. Contractor shall organize the annual reports by Hospital Service Area (HSA), by insurer, and by HSA for each major insurer as identified by the State. In addition to the annual reports, Contractor shall provide the State raw data files used to generate the Expenditure & Utilization reports in a format specified by the State. Contractor shall provide the annual reports based on consolidated annual data for incurred claim period of January 1 through December 31 and run-out through March 31 no later than August 31 starting in 2011. (RFP/p.18)

Onpoint has a long history of working with clients to create customized reports that meet specific needs. This strength already has been applied in Vermont. During 2009, Onpoint worked extensively with BISHCA and Blueprint to develop the Health Utilization and Expenditure Report (HUER). This report was designed to meet the needs of BISHCA reporting categories and the Blueprint medical home financial business model reporting categories. Onpoint presently is refining the HUER to separate psychotherapeutic medications.

Onpoint will review existing reports with BISHCA and DVHA to ensure that Vermont’s needs are met and will work collaboratively to identify areas for improvement in reporting. Onpoint has enhanced its reporting to incorporate a multiyear trend (2008–2010) for the August 2011 delivery date. Current report measures (columns) are used to determine utilization and cost rates. For trend reporting, Onpoint will add average paid per service for each category to distinguish whether changes in utilization or in unit price are driving cost increases.

Onpoint currently outputs its reporting in Microsoft Excel format for further use and manipulation. Summary report results tabulated by year, health service area (HAS), major payer, and utilization and expenditure category will continue to be output to Excel or in another format as requested by BISHCA.

Two other examples of areas where Onpoint envisions possible reporting enhancements:

- **Enhancements to Blueprint reporting** — Initial Blueprint reporting indicated that Blueprint-flagged members were significantly older than non-Blueprint members. Further stratification of the data between children and adults or by other age groupings may be useful to BISHCA.
- **Reporting on Medicaid and Medicare in addition to the commercial payers** — Since Medicaid covers and pays for services that typically are not considered medical services and since these services represent a significant proportion of Medicaid payments, reporting on Medicaid and Medicare in addition to the commercial payers likely would provide a great array of additional information for comparison. Handling of dual Medicaid-Medicare eligibles could be evaluated, and stratification of reporting by eligibility groupings (e.g., low income, disabled) also may be recommended.

For these reports, Onpoint will construct a brief executive summary, identifying key drivers of trend as well as sources of variation in utilization rates, unit price, and cost per member per month. Key results will be displayed graphically using trend charts and maps as needed. Onpoint's standard process will allow for review of the draft executive summary by BISHCA before finalization.

**EXHIBIT A: 3.1.2.** Contractor shall consult with the State and provide an annual Healthcare Report Card for the commercially insured population for comprehensive major medical insurance and benefit plans. Contractor shall consult with State regarding incremental report improvements based on the report published by the State per the following Internet [link](#). In the annual reports, Contractor shall trend the data from base years identified by the State and from the prior year. Contractor shall include an executive summary in each annual report that identifies major findings in narrative and graphical formats. Contractor shall organize the annual reports by Hospital Service Area (HSA), by insurer, and by HSA for each major insurer as identified by the State. In addition to the annual reports, Contractor shall provide the State raw data files of measures used to generate the Healthcare Utilization Report Card in a format specified by the State. Contractor shall provide the annual reports based on consolidated annual data for incurred claim period of January 1 through December 31 and run-out through March 31 no later than August 31 starting in 2011. (RFP/p.18)

Onpoint has developed and will produce the specified report (i.e., Report Card, Version 3) for BISHCA for the first time in October 2010 (using 2007–2009 data). The report is designed for a three-year trend, and Onpoint will allow for data capture to evaluate a four-year trend (2007–2010) by October 2011.

As previously noted, Onpoint has a long history of working with clients to create customized reports that meet their specific needs. We will review and consider BISHCA and DVHA/Blueprint input to modify and enhance the report, generating an enhanced Report Card (Version 4) for October 2011. Modifications also may derive from input and feedback from our clients in other states.

Onpoint will output report summary data tabulated by year, HSA, major payer, and Report Card measure to Excel (or other desired format) for further use by BISHCA. This output will include 95 percent confidence intervals for selected utilization and National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) sections. As described in the prior section, Onpoint also will consider reporting Medicaid and Medicare in addition to the commercial payers, additionally enhancing the report.

Onpoint will construct a brief executive summary, identifying key findings from analysis of the Report Card. This will include evaluation of health status, prevalence of disease, utilization, payments, effectiveness of care

(HEDIS), and episodes of care. Trends and variation will be evaluated, key results will be displayed graphically, and maps will be included as needed. Onpoint's standard process will allow for review of the draft executive summary by BISHCA before finalization.

**EXHIBIT A: 3.1.3.** To support the State's need for paid claims and enrollment reports for the [Health Information Technology Fund Surcharge Program](#), Contractor shall provide a paid claims report for comprehensive major medical coverage payer including health insurers, TPAs, and PBMs on a fiscal year incurred claims basis of July 1 through June 30 with run-out through September 15 or for an alternative period as identified by the State by October 1 on an annual basis starting in 2011. For the same fiscal year basis, Contractor shall provide an average enrollment report for Medicare Supplement insurance by company by October 1 on an annual basis starting in 2011. Contractor shall refresh the annual reports provided October 1 by every following March 1 for the same incurred claims period starting in 2012. Contractor shall consult with the State regarding incremental report improvements based on prior reports published by the State per the following Internet [link](#). (RFP/p.18)

Onpoint currently provides the Health Information Technology Fund report in Excel format to BISHCA. Onpoint will provide this report on an annual basis beginning October 1, 2011, with refreshes by each following March 1 beginning in 2012. In addition, Onpoint will continue to provide this report quarterly after each data consolidation refresh to assist BISHCA with evaluation of the consolidated data.

**EXHIBIT A: 3.1.4.** Contractor shall provide the State with an annual Medicare Products Summary Report that includes Medicare Supplement insurance (Enrollment only), Medicare Part C (Enrollment and claims), and Medicare Part D (Enrollment and pharmacy claims) at the company level for summary reporting of enrollment and paid claims amount. For Medicare Part D, Contractor shall provide an enrollment report by HSA and grouping of statewide pharmacy claims by drug classes with metrics for utilization and expenditures. Contractor shall work with the State to develop the specifics for the Medicare Part D utilization and expenditure report. Contractor shall provide the annual reports based on consolidated annual data for incurred claim period of January 1 through December 31 and run-out through March 31 no later than August 31 starting in 2011. (RFP/p.19)

Onpoint currently provides BISHCA with the Medicare Products Summary Report, which is tabulated by age and by pharmacy therapeutic categories. Results are output in Excel format.

Onpoint customizes reports to meet client needs and will work with BISHCA to develop the Medicare Part D utilization and expenditure report. Onpoint uses Red Book® as a source of pharmacy claims classification. Depending on BISHCA's goals, one solution may be to modify the existing Onpoint Medicare report. Onpoint will provide Medicare Part D enrollment report by HSA.

## HEALTH INSURANCE RATE REVIEW

**EXHIBIT A: 4.1.1.** Between January and June 2011, Contractor shall consult with the State and its actuarial consultant to customize VHCURES reporting to support rate review. Contractor shall compare the VHCURES categorization applied to the Annual Expenditure & Utilization Report and the Healthcare Utilization Report Card as referred to in sections 3.1.1 and 3.1.2 above to the categorizations of enrollment/demographics, utilization and expenditures used by the State's actuaries. Contractor shall also identify an inventory of insurance product types reported to VHCURES, evaluate the categorizations in relationship to the insurance rate review process, and identify the categories that would be most applicable to the rate review process. By July 31, 2011, Contractor shall provide a report comparing current VHCURES categorizations for enrollment/demographics, utilization, expenditures, and insurance products types and recommend an approach and content for reports to enhance the rate review process. (RFP/p.19)

Onpoint and Compass Health Analytics look forward to working with BISHCA to enhance the health insurance rate review process. The Onpoint/Compass team is familiar with rate review processes and the reporting described in the RFP. Compass actuaries consult with BISHCA, the Maine Bureau of Insurance, the Massachusetts Division of Health Care Finance, and other agencies on rate review and rate-related actuarial issues. Our team's experience includes production and analysis of claim lag triangle reports, determination of completion factors, development of claim trends, and production of reporting containing historical and projected incurred claim levels. Compass has extensive experience designing and building data warehouses for actuarial analysis, and Onpoint has generated reports for actuarial use on other projects. Our team is well prepared to engage in efficient and productive discussions with BISHCA and their actuarial consultants. Onpoint already is familiar with the issues related to provider identification and carve-outs in Vermont identified in this section.

Onpoint/Compass propose two conference calls in January/February 2011 to review the current incurred reports described in 3.1.1 and 3.1.2 and discuss insurer product types. During March/April 2011, Onpoint will draft modifications to reports as needed and develop the inventory of product types reported to VHCURES. Compass Health Analytics will be involved in all discussions about proposed enhancements.

Onpoint notes that current reporting of product types in VHCURES claims does not distinguish high-deductible health plans (HDHPs). As part of the inventory of insurance product types, Onpoint proposes the tracking and noting of limitations in current VHCURES product type claims coding with consequent recommendations to BISHCA for enhancements.

**EXHIBIT A: 4.1.2.** Starting in July 2011 and continuing through December 2011, Contractor shall develop and provide trend reports on incurred and paid claims bases for enrollment/demographics, utilization, and expenditures for the State based on the approach approved by the State per section 4.1.1 above. Contractor shall provide the report by insurer and by insurance product types as defined in the VHCURES data set for selected insurers as directed by the state. Contractor shall provide technical assistance to the State in interpretation and use of the reports. (RFP/p.19)

Onpoint presently is generating reports by insurer and will add product type stratification to these reports as well as any modifications identified under 4.1.1. Identification of HDHP products currently is unavailable in the VHCURES data.

The RFP and State responses to bidders' questions leave unclear the meaning of "incurred and paid claims bases." While Onpoint has the capability to generate claims triangulation reports and Compass Health Analytics can provide estimates of costs incurred but not reported (IBNR), our assumptions are that estimated costs, including IBNR, are not required.

**EXHIBIT A: 4.1.3.** Between January and June 2011, Contractor shall consult with the State to develop an inventory of insurer carve-out relationships, identify how carve-out data is submitted and consolidated in VHCURES, and determine the contents and approach to generating VHCURES reports that reflect consolidation of carve-out relationships based on members and/or insurers. By July 31, 2011, Contractor shall provide a report addressing the components including the inventory of carve-out relationships, VHCURES data submission and processing issues; and recommendations for the content and approach for VHCURES carve-out reporting. (RFP/p.20)

Onpoint is familiar with major carve-outs in the Vermont data and will develop the inventory by June 2011. The inventory may include:

- Types of carve-out (e.g., behavioral health, pharmacy)
- Carve-out (e.g., CIGNA Behavioral, Express Scripts)
- Medical insurer(s) related to the carve-out (e.g., Connecticut General, Aetna)
- Medical insurer(s) product type related to the carve-out
- Medical insurer(s) group number related to the carve-out
- Dates (year/month) of relationship start/end
- Whether the carve-out provides Social Security numbers to create encrypted IDs
- Whether the medical insurer(s) provides Social Security numbers to create encrypted IDs
- Whether the carve-out can be linked to medical insurer(s) using other fields

The Onpoint/Compass team will review with BISHCA the level of detail required in the carve-out inventory. For example, tracking carve-out relationships at the group number level may be useful but beyond the scope of need for BISHCA. Completion of the inventory likely will require direct contact with insurers and carve-outs. The Onpoint/Compass team will provide recommendations in a report by July 31, 2011.

Carve-outs are considered in the rates and are provided separately by the carrier as an additional piece of information on the cost to them to pay their vendor. If the APCD does not require these claims to be submitted, then this would be an unsupported part of the APCD's rating process. If the claims are in the database, then they should be identified and tied to their correct carrier/product. An inventory of carve-outs would help BISHCA make sure they are getting all of the cost data from the carriers.

Onpoint notes that if both the medical insurer and the carve-out insurer are using Social Security numbers as input to encrypted IDs, then the cross-walking of carve-out in reporting can be achieved. If Social Security numbers are not provided, linkage methods (e.g., date of birth, age, gender, ZIP code) may be employed.

**EXHIBIT A: 4.1.4.** Starting in July 2011 and continuing through December 2011, Contractor shall develop and provide periodic consolidated enrollment/demographics, expenditures, and utilization reports for carve-out relationships as directed by the State. (RFP/p.20)

Onpoint and Compass Health Analytics will review with BISHCA the carve-out relationships and develop a data reporting solution. This may include cross-walk of membership IDs between medical and carve-out insurers.

**EXHIBIT A: 4.1.5.** Between January and June 2011, Contractor shall consult with the State regarding applications and improvements to the VHCURES Master Provider Index to support provider level reporting of expenditures and utilization for the insurance rate review process. Contractor shall identify approaches, methods, and issues related to provider-level reporting to identify cost drivers and enhance the rate review process. Contractor shall address provider-level reporting by insurer. By July 31, 2011, Contractor shall provide a report addressing the current status of the MPI including any shortcomings and areas for improvement and recommend approaches, methods and content for provider-level reporting of expenditures and utilization. (RFP/p.20)

Starting with a January 2011 kickoff meeting, Onpoint will review with BISHCA, DVHA, and other interested Vermont agencies, the goals of the report required by July 2011. The scope of provider-level reporting will be defined to help set priorities for Master Provider Index (MPI) improvement. For example, the following categories of providers could be prioritized in the following order:

1. In-state hospital
2. Neighboring state hospital
3. In-state primary care practices and individual primary care physicians
4. Neighboring state primary care practices and individual physicians
5. In-state physician specialist care practices and individual physicians
6. Neighboring state physician specialist practices and individual physicians
7. In-state non-physician providers and other facility providers
8. Neighboring state non-physician providers and other facility providers

Onpoint will review with BISHCA the potential sources, independent of claims and licensure files, that will identify specific physician providers associated with larger group primary care or specialty practices. Onpoint has collected information of this type for primary care practice reporting in other states. Due to limitations in the servicing provider identification in claims data, claims data currently do not fully support individual doctor reporting and instead must roll up to the practice level. Overcoming this limitation is critical to successful physician provider reporting.

Examples of measures used to evaluate needs for improvement in servicing provider information will include:

- The percentage of claims that are not assigned to an MPI
- The percentage of professional claims with CPT or other procedure codes specific to the specialty that are not assigned to the correct specialty
- The percentage of physician office visit (E&M codes) assigned to a hospital MPI
- The percentage of professional claims that can be assigned to individual physicians instead of group practices

Onpoint's previous MPI work has demonstrated that while 90 percent of members can be assigned to a single practice, only 50 percent can be assigned to a single provider. This underscores the need for provider-to-practice assignment in addition to accurate MPI assignment.

**EXHIBIT A: 4.1.6.** Starting in July 2011 and continuing through December 2011, Contractor shall develop and provide periodic provider-level reporting on expenditures and utilization by insurer as requested by the State on an ad hoc basis. (RFP/p.20)

Onpoint has a breadth of experience in provider-level reporting. We provide reporting on the utilization of specific services at a hospital level, and analyze hospital payments adjusted for service mix using inpatient and outpatient claims data. To accomplish this, Onpoint uses diagnosis-related groups (DRGs) for inpatient and Ambulatory Payment Classification groups (APCs) and Ambulatory Patient Groups (APGs) for outpatient hospital service assignment.

Onpoint also has worked on a variety of projects reporting physician practices, conducting projects and analytics for and about physicians, other provider specialties, physician-hospital organization (PHOs), and associations. Examples include gastroenterology, chiropractic, orthopedics, primary care practice groups, and the Maine Primary Care Association.

In response to BISHCA's anticipated needs for provider-level reporting, Onpoint will work with BISHCA to determine the scope of reporting, including any overlap with other DVHA needs, and will prepare a proposal and cost estimate for each ad hoc report.

## SPECIAL STUDIES & AD HOC REPORTING

**EXHIBIT A: 5.1.** The State anticipates at least one special study per year requiring background research and literature review, data analyses including application of statistical methods for adjusting and reporting data, and generation of a narrative report that includes background information and presentation of the purpose of the study and/or research hypothesis; executive summary of major findings and next steps; research findings presented in narrative, tabular, and graphic formats; reference citations and bibliography. For a sample of such a report, refer to the “Tri-State Variation in Health Services Utilization & Expenditures in Northern New England” posted by the State at [[this link](#)]. (RFP/p.20)

Onpoint has developed special customized studies and ad hoc reports from claims and other health clinical and administrative data sets for more than 30 years. Onpoint has a dedicated staff of health researchers, analysts, and programmers familiar with the claims data and experienced in special studies and ad hoc reports. While Onpoint anticipates that in-house staff can sufficiently handle most ad hoc requests, Compass Health Analytics may be used as a consultant depending on the request’s topic.

Onpoint will work with BISHCA to define the scope of desired special studies. We anticipate an iterative process in which a concept paper will be developed to define the specific questions to be addressed in the study as well as the scope of the reporting and analysis. The development of a concept paper will ensure that the study questions and methods are well defined and that the results will meet BISHCA’s analytic needs. Depending on the nature of the special study, results may be applicable to BISHCA’s needs alone. However, the RFP suggests the possibility of some overlap in the interests and needs of BISHCA, DVHA, and other agencies.

Onpoint developed the RFP’s described tri-state variation report in response to the requirements of Vermont’s Act 49, “An Act Relating to Containing Health Care Costs by Decreasing Variability in Health Care Spending & Utilization.” Onpoint generates special studies and annual reports for other clients on a regular basis. For example, nine special studies are developed annually for the New Hampshire Department of Health and Human Services. Onpoint also has developed reports and analyses for the Maine Bureau of Insurance concerning mandated benefits (e.g., maternity length of stay, mental health, chiropractic care).

Our Health Services Research team has intimate knowledge of data collected in Vermont and other states, giving us valuable insight into the data’s limitations for analyses. Our researchers also benefit from working closely with the programmers who process the data and can provide key input regarding the various statistical methods and tools (e.g., SAS, ArcGIS) used to create these reports.

**EXHIBIT A: 5.2.** The State anticipates requests for ad hoc reports on health care utilization and expenditures related to selected health care services on any combination of population characteristics, insurer, provider or facility type bases. Contractor shall provide tables, graphs, and explanation of technical methods and specifications in electronic formats and applications as requested by the State. (RFP/p.21)

Onpoint has a long history of creating customized reports on an ad hoc basis, maintaining a core research and analytic and programming staff to complete such requests. Onpoint will identify any data limitations that will impact BISHCA’s ad hoc requests and will clarify the needs and scope of provider reporting. For example, we are assuming that provider reporting initially means provider types (instead of specific providers) and will

review with BISHCA a phased approach to provider-specific reporting beginning with hospitals in Year 1. Further consultation with BISHCA will clarify the need for reporting by specific primary care practice or specialists in Year 2.

The volume of ad hoc reports is not specified in the RFP. Onpoint will plan staff availability to respond to two ad hoc reports per year during Year 1 of the contract. BISHCA has requested development of in-house reporting capacity in [Section 6.1](#), which may reduce or replace the need for ad hoc reporting by the contractor by Year 2.

**EXHIBIT A: 5.3.** For every special study and ad hoc report requested by the State, Contractor shall provide a detailed proposal including time line and cost itemized by hourly rates. Contractor shall obtain written approval by the State before beginning any work. ([RFP/p.21](#))

We estimate that about half of all ad hoc requests can be anticipated and responded to through the development of a pre-summarized reporting tool such as a business intelligence (BI) tool. Onpoint's ad hoc reporting will be built around the same capabilities as those described in [Table 1](#) and [Section 5.1.2](#) of this proposal. Specifics will be determined after review with BISHCA.

## DEVELOPMENT & SUPPORT OF IN-HOUSE REPORTING CAPABILITY

**EXHIBIT A: 6.1.** Contractor shall consult with the State to identify anticipated needs for in-house reporting capability. By April 2011, Contractor shall provide a report that includes a phased plan and recommendations and requirements for staffing, initial and ongoing training by the Contractor and other consultants, customized business intelligence tools, hardware and software licenses, secure data transfer and storage, and other resources. (RFP/p.21)

Onpoint will schedule one on-site visit and two conference call meetings in January/February 2011 to review and discuss BISHCA's needs for in-house reporting. By the end of March 2011, Onpoint will provide a draft phased plan for review, which will be finalized in April 2011.

**EXHIBIT A: 6.2.** As directed by the State, Contractor shall provide consulting services and training to assigned State staff to support incremental development of in-house VHCURES reporting capability. Consulting services may include training in understanding and use of claims data and the VHCURES data set to support basic queries and custom reporting; advising on hardware and software acquisition to accommodate the size of the data set, anticipated processing time; and analytical needs; advising on security procedures; providing technical assistance to State staff in generating specific reports; and reviewing and validating reports generated by State staff. Consultant shall provide customized business intelligence tools as requested by the State to support efficient in-house use of the VHCURES data set and generation of usable reports in tabular and graphical formats. (RFP/p.21)

Onpoint will provide in-house reporting consulting services through a series of coordinated initiatives with BISHCA and DVHA. Each initiative will be scoped out and approved by the State prior to start. Consulting services could include, but are not limited to:

- The development of training materials to understand and interpret Vermont claims data (eligibility, medical, and pharmacy) from the VHCURES data set, including definitions, data dimensions, periodicity, data quality and limitations, current reports, measures (e.g., demographics, health status and prevalence, episode grouping (ETG), HEDIS effectiveness of care, utilization, payment measures)
- The design, scheduling, and administering of direct and/or online training regarding the use of VHCURES data
- All phases of business intelligence (BI) tool development, including specifications/use cases, data dimension and granularity identification, database design, data ETL (extraction, transform, and load) and aggregation, user interface and report design, and data quality assurance
- Technical assistance for deployment of an in-house business intelligence (BI) reporting tool that includes server hardware, database management system, data access, security, and performance metrics
- Ongoing support of an in-house BI tool, including end-user and technical training, database and reporting enhancements, and report validation

Onpoint's current BI tool platform and experience is with SAP Business Objects Edge using an Oracle 10i database.

### 5.1.2.B. DVHA Deliverables (Exhibit B)

Onpoint proposes to generate three customized studies each year to meet the needs of DVHA and other agencies. This may include a Medicaid study (due in April), a Blueprint evaluation (due in August), and other agency study (due in December). DVHA has requested ad hoc reporting option; depending on DVHA's needs, two smaller ad hoc reports may be substituted for one of the customized studies.

Onpoint and subcontractors will work collaboratively with DVHA and other state agencies to develop customized studies and reports to meet their current and future needs. Onpoint has deep experience in other states with similar needs and we understand three critical aspects of this work:

1. Health reform and new models of delivery of care and payment are actively evolving and require new levels of population-based analytics built on top of all payer claims databases to assess quality, utilization, cost, and opportunities for improvement. Opportunities for improvement will inform payment models, and payment incentives for quality and efficiency may be structured differently, requiring models to predict potential incentive impacts at different levels of response. The value of reducing and shifting utilization patterns can be estimated.
2. Analytic partners must work collaboratively with State agencies. Onpoint's model for customized studies in other states has been to collaborate with such agencies to ascertain their needs, develop a concept paper outlining study scope, and review and edit final study reports. Our studies are collaborative products. We also understand that there is potential for overlap in studies and reporting needs for DVHA, Blueprint, BISHCA, and other agencies. Although the BISHCA contract is separated in the proposal, Onpoint believes that both projects will benefit through ongoing collaboration in the planning of custom studies and reports.
3. Onpoint understands that DVHA is looking for more than reports and simple analytics, seeking in addition expert analysis and consulting in the planning, interpretation, analytic methods, and uses of the information. To ensure that this capability is available, Onpoint is working with subcontractors Burns & Associates and Compass Health Analytics, providing key expertise in Medicaid deliverables and health insurance rate review, respectively. Our subcontractors roles are detailed further in sections 5.1.5 and 5.2.4.

## CUSTOM MEDICAID STUDIES

**EXHIBIT B:** The contractor will be responsible for providing reports as requested by the Vermont Department of Vermont Health Access and other departments within the Agency of Human Services as agreed upon between the parties. Examples of possible reports include Custom Medicaid studies, for purposes such as: (1) Providing information about the varying cost of procedures in different medical facilities or across provider types; (2) Exploring the value equation (cost and quality) for services provided; (3) Inform the design and evaluation plan of payment reform models including the medical home model and accountable care organizations; (4) Evaluating the effect of health reforms on the cost, quality, and access to care in a state; (5) Comparing the prevalence of disease across a population; (6) Comparing utilization patterns to identify successful cost containment strategies; (7) Estimate the cost of potential legislative changes affecting Medicaid and later calculating the actual cost and impact of the legislation. (RFP/p.30)

Onpoint staff have more than 20 years' experience with Medicaid studies and reporting, including both Medicaid fee-for-service and Medicaid managed care systems. Onpoint has conducted more than 25 customized studies for MaineCare and New Hampshire Medicaid. Using Medicaid and commercial claims data, Onpoint has developed a standardized online reporting system as well as rate-setting reports for New Hampshire Medicaid.

For their part, Burns & Associates' employs a flexible approach to analytic studies based on the nature of the evaluation. Some may be more analytic in nature (e.g., measuring the fiscal impact of a policy change), while others may be evaluations that are qualitative in nature but may be broad-based and have a quantitative component (e.g., conducting a survey). Still others are qualitative in nature, extremely in-depth, and use a small sample (e.g., a case file review).

Each of these evaluation types is very distinct and would require a work plan specific to the task requested. Our team will complete work plans as projects are assigned to us by DVHA. Anticipated tasks for conducting each of these types of evaluations for DVHA may include:

### ANTICIPATED TASKS — FISCAL IMPACT ANALYSIS

1. Identify what the question(s) is that needs to be answered.
2. Develop a methodology for conducting the analysis.
3. Write up the methodology and obtain agreement from all project participants.
4. Identify any limitations in the project (e.g., availability or reliability of data) at the outset.
5. Identify all data sources required to conduct the analysis.
6. Complete an initial validity test on the data received from each source.
7. Obtain new or refreshed data, as needed, based on the findings from the validity testing.
8. Conduct a second validity test on new data received.
9. Reconvene project participants to either confirm or refute any limitations identified at the outset. Revise the methodology as needed.
10. Conduct the fiscal analysis as prescribed by the methodology.
11. Report findings in the manner agreed upon with the project participants.

## ANTICIPATED TASKS — BROAD-BASED EVALUATION

1. Identify the question(s) to be answered or the policy to be validated.
2. Identify the unit of measurement (e.g., in surveys, satisfaction ratings; in access studies, percentage of members within x miles of a provider) and any external benchmarks.
3. Write the data request to gather secondary data to use in the evaluation.
4. Stratify the data received across cohorts for sampling.
5. Review the data stratified with the client to discuss the sampling methodology.
6. Draw the sample to be used in the study.
7. Conduct primary research (e.g., administer the survey, conduct GeoAccess studies).
8. Tabulate primary research results.
9. Identify aberrant data to exclude.
10. Compile findings.
11. Summarize results in a format specified by the client.
12. Answer the question posed or report on the policy to be evaluated. Provide analysis or documentation to substantiate the answer.

## ANTICIPATED TASKS — SMALL SAMPLE EVALUATION

1. Identify the question(s) to be answered or the policy to be validated.
2. Identify any background research that may be helpful in developing a review tool (e.g., In the study of case management or care plan files, what are best practices used in other states?).
3. Identify any external benchmarks that the study sample can be compared against (e.g., In the study of prior authorization policies and procedures, what are the standard denial rates for authorizations by service in Medicaid managed care plans nationally?).
4. Write the data request to gather secondary data to use in the evaluation. Depending upon where the secondary data is being obtained, an overview of the study may also be appropriate to solicit compliance from the source who is providing the data.
5. Stratify the data received across cohorts for sampling.
6. Review the data stratified with the client to discuss the sampling methodology.
7. Draw the sample to be used in the study.
8. Develop a tool for conducting the case file review.
9. Conduct the case studies and complete a tool for each study sample.
10. Tabulate primary research results.

11. Identify aberrant data to exclude.
12. Compile findings.
13. Summarize results in a format specified by the client.
14. Answer the question posed or report on the policy to be evaluated. Provide analysis or documentation to substantiate the answer.

The following numbered sections address the specific bullets identified in the “Custom Medicaid Studies” section as possible DVHA deliverables in Exhibit B:

**1. CUSTOM MEDICAID REPORT POSSIBILITY: PROVIDING INFORMATION ON COST OF PROCEDURES IN DIFFERENT MEDICAL FACILITIES & ACROSS PROVIDER TYPES**

Onpoint has been comparing providers on cost and procedures for more than 30 years, dating back to our first reporting from hospital discharge data. We use claims data to compare the cost of inpatient and outpatient hospital care for specific hospitals, often reporting to hospitals at the inpatient DRG, 3M™ All Patient Refined DRG (APR-DRG), and outpatient APC and APG levels. We also prepare case-mix-adjusted analyses of cost differences between hospitals. Prior analyses have incorporated hospital size as well as the mix of Medicare, Medicaid, commercial, and uninsured populations. Onpoint has used claims data to compare the payments made by Medicaid to payments made by commercial insurers.

One option that may be considered for analysis is the comparison of utilization and cost for the same or similar services within different placement settings. For example, radiology procedures could be delivered and billed in a physician’s office, a radiology center, and an outpatient hospital setting. Understanding how often and where these services are delivered may suggest to DVHA which payment options could achieve the highest cost-effectiveness. For example, the Medicare Resource Based Relative Value Scale (RBRVS) pays for radiology at the lesser of the Medicare RBRVS rate or the Medicare Outpatient Prospective Payment System (OPPS) rate. DVHA may choose to employ this pricing methodology regardless of whether the service is billed in a hospital outpatient setting or in an office setting.

Onpoint will review with DVHA its interest and needs in this area. Onpoint recommends consideration of possible overlap with BISHCA’s needs and interests in procedure and specific provider types. DVHA will participate in the review of methods and tools selected for reporting. This may include use of an online reporting tool to allow for public or credentialed user access to procedure- and provider-specific data.

Onpoint will review with DVHA a phased approach to provider-specific reporting for hospitals, primary care practices, and specialists.

## 2. CUSTOM MEDICAID REPORT POSSIBILITY: EXPLORING THE VALUE EQUATION (COST & QUALITY) FOR SERVICES PROVIDED

Onpoint has developed methods for reporting and evaluating both cost and quality. We use claims data and clinical practice data for these purposes.

**Cost:** We typically use two methods to measure costs from claims data: (1) claims payment (plan plus member cost share) and (2) standardized cost. Standardized costs are the more complicated of the two and are derived from the claims data and based on utilization. For outpatient data, cost is standardized using the relative value units (RVUs) based on claims' CPT codes. For services without any CPT-related RVU, the statewide average for that service is used to assign a weight. For inpatient services, DRG weights are used. Using these aggregate weighting systems, standardized costs are derived. Standardized costs have the advantage of minimizing the confounding effects of local hospital cost variances and insurer payment rate differences. Standardized costs are useful for physician practice reporting and may be useful in evaluating differences in geographic areas or between Medicaid and commercial populations.

**Quality:** Onpoint has experience with quality measurement from hospital data, claims data (Medicaid and commercial), and from practice reported clinical measurement systems. To measure quality in hospitals, Onpoint has developed measures through the Refined DRG project and has used the Agency for Healthcare Research and Quality (AHRQ) indicators, which include Prevention Quality Indicators (PQIs), Inpatient Quality Indicators (IQIs), Patient Safety Indicators (PSIs), and Pediatric Safety Indicators (PDIs).

Onpoint also has extensive experience in assessing quality using HEDIS measures. Onpoint reports NCQA HEDIS effectiveness of care, access to care, and preventive visit measures from Medicaid and commercial claims data. A subset of these measures is identified in Onpoint's Report Card referenced in [Section 3.1.2](#). In our work with New Hampshire Medicaid, we have conducted studies to further evaluate HEDIS measures. For example, Onpoint developed a customized study for New Hampshire Medicaid that showed that expanding the one-year window required in HEDIS specifications to 15 months for a well-child visit increased the rate significantly.

Onpoint compares rates in the Medicaid population to national rates and to state commercial rates. We have added to this proposal the acquisition of the NCQA Quality Compass that will ensure national and regional comparative HEDIS rates for Vermont Medicaid.

Collection and analysis of clinical practice data is another key component of measuring quality. Onpoint currently is collecting clinical practice data for a project in Maine and New Hampshire, including measures that cannot be derived through administrative claims data (e.g., HbA1c level, blood pressure, weight). Onpoint's clinical consultant, Dr. Daniel Mingle, provides consultation on the meaningful use (MU) measure implementations and his organization (MSO) is implementing electronic medical records (EMRs) and MU reporting measures in a number of states. He also has provided input to Onpoint in the use of HEDIS and a composite quality care measure in Onpoint's Report Card. Dan will provide similar consultation, as needed, on measurement of clinical data for DVHA.

**Special Populations:** Onpoint believes that the value equation for Medicaid must incorporate consideration of the cost and quality of care as it relates to special populations, such as enrollees with severe mental disorders or physical disabilities. Onpoint has conducted custom studies and special reports on special populations for

MaineCare and New Hampshire Medicaid. In addition, Onpoint's New Hampshire reporting is stratified to distinguish the mentally and physically disabled populations from low-income eligibility groups.

Onpoint Health Data and Burns & Associates will collaborate on such studies for DVHA. This past year, subcontractor Burns & Associates evaluated the impact of medical savings in Vermont's Chronic Care Initiative (VCCI). In this study, the medical costs for participants in the VCCI program were measured against the medical costs of individuals that would have been eligible for the VCCI prior to the baseline year. One limitation of the review was that the VCCI population could not be stratified between those that receive in-person care management in the community and those that receive telephonic disease management. One potential follow-up study would be to analyze the potential medical savings of those receiving in-person care management against the cost to deliver the care management. Further, a qualitative component could be introduced that would measure whether or not the intended outcomes of each beneficiary were met.

3. **CUSTOM MEDICAID REPORT POSSIBILITY: INFORM THE DESIGN & EVALUATION PLAN OF PAYMENT REFORM MODELS INCLUDING THE MEDICAL HOME MODEL & ACCOUNTABLE CARE ORGANIZATIONS.**
4. **CUSTOM MEDICAID REPORT POSSIBILITY: EVALUATING THE EFFECT OF HEALTH REFORMS ON THE COST, QUALITY, & ACCESS TO CARE IN A STATE**

Onpoint understands that payment reform and system redesign are both a significant undertaking and a collaborative learning experience for all involved. At a high level, accountable care is a concept that is difficult to dislike; however, being clear about who is accountable, what they are specifically accountable for, and to whom they are accountable requires additional thought and work. Primary care medical homes are part of the solution since they, like accountable care organizations (ACOs), assume responsibility for the healthcare of patient populations. Two key features are part of this framework: (1) All people in the population attributed to the provider (or provider/delivery systems) need to be included in any analysis of the performance, and (2) all care, regardless of point of care, needs to be included. Onpoint is uniquely positioned as an all payer claims aggregator, analytic, and reporting shop to address and provide insight and details regarding infrastructure and payment reform.

Informing the design and evaluation plan for payment reform and system design requires detailed analysis of system performance, including an examination of whether services were provided, by whom, and at what rate for risk-adjusted populations (see [Table 1](#) for sample dimensions of available Onpoint reporting). Onpoint has the in-house capability and expertise in providing this critical risk-adjusted benchmarking and monitoring of system performance at both the aggregate and detailed service levels for accountable populations. Monitoring detailed cost and utilization by service category, payer, product, population segment, and risk strata against benchmarks can be used to identify successful cost containment strategies and evaluate the impact of payment reforms.

Vermont has taken a leadership position and is progressing rapidly through multiple reform initiatives, including reducing the number of uninsured (Catamount Health), health IT funding and implementation (DocSite), and delivery system reform (Blueprint enhanced medical homes and community care teams). Vermont also is leading in collaborating with other states in the development of multipayer advance primary care practice — a foundation that will increase the probability of success of financial reforms such as those envisioned by ACOs.

Onpoint looks forward to the opportunity to evaluate these innovative initiatives and recognizes that the consultant, reporting, and analytic needs to support these efforts will be ongoing and require adaptation to changing and perhaps unpredictable needs. In Vermont, we anticipate the use of case-control matched studies and other designs in evaluating the impact of health reform changes with incremental rollout by specific geographic area (e.g., Blueprint phased rollout).

Onpoint and our team bring significant capabilities and expertise to the evaluation of these initiatives, including:

- **The capacity to report from claims data by location of residence, location of provider, primary care practice, hospital, and specialist** — These will be key components of any analytic or reporting effort related to payment reform.
- **Reporting on quality** — Onpoint utilizes a variety of measures of utilization, access, and cost. Onpoint also uses HEDIS to measure the effectiveness and quality of care and to present a composite care measure. Many of these key measures are presented in Onpoint's Report Card as identified in [Section 3.1.2](#) (see also [Appendix B-2](#)). This starting set can be enhanced and modified to meet Vermont's reform needs.
- **Reporting on access to care** — The new Patient Protection and Affordable Care Act (PPACA) offers states a number of opportunities both to expand coverage to additional state residents and to offer innovations in the delivery of care. Whatever the State's priorities, our team is ready to assist in evaluating the impact of these significant changes. Some examples of evaluations may include: (a) assessing the accessibility to primary care providers (in terms of both distance and appointment availability) in the advent of additional citizens being covered either through Medicaid or a statewide exchange; (b) the impact, if any, on utilization and cost to treat additional emergency room cases if accessibility is lacking in specific hospital districts; and (c) the utilization patterns and per member per month costs of Medicaid expansion populations or Exchange population versus pre-PPACA Medicaid covered beneficiaries or privately insured health plan members.
- **Episodic reporting** — Onpoint applies Ingenix Episode Treatment Groups® (ETGs) to claims. ETGs can be an important tool in analysis and reporting, assisting in the planning and evaluation of transitional or hybrid models of payment reform. Onpoint has utilized ETGs to make geographic primary care practice and specialist comparisons. Aided by clinical consultant Dr. Daniel Mingle, Onpoint also has developed service-specific profiles of utilization within specific ETGs — a feature not provided in the Ingenix software.
- **Health risk adjustment** — Onpoint also will provide the capability to adjust rates for health status risk using Ingenix Episode Risk Groups® (ERGs), which will be useful in the reporting of geographic or practice variation in utilization and cost.
- **Experience supporting ACO evaluation** — Onpoint already has generated reports that are being used in an effort by Maine State Employee group to develop an ACO with MaineGeneral in the Augusta/Waterville area. Reports have been provided for other geographic areas in anticipation of expanding this initiative.

Onpoint notes that the special populations (e.g., enrollees with severe mental disorders or physical disabilities) and unique services covered by Medicaid (e.g., non-medical institutional costs, case management, special education) will need to be addressed in the State's reporting and analytic needs related to health reform.

The Onpoint team brings the extensive expertise needed to aid in such health reform evaluations. Dr. Michael DeLorenzo will provide key consultation related to ACO development. Michael and Onpoint are working actively with the Maine State Employee group and the Maine Health Management Coalition to develop reporting and analytics in support of ACO development in Maine. Michael also has provided analytic support and development for the payment reform efforts in Louisiana and on Pathways to Excellence physician reporting in Maine. For the latter initiative, a comprehensive provider evaluation tool was developed covering quality of care, utilization, and cost efficiency.

Onpoint's project lead, Karl Finison, has been working on development of the Blueprint medical home evaluation and leads a team of health services researchers whose members were involved in some of the early survey and interviewing for evaluating Vermont's Catamount program and are familiar with key stakeholders. Our clinical consultant, Dr. Mingle, provides the team with clinical support for reporting development and will provide additional consultation on EMRs or MU clinical reporting as needed.

#### **5. CUSTOM MEDICAID REPORT POSSIBILITY: COMPARING THE PREVALENCE OF DISEASE ACROSS A POPULATION**

Onpoint has been using claims data to compare prevalence of disease across populations since 1990. We have integrated this capability into our standard reporting, including the Report Card as well as customized studies. We have conducted such studies on specific conditions for MaineCare and New Hampshire Medicaid as well as for specific employers using commercial claims data. These have included studies of diabetes, cardiovascular disease, respiratory diseases, and mental health disorders. Onpoint also has compared disease rates between Medicaid, SCHIP, and commercial populations.

Different algorithms may be used to determine the prevalence of disease from claims data. Some algorithms make use of pharmacy or multiple visits with diagnoses reported during the year. Onpoint utilizes national HEDIS specifications for claims to define diseases when available. Vermont will be afforded the opportunity to use VHCURES data to compare the results of HEDIS measures related to disease prevalence against Medicare, Medicaid, and commercial populations as well as against national Medicaid and commercial benchmarks published by the National Committee for Quality Assurance (NCQA).

For the Medicaid population, mental health and substance abuse disorders are of particular interest. Onpoint has conducted specific studies on these disorders for MaineCare and New Hampshire Medicaid and has incorporated sections on mental disorders into other studies. Onpoint uses ICD-9 diagnoses from the claims and categorizes mental health and substance abuse disorders according to a classification developed for the Substance Abuse and Mental Health Services Administration by Medstat. Onpoint will review these definitions with DVHA for their approval.

Onpoint also provides a global disease measure using Ingenix ERGs. This measure will be available for Vermont Medicaid reporting as well as in support of health reform initiatives or other reporting needs.

## **6. CUSTOM MEDICAID REPORT POSSIBILITY: COMPARING UTILIZATION PATTERNS TO IDENTIFY SUCCESSFUL COST CONTAINMENT STRATEGIES**

Unnecessary utilization is a primary driver of healthcare costs under a fee-for-service payment system that rewards providers for increased utilization. Onpoint has been generating comparative utilization rate reports from hospital and claims data sources for more than 30 years. Some of the earliest reports formed the basis for the work that became the Dartmouth Atlas of Health Care, which analyzed unwarranted variation in healthcare use throughout the country. Our recent tri-state report identified variation among and within three northern New England states (Vermont, New Hampshire, and Maine) using VHCURES commercial data and claims data from Maine and New Hampshire.

In New Hampshire, Onpoint has compared utilization rates geographically for the Medicaid and commercial populations. By geographic area (HSA), Onpoint has compared the Medicaid population's utilization and cost by setting of primary care (e.g., Dartmouth-Hitchcock clinics, FQHCs, RHCs, and other primary practices). Onpoint believes that the Dartmouth model that partitions care into three categories as effective care, preference-sensitive care, and supply-sensitive care is a useful model when thinking about utilization patterns, unwarranted variation in care delivery, and cost containment strategies.

Project consultant Dr. Michael DeLorenzo will assist with analytic and reporting needs related to this type of study. Dr. DeLorenzo, previously with Health Dialog, has worked on projects with the Dartmouth Institute and is familiar with classification of utilization into the categories of unwarranted variation as well as the use of shared decision-making tools to reduce unnecessary preference-sensitive care.

## **7. CUSTOM MEDICAID REPORT POSSIBILITY: ESTIMATE THE COST OF POTENTIAL LEGISLATIVE CHANGES AFFECTING MEDICAID & LATER CALCULATING THE ACTUAL COST & IMPACT OF THE LEGISLATION**

While Onpoint is an independent organization and does not advocate for specific policy changes, we welcome the opportunity to provide reliable data to inform policymakers and the public alike. Our nonpartisan work includes helping states study their data to estimate the costs and impacts of policy changes. We have a history of responding to ad hoc and legislative requests with timely, customized reporting and have provided this type of information for Medicaid and commercial employers. In addition, our research team has a strong understanding of the power of the data for answering questions regarding Medicaid and its limitations.

In developing cost estimates, Onpoint will utilize Compass Health Analytics as an actuarial consultant when needed to help in the design of reporting, analysis, and evaluation. Both Compass Health Analytics and Burns & Associates already have experience working on this type of project for the State. Most recently, Burns & Associates assisted DVHA in developing scenarios for administering a restored \$20 million increase in inpatient hospital services that was implemented on July 1, 2010.

Burns & Associates also has assisted DVHA in developing analyses to support recommendations in the governor's proposed budget. In the last budget cycle, Burns & Associates analyzed the fiscal impact of limiting specific types of lab tests per member over a defined period of time.

## CUSTOM BLUEPRINT STUDIES

**EXHIBIT B:** The contractor will be responsible for providing reports as requested by the Vermont Department of Vermont Health Access and other departments within the Agency of Human Services as agreed upon between the parties. Examples of possible reports include . . . Custom Blueprint studies, for purposes such as: (1) Evaluating the impact of the Blueprint Multi-insurer Advanced Model of Primary Care Practice (MAPCP) on utilization and healthcare expenditures for patients treated in medical homes as compared to routine care; (2) Evaluating the impact of the MAPCP model on utilization and expenditures in Hospital Services Areas (HSAs) as the model expands statewide; (3) Evaluating the impact of additional payment reforms on utilization and expenditures as they are added to the MAPCP model; (4) Evaluating regional and institutional variability of healthcare quality, utilization, and expenditures as healthcare reforms expand statewide. (RFP/p.30)

During 2009, Onpoint worked extensively with BISHCA and Blueprint to develop the Health Utilization and Expenditure Report (HUER), which was designed to meet the needs of BISHCA reporting categories and the Blueprint medical home financial business model reporting categories. The HUER and other incurred reports, including Onpoint's Report Card, will be run by HSA for both Blueprint participants and nonparticipants. Onpoint proposes to restrict these reports to adults to reflect the initial focus of Blueprint's efforts.

Onpoint is in the process of implementing an evaluation of Blueprint medical home pilots in St. Johnsbury and Burlington using VHCURES commercial claims data. The evaluation will be based on a matched-control study design and will be customized to the needs of the Blueprint program's early initiatives. Onpoint is participating and may incorporate additional measures proposed by Dartmouth researchers evaluating Vermont Blueprint using Medicare data.

Onpoint believes it is ideally suited to incorporate Medicaid into the Blueprint evaluation in light of our experience working with Medicaid claims data in multiple states. Incorporating Medicaid into the evaluation of Blueprint will require careful consideration of the special nonmedical services and costs provided by Medicaid as well as the special populations covered by Medicaid.

The cost of care will be a key component of evaluation. Onpoint has [described above](#) two methods of cost measurement (actual and standardized) that can be used in evaluation. In addition, Onpoint believes institutional (hospital) costs and care delivered outside of the local area may influence cost in the evaluation. This would include care that Vermont residents receive out of state (e.g., in Massachusetts, New Hampshire and New York) and could influence use and cost rates; this influence likely would vary among Vermont HSAs as the Blueprint programmed is phased in statewide.

Although portions of the RFP suggest an interest in practice-level reporting, the document does not specifically call for the evaluation or reporting of Blueprint at the practice-specific level. Onpoint therefore has assumed that practice-specific reporting will not be required when developing this proposals cost estimates. Onpoint assumes that the sources of data for evaluation of Blueprint are the VHCURES claims data with inclusion of Medicaid and possibly Medicare at later dates. Clinical data are being collected by practices in Vermont; under the final rules of meaningful use, Onpoint anticipates that data would be included in any evaluation. Onpoint would be interested in assisting Vermont in the capture and reporting of practice-level clinical data as we currently are doing for a project involving Maine and New Hampshire practices.

Onpoint will utilize consultants Dr. Michael DeLorenzo and Dr. Daniel Mingle for consultation on the Blueprint as needed. Michael has worked on reporting and analytics for the Pathways to Excellence program in Maine. Dan provides clinical consultation to Onpoint in reporting development. Should clinical data and meaningful use measures become a part of the evaluation plan, Dan's experience with EMRs and MU reporting in other states may prove highly valuable.

## SPECIAL REPORTS & STUDIES FOR OTHER AGENCY OF HUMAN SERVICES DEPARTMENTS

**EXHIBIT B:** The contractor will be responsible for providing reports as requested by the Vermont Department of Vermont Health Access and other departments within the Agency of Human Services as agreed upon between the parties. Examples of possible reports include . . . special reports and studies for other Agency of Human Services departments. These departments include Health, Aging and Independent Living, Children and Families, Mental Health, and Corrections. (RFP/p.30)

Onpoint has extensive experience working with a wide array of agencies, such as those mentioned above, in the development of customized studies and reports. In New Hampshire, Onpoint collaborated with the Division of Children, Youth, and Families to conduct a study of health factors that compared children in out-of-home placement (e.g., foster care) with other children covered by Medicaid. Onpoint also linked birth and death certificates to claims in New Hampshire to support additional studies.

Onpoint understands the special roles these other agencies have in providing and coordinating services for Medicaid and other populations. We will be able to provide customized reports and studies on these and other topic areas for the VHCURES commercial claims data and Medicaid and Medicare data when available.

Our cost proposal provides an estimate for one customized study each contract year. Depending on DVHA's needs, two smaller ad hoc reports may be substituted for one of the customized studies.

**5.1.3.** A summary of the challenges that the bidder might reasonably expect to encounter and solutions to those anticipated challenges must be provided. (RFP/p.9)

This project presents a number of challenges, which can be categorized broadly into five major areas: (1) data availability and data quality, (2) value-added data, (3) methodological issues, (4) customized study scope and "iterative process," and (5) national comparative data.

### Data Availability & Data Quality

The project timeline (see [Appendix A](#)) assumes that data is available, complete, and accurate. Dates for incorporation and availability of Medicaid and Medicare are not firm. Onpoint will assess and report on the availability and quality of data for required reports in order to assist BISHCA and DVHA in determining whether project due dates will require adjustments.

Among the methods Onpoint will use to evaluate the quality of the data before reporting is the Onpoint Healthcare Utilization Profile (HUP) report. This three-page report, run for each payer on incurred data, provides a wealth of information by insurer on demographics, specific diseases, utilization, and cost. The HUP will be used as an additional check on the reliability of specific payer data and for the State in total. Onpoint also has developed for Vermont a report to monitor the submission of the Blueprint identification flag, which is critical to Blueprint reporting and evaluation. This report tabulates Blueprint members by month, payer, and HSA of residence.

BISHCA seeks to enhance the insurer rate review process by using reports from VHCURES claims data. This will be influenced by the timeliness of data. Insurers will use the most current data of the insurer for rate review submissions, while the VHCURES data source will lag behind as data must be submitted and consolidated; Onpoint and Compass Health Analytics will review this issue with BISHCA. The RFP and State responses to bidders' questions leave unclear the meaning of "incurred and paid claims bases." While Onpoint has the capability to generate claims triangulation reports and Compass Health Analytics can provide estimates of costs incurred but not reported (IBNR), our assumptions are that estimated costs, including IBNR, are not required.

## Value-Added Data

The eligibility and claims data alone require further enhancement to support most reporting and analyses. Onpoint will apply a number of groupers (e.g., BETOS, ETGs, ERGs, Red Book®) to group data in preparation for reporting. All of these groupers are required to meet the requirements of the current reports identified in the RFP.

Working with BISHCA on development of a Master Provider Index is a component of this RFP (see [Section 4.1.5](#)). Resolving individual provider identification and specialty will be critical to support any reporting at the provider level. Onpoint has extensive experience cross-walking primary care providers to their appropriate practice assignment in other states and will apply this experience in consultation with BISHCA.

Carve-out issues are identified in the RFP (see [Section 4.1.3](#)) as a priority. This will impact primarily pharmacy data and to a lesser degree behavioral carve-outs. Onpoint will thoroughly evaluate carve-out relationships and propose solutions to address current data issues. This includes the cross-walking for pharmacy carve-out members to their medical eligibility and claims. Onpoint uses probabilistic and other algorithms for these cross-walks.

Vermont anticipates the inclusion of Medicaid and Medicare claims data. Since members may receive coverage from multiple payers, Onpoint will assess and report to BISHCA the capabilities and challenges associated with linking members with multiple payers across payers.

For inpatient claims data, assignment of Medicare Severity Diagnosis Related Groups (MS-DRGs), DRGs, or APR-DRGs to claims data is not specifically identified as a task in the RFP. While capture of a DRG is being added as part of claims submission, it is unavailable in data from 2009 or prior years. Onpoint anticipates that that MS-DRG may be required to support provider-level and procedure-level reporting or for customized analyses and provider-practice reporting that use "standardized" cost measures. Onpoint assigns DRG groupers to claims data and is evaluating the reliability of this assignment directly from claims data linked to

hospital discharge data in another state. Present on Admission is unavailable on claims data but is used in assignment of MS-DRG. Onpoint also creates algorithms that roll inpatient claims into inpatient discharges. Finally, Onpoint will make use of the Ingenix Episode Treatment Group (ETG) Confinement File which captures both facility and professional cost for inpatient care. Onpoint proposes to acquire the Vermont hospital inpatient data and compare direct assignment of MS-DRG to claims with MS-DRG as assigned on the hospital data. Records will be linked between the two data sources to determine the degree of correspondence.

## Methodological Issues

Onpoint will incorporate standardized cost measures in provider-practice reporting. We will utilize relative value units (RVUs) and MS-DRG weights to assist in the development of standardized cost measures. For services where no RVU or MS-DRG is available, Onpoint will use the statewide average cost for that service to construct a standardized cost for each service type.

High-cost outlier cases are another important consideration for the analysis of cost and can be handled in a variety of ways depending on the needed report or customized study. Onpoint has used a number of different methods, including arbitrary cutoffs, removal of outlier cases, and capping of outliers based on percentile. Use of log transformations, medians, and non-parametric methods on cost data also have been used by Onpoint. We will discuss these methods and propose an appropriate solution to BISHCA and DVHA when needed.

Small numbers will be a significant methodological challenge for Vermont — as it has been in our work in Maine and New Hampshire. Onpoint constructs confidence intervals on adjusted disease prevalence, utilization rates, and HEDIS measures for customized studies and other reports. Onpoint uses both binomial and Poisson distributions in construction of confidence intervals. Other options include the blinding of results for providers or other reporting entities with a minimum number of patients (e.g., fewer than 20) and increasing the number of years included in analyses.

Medicaid covers services that are never covered by commercial insurers, rarely covered by commercial insurers, or rarely used by members covered by commercial insurance. Examples include case management, private nonmedical institution housing, special education, nursing facility care, and dental services. These impact cost comparisons in customized studies between Medicaid and commercial populations and can reflect as much as one-half of total Medicaid costs. Onpoint, in its sixth year in a contract with New Hampshire Medicaid, has developed methods to identify and report separately the costs associated with these services.

In the area of provider-practice attribution, Onpoint has developed practice attribution algorithms from claims data for several other client projects. Alternative methods have been used depending on the purpose of the attribution. They include the assignment of members to a single primary care practice and the assignment of member experience to all practices used by the member. The first method is used to identify cohorts under the care of a single provider or practice; when identified, the quality, quantity, and efficiency of care delivered by the provider can be measured with proper numerators and denominators. Assignment is based on plurality and recency of evaluation and management face-to-face visits, indicating the primary care provider exhibiting the greatest patient management for each patient, as determined by billing practice. This is a standard method for attribution, is well tested, avoids ambiguity about responsibility for quality and efficiency of care delivery, and is consistent with medical home and ACO concepts.

Attribution of patients to hospitals to create empirical systems of care can be done by assigning physicians to hospitals and then attributing the physician's entire panel to the hospital. Physicians are attributed by a plurality rule — assigned to the hospital to which they admit (or their patients are admitted) most often. Care must be taken to identify specialty hospitals.

## Customized Study Scope & “Iterative Process”

The RFP calls for a number of customized studies that currently are undefined. Onpoint, as described above, utilizes a formal process for scoping out a customized study with a concept paper or detailed description of scope. The concept paper will be a clear and concise statement of what questions the study or report will address.

Research and analytics are, by nature, iterative processes. Generation of results and analyses inevitably result in additional questions, often suggesting additional reporting and analysis. Onpoint has built into the special study process and cost estimates an assumption that each customized study may lead to one or two additional queries of the data to answer a question about the results. These follow-up requests are assumed to be limited in scope. More significant changes to the core reports or analysis defined for the study, however, would need to be addressed by another customized follow-up study with additional associated cost.

## National Comparative Data

Onpoint will acquire the NCQA Quality Compass as a primary source for national and regional comparative rates. This will include both commercial and Medicaid comparisons. Onpoint will use data from other states (e.g., Maine and New Hampshire) for comparisons when available.

**5.1.4.** Adequate information must be provided so that the State is assured that the Contractor will be prepared to immediately establish operations on the contract's effective start date to keep the deliverables specified in both Exhibits A and B on schedule. (RFP/p.18)

Onpoint is uniquely positioned to meet the diverse and time-sensitive requirements set forth in the Vermont RFP. As the data management vendor responsible for initial development and ongoing management of the VHCURES claims database, Onpoint brings an unmatched knowledge of the core analytic resource; we understand not only VHCURES' design and construction, but also its limitations, allowing us to efficiently and effectively assist the State in carrying out its research and analysis.

As the State's current and principal claims data reporting and analysis partner, we have spent the last two years working with the VHCURES data set, meeting a series of in-depth analytic deliverables designed to support statewide health planning efforts. These same deliverables continue with some modification under this RFP. We point to a track record of quality work, responsive service, and skilled and knowledgeable staff as the most direct measure of our capacity to continue under an expanded contract.

Over the past two years, Onpoint has gained an unmatched knowledge of the State's underlying data, critical experience completing analytic work using VHCURES data, and built strong relationships with key Vermont stakeholders. For this proposal, we have strengthened our team further, including consultants to assist with specific RFP deliverables. We have added Burns & Associates to the team to collaborate on Medicaid deliverables; they bring many years' experience working with Vermont's Medicaid claims data and completing various analytic initiatives. We also have added Compass Health Analytics; their financial and actuarial analysis skills will help our team fulfill the RFP's rate-setting deliverable.

## **About Onpoint Health Data's Analytic Services**

Onpoint Health Data is a full-service health data organization. We design, deploy, and manage large, complex, integrated healthcare claims databases — and then we put that data to use through innovative analytic work by our research team.

Our staff is distinguished by the depth of their experience working with healthcare data. Onpoint's research and analytic services staff is comprised of experienced health services researchers, information technology staff, statisticians, programmers, and analysts. Staff credentials range from a board-certified physician to a doctorate-level health services researcher. Other analytic staff have bachelor's and master's training in public health and related fields.

Our staff also have advanced training in statistical methods and other analytic skills. Onpoint staff routinely utilize univariate and multivariate statistical methods in their work. Staff also have experience with statistical process control (SPC) charting for quality improvement. Reports, analyses, and profiling often are adjusted for age, clinical risk, outliers, and other factors. Onpoint staff have experience with the application of Bayesian statistical methods for probabilistic linkage and have utilized methods of imputation to adjust for missing values. Onpoint currently has six staff members with strong SAS (Statistical Analysis System) skills.

Our staff have been working with healthcare data for more than 30 years. During that time, they have gained extensive and valuable knowledge about the use and limitations of the various data sets, including the health policy, strategic, and operational questions that each can answer. Onpoint has experience linking disparate data sets, when necessary, to answer questions that one data set, on its own, is unable to address.

We work with a wide range of healthcare data sources, including eligibility, dental, medical, and pharmacy claims; clinical registry data; birth and death certificates; and hospital inpatient and outpatient claims. We partner with clients across the country on a diverse range of cutting-edge initiatives addressing healthcare use, cost, and quality issues. We have profiled practices and health systems from a quality and cost perspective, evaluated program effectiveness, assessed geographic variation in care and quality, tracked reimbursement and market share trends, evaluated the impact of benefit design differences, and compared different populations to understand variation in service use and access.

**5.1.5.** The bidder must disclose detailed information concerning any subcontractors that are proposed for use during the performance of the responsibilities under the contracts specified under both Exhibits A and B including the specific deliverables that will be assigned to any subcontractor. (RFP/p.18)

Subcontractors retained by Onpoint for this initiative include:

- **BURNS & ASSOCIATES — MARK PODRAZIK, MBA**

Mark Podrazik has more than 13 years' experience in healthcare consulting, specializing in the reimbursement and evaluation components of healthcare programs. Prior to Burns & Associates, Mark was a corporate manager at EP&P Consulting. He has served as project manager on engagements with public programs in 12 states. He currently manages Burns & Associates' engagement with Indiana's Medicaid program, which includes evaluations of their managed care program, Hoosier Healthwise; their care management program, Care Select; and, beginning in 2009, their program for low-income working uninsured, Healthy Indiana Plan. Other evaluations have been for Oklahoma's ESI subsidy program (Insure Oklahoma) and New York's reinsurance subsidy program (Healthy NY). He also recently implemented DRG and Medicare OPPS-based reimbursement systems for the Department of Vermont Health Access. Previously, Mark managed reimbursement engagements for Medicaid programs in Arizona, Georgia, Nevada, and Ohio.

Mark will assist Onpoint in providing the following deliverables to the State:

- Custom Medicaid studies (Exhibit B)
- Special reports and studies for other Agency of Human Services departments (Exhibit B)

*Mark received a bachelor's of science in finance and marketing from Syracuse University (Syracuse, New York) and an MBA from Johns Hopkins University (Baltimore, Maryland).*

- **COMPASS HEALTH ANALYTICS — JAMES HIGHLAND, PHD, MHSA**

James Highland is the founder and president of Compass Health Analytics. Jim has worked as a health information systems consultant for the precursor to the consulting firm Accenture, as a consultant at a healthcare think tank, and has worked at Blue Cross and Blue Shield of Massachusetts. Since founding Compass in 1997, Jim has worked extensively in public policy processes that are highly visible and involving parties with divergent interests, providing analysis and advice that navigate processes to successful, defensible conclusions. Jim is a member, at the invitation of the governor, of Maine's Advisory Council on Health System Development and its payment reform subcommittee.

Jim will assist Onpoint in providing the State's [health insurance rate review](#) (Exhibit A) deliverable.

*Jim holds a Ph.D. in health economics from the Wharton School of the University of Pennsylvania, where he also taught health economics and healthcare financial management. He also holds a master's of health services administration from the University of Michigan with concentrations in finance and information systems and a bachelor's from Northwestern University.*

## 5.2 ORGANIZATIONAL EXPERIENCE

### 5.2.1. Location of the bidder's headquarters and offices. (RFP/p.9)

Onpoint Health Data is headquartered in Manchester, Maine, and operates a satellite office in Portland. Addresses for both locations follow:

- **ONPOINT HEALTH DATA – HEADQUARTERS**

16 Association Drive  
P.O. Box 360  
Manchester, ME 04351  
Phone: 207-623-2555  
Fax: 207-622-7086

- **ONPOINT HEALTH DATA – PORTLAND OFFICE**

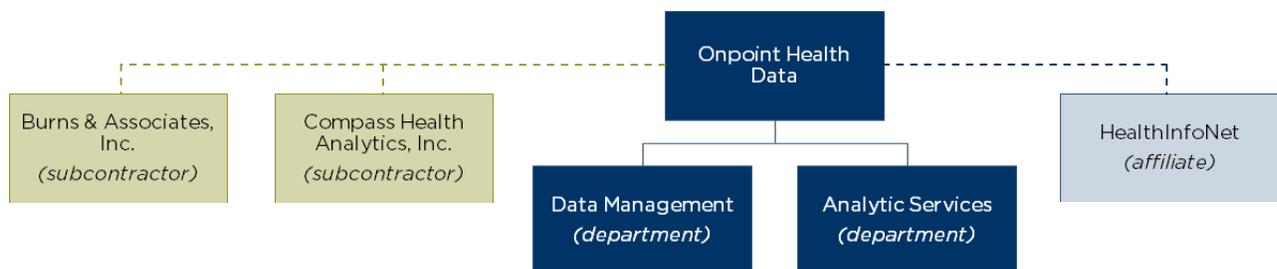
245 Commercial Street, Suite 201  
Portland, ME 04101  
Phone: 207-623-2555  
Fax: 207-622-7086

**5.2.2.** A description of the following information about the bidder and any parent corporation and all subsidiaries and affiliates: 1) an organizational chart of all affiliated and sub-contracted entities; 2) the names and addresses of each affiliated and subcontracted entity; and 3) the names and addresses of members of the governing board of each entity. (RFP/p.9)

#### 5.2.2.1. Organizational Chart of Onpoint Affiliates & Subcontracted Entities

Onpoint Health Data has one affiliate organization, HealthInfoNet, Maine's health information exchange. For this proposal, Onpoint will retain the services of two subcontractors, Burns & Associates and Compass Health Analytics, as diagrammed below in Figure 1:

**Figure 1.** Onpoint Health Data's Affiliates, Subcontracted Entities, and Internal Divisions



### 5.2.2.2. Names & Addresses of Affiliated & Subcontracted Entities

- **HEALTHINFONET (AFFILIATE)**  
125 Presumpscot Street  
Portland, ME 04103  
Phone: 207-541-9250  
[www.hinfonet.org](http://www.hinfonet.org)
- **BURNS & ASSOCIATES, INC. (SUBCONTRACTOR)**  
3030 North Third Street  
Suite 200  
Phoenix, AZ 85012  
602-241-8520  
[www.burnshealthpolicy.com](http://www.burnshealthpolicy.com)
- **COMPASS HEALTH ANALYTICS, INC. (SUBCONTRACTOR)**  
477 Congress Street, 7th Floor  
Portland, ME 04101  
207-541-4900  
[www.compass-inc.com](http://www.compass-inc.com)

### 5.2.2.3. Names & Addresses of Board Members

#### ONPOINT HEALTH DATA

Onpoint Health Data’s board consists of lifetime core members from our founding organizations as well as at-large individuals from the healthcare community.

**Table 2.** Onpoint Health Data Board Members

NAME	TITLE	AFFILIATION	CITY	STATE
Mark Battista, MD, JD	CEO	Medical Care Development Inc	Portland	ME
Karen Bell, MD	Chair	Certification Commission for Health Information Technology	Weston	MA
Andrew Coburn, PhD	Director, Institute for Health Policy	Muskie School of Public Service, USM	Portland	ME
James Harrison	President / CEO	Onpoint Health Data	Manchester	ME
Kala Ladenheim, PhD	Principal	Maine Health Policy dot Info	Gardiner	ME
John Marr	Senior Vice President of Claims	Maine Employers Mutual Insurance Co.	Portland	ME
Frank McGinty	Executive Vice President & Treasurer	MaineHealth	Portland	ME
Steven Michaud	President	Maine Hospital Association	Augusta	ME
Lisa Miller	Senior Program Officer	The Bingham Program & (Rep - ME Legislature)	Somerville	ME
Elizabeth Mitchell	CEO	Maine Health Management Coalition/Foundation	Portland	ME
Stephen Norton	Executive Director	New Hampshire Center for Public Policy Studies	Concord	NH
Roderick Prior, MD	Medical Director	Office of MaineCare Services / Maine DHHS	Augusta	ME
James Raczek, MD, FAAFP	Vice President & CMO	Eastern Maine Medical Center	Bangor	ME
Gordon Smith, JD	Executive Vice President	Maine Medical Association	Manchester	ME
Angela Cole Westhoff	Executive Director	Maine Osteopathic Association	Manchester	ME
Bill Whitmore	RVP of Underwriting	Anthem Blue Cross and Blue Shield in ME	South Portland	ME
John Wipfler, JD	CEO	OA - Centers for Orthopaedics	Portland	ME

### BURNS & ASSOCIATES

Burns & Associates is directed solely by its president, Peter Burns, from Phoenix, Arizona. There is no governing board.

### COMPASS HEALTH ANALYTICS

Compass Health Analytics is a Maine sub-chapter S corporation solely owned by James Highland and has no parent or subsidiary organizations. Its corporate officers and only board members are Dr. Highland, who is president of the corporation, and its secretary and legal counsel, Arnold MacDonald.

**Table 3.** Compass Health Analytics Board Members

NAME	TITLE	AFFILIATION	CITY	STATE
James Highland	President	Compass Health Analytics	Portland	ME
Arnold MacDonald	Shareholder	Bernstein Shur	Portland	ME

**5.2.3.** A description of the bidder's background and experience in research, analyses, and reporting related to health services, health policy, Medicaid, human services, and public health, and its general understanding of the health insurance and health care system in Vermont. Documentation that clearly demonstrates the bidder's proven experience and excellent performance in producing similar work as described in Exhibits A and B must be included. Bidders must include a list of references that reflect this experience. Bidder must ensure that references and contact information are current and that references familiar with the bidder's work can be contacted by the State. Bidders with prior experience analyzing and generating reports from multipayer claims data sets should make this clear in the bid. Familiarity with commercial and Medicaid claims data, use of statistical methods and tools for risk-adjusting and episode-grouping applicable to claims analysis, and publication of Medicaid reports and studies are important considerations. (RFP/p.9)

Onpoint has a long history of experience working collaboratively with government agencies, purchasers, hospital providers, professional providers, and multi-stakeholder groups to generate customized reports and analyses. Onpoint staff have experience working with commercial insurer claims data dating back over 25 years.

The following section provides in-depth detail regarding Onpoint's background and experience in producing the seven types of deliverables outlined in the RFP's exhibits A (for BISHCA) and B (for DVHA). The following responses — subsections 5.2.3.A and 5.2.3.B — also include contact information for references able to speak to our work.

### **5.2.3.A. Background & Experience — BISHCA Deliverables (Exhibit A)**

#### **BACKGROUND & EXPERIENCE — STANDARD ANALYSIS & REPORTING**

Onpoint has extensive experience in standard analysis and reporting among a wide range of clients, including the use of multipayer commercial claims to generate reports and analyses for several state insurance departments. For the Maine Bureau of Insurance, Onpoint used commercial claims data to generate reports on mandated benefits; these reports were stratified by insurance product type (e.g., HMO, POS, indemnity). For the New Hampshire Insurance Department, Onpoint generated rate-setting reports. In Vermont, Onpoint generated HIT fund reports, Medicare Products Summary Reports, Health Utilization Profile (HUP) reports, and customized Health Utilization and Expenditures Reports (HUEs) for BISHCA.

We have worked with purchaser and government clients to design Onpoint's Report Card and with the Maine Medical Assessment Foundation to generate service- and provider-specific reporting from Medicare Part B claims data. We also have generated practice-specific reporting for the Pathways to Excellence program in Maine. We have experience linking claims data to other data sources, including hospital inpatient discharge, hospital outpatient, death certificate, and birth certificate data. We have worked with hospital clinical data for the Maine Health Management Coalition's Medication Spotlight project and with an intervention program evaluation for children in foster care in Maine.

Onpoint has prepared written analyses and studies from claims and linked data sources, including analytic studies for BISHCA, the Maine Bureau of Insurance, the Maine Health Management Coalition, the Maine Hospital Association, the Maine Primary Care Association, the Maine Self-Insurance Guarantee Authority, Maine State Employee group, MaineCare, and New Hampshire Medicaid, as well as for hospitals, physicians, physician organizations, and other specialty provider groups (e.g., chiropractors).

Onpoint has used risk-adjusted rates, confidence intervals, and multivariate statistical methods on projects. Onpoint is licensed to use Ingenix Episode Treatment Groups (ETGs) and Episode Risk Groups (ERGs) in Vermont, New Hampshire, and Maine claims data. In Maine, ETGs and ERGs have been used for reporting and special studies requested by provider clients and by employers. ETGs and ERGs are being implemented in Vermont reports during fall 2010. Onpoint also has used other adjustment tools such as Clinical Risk Groups (CRGs) in New Hampshire. Onpoint has staff dedicated to implementing the detailed specifications for NCQA HEDIS measures and has generated HEDIS measures on Maine, New Hampshire, and Vermont commercial claims data and New Hampshire Medicaid data. Over 50 different HEDIS measures are generated by Onpoint from claims data.

For examples of our standard analysis and reporting work, see [Appendix B](#).

#### **BACKGROUND & EXPERIENCE — HEALTH INSURANCE RATE REVIEWS**

Onpoint staff have experience working with actuarial organizations on projects in Massachusetts and Maine. In Massachusetts, we worked with actuaries to set health services fund budgets in an independent practice association model HMO. In Maine, we generated reporting for use by several employers' actuaries, including claims-triangulation reports.

Onpoint has generated analyses of provider variation in cost for the Maine Health Management Coalition as well as for individual employers. Our staff are familiar with the variety of benefit packages offered by insurers and collect and evaluate the results of a health insurance benefits survey for employers in Maine.

For this proposal, Compass Health Analytics will join the Onpoint team to assist with the rate review project, providing consultation on the relevant utility of the VHCURES claims data. Compass Health Analytics has worked with BISHCA staff to fulfill other analytic needs and has recent experience in other states addressing rate-review needs similar to those outlined by the State.

For a sample Onpoint triangulation report, see [Appendix C](#).

#### **BACKGROUND & EXPERIENCE — SPECIAL STUDIES & AD HOC REPORTING**

Onpoint has generated special studies for government agencies, purchasers, and providers. In Maine, we generated detailed written studies for Maine employers, the Maine Bureau of Insurance, MaineCare, and hospitals. In New Hampshire, we generated reports for New Hampshire Medicaid and the New Hampshire Division of Children, Youth, and Families. In Vermont, we created a tri-state report examining regional variation in the health services utilization and cost.

Onpoint also has generated a study of study of Medicare enrollee mammogram screening rates by specialty of primary care physician for the Maine Medical Assessment Foundation.

A sample special study, see [Appendix D](#).



## BACKGROUND & EXPERIENCE — IN-HOUSE REPORTING TRAINING

For more than 30 years, Onpoint has successfully generated customized reporting. Our success depends on understanding the needs of each client as well as the data and the tools to deliver the information effectively.

Onpoint presently is working to develop in-house reporting capacity for the Maine State Employee group in a SAP Business Objects / Oracle environment. Onpoint is experienced in the generation of person-level records (PLRs) to support client internal reporting and analysis. We developed a web-based reporting (BI) tool for the New Hampshire Comprehensive Health Care Information System (NH CHIS) to fulfill the state's mandate to make healthcare data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices."

The [NH CHIS](#) website, built and maintained by Onpoint, provides dynamic online reports utilizing claims and eligibility data from New Hampshire Medicaid and commercial payers. These reports provide information in a wide variety of formats and range from enrollment and claims payment reports to more detailed and complex reporting of disease cohorts and related preventive and service utilization patterns.

For examples of dimensions for a BI tool are provided in [Appendix E](#).

### 5.2.3.B. Background & Experience — DVHA Deliverables (Exhibit B)

#### BACKGROUND & EXPERIENCE — CUSTOM MEDICAID STUDIES

Onpoint's staff have more than 20 years' experience with Medicaid studies and reporting, including both Medicaid fee-for-service and Medicaid managed care systems. Onpoint has conducted more than 25 customized studies for MaineCare and New Hampshire Medicaid. Using Medicaid and commercial claims data, Onpoint has developed a standardized online reporting system as well as rate-setting reports for New Hampshire Medicaid.

Types of special studies and reports include:

- Disease-specific reports (e.g., chronic respiratory disease, cardiovascular disease, depression)
- Utilization-specific reports (e.g., emergency department use, ambulatory care sensitive conditions, repeat users, preventive healthcare for adults)
- Children's studies (e.g., children in out-of-home placement, children with no preventive visit, adolescent child health, annual Medicaid, SCHIP, and commercial reports)
- Vital statistics linkage studies (e.g., death certificate linkage, birth certificate linkage, patterns of delivery of care, high-cost newborns, in-home visits for newborn care)
- Program evaluations (e.g., primary care by practice setting and location)
- HEDIS measure reporting from plans and from claims data
- Rate-setting reports comparing Medicaid and commercial payments by specific service types in the inpatient and outpatient setting

Studies completed by Onpoint have utilized both Medicaid and commercial claims data for comparisons. Onpoint has tailored reporting and analyses to adjust for the special nature of the Medicaid populations when making comparisons. Onpoint routinely reports by dual-eligible status, major eligibility aid groupings, geographic area of residence, poverty-level groupings, health status categories, age, and gender.

For the DVHA contract, Onpoint will team with Burns & Associates, which has extensive experience both in working with Vermont Medicaid data and in conducting studies for Medicaid in other states.

DVHA may be interested in studies that could inform policy decisions regarding healthcare reform and accountable care organization development. Project consultant Dr. Michael DeLorenzo will provide Onpoint with key insights into such work. Michael currently is working with Onpoint on reporting and analysis in support of the development of an ACO in central Maine. Identification of services provided locally and out-of-area is a key component of this analysis. Michael brings to the Onpoint team additional experiences at Health Dialog with utilization and cost-containment strategies such as informed decision making and other utilization review efforts.

For examples of Onpoint's custom reporting and studies using Medicaid claims, see [Appendix F](#).

## **BACKGROUND & EXPERIENCE — CUSTOM BLUEPRINT STUDIES**

The Onpoint team has experience with reporting for primary care practice groups as well as the evaluation of medical home and other provider projects.

In Maine, Onpoint evaluated the impact of an early medical home intervention on utilization and cost and provided provider-specific reporting for the Pathways to Excellence. Onpoint currently is collecting clinical data for primary care practices in Maine and New Hampshire. Project consultant Dr. Michael DeLorenzo has worked on the development of practice-specific reporting for the Maine Health Management Coalition, while clinical consultant Dr. Daniel Mingle has extensive experience with the implementation of electronic medical records in practices and with meaningful use reporting needs. Dan will provide additional consultation, as needed, for implementation of clinical measures in Blueprint reporting and evaluations.

Onpoint is developing an evaluation plan for Vermont Blueprint using a matched-control study design. The evaluation plan was tailored specifically to the nature of the early pilot interventions in St. Johnsbury and Burlington and includes measurement of health status, effectiveness of care (HEDIS), utilization, and cost.

For examples of Onpoint's work related to medical home and practice reporting, see [Appendix G](#).

## **BACKGROUND & EXPERIENCE — SPECIAL REPORTS & STUDIES**

Onpoint has experience working with Human Services agencies. In New Hampshire, we collaborated with the Division of Children, Youth, and Families to conduct a study of health factors that compared children in out-of-home placement (e.g., foster care) with other children covered by Medicaid. Onpoint also linked birth and death certificates to claims in New Hampshire to support additional studies. In Maine, Onpoint collaborated with the state diabetes and cardiovascular disease programs in customized studies of the impact of those diseases on utilization and cost in the Medicaid program.

Onpoint will collaborate with Burns & Associates on special studies for other Vermont Agency of Human Services departments.

For examples of Onpoint projects related to the interests of Human Services agencies, see [Appendix H](#).

### 5.2.3.A-B. References

To inquire about Onpoint's past experience related to deliverables similar to those outlined in both Exhibit A (for BISHCA) and Exhibit B (for DVHA), we offer the following references:

- **INSTITUTE FOR HEALTH POLICY, UNIVERSITY OF SOUTHERN MAINE**

Contact	Susan Payne, PhD, MPH, Professor of Health Policy Management & Senior Research Associate
Telephone	207-780-5104
Email	<a href="mailto:spayne@usm.maine.edu">spayne@usm.maine.edu</a>
Address	P.O. Box 9300 Portland, ME 04104-9300
Type of Work	Provider reporting

- **MAINE DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES**

Contact	Frank Johnson, Executive Director, Office of Employee Health and Benefits
Telephone	207-287-4515
Email	<a href="mailto:frank.a.johnson@maine.gov">frank.a.johnson@maine.gov</a>
Address	220 Capitol Street 114 State House Station Augusta, ME 04333-0114
Type of Work	Provision of reporting for actuarial consultants; customized reporting; provider reporting; procedure reporting; evaluation of tiered benefits; evaluation of program interventions (e.g., diabetes)

- **MAINE HEALTH MANAGEMENT COALITION/FOUNDATION**

Contact	Elizabeth Mitchell*
Telephone	207-899-1971
Email	<a href="mailto:emitchell@mehmc.org">emitchell@mehmc.org</a>
Address	245 Commercial Street, Suite 202 Portland, ME 04101
Type of Work	Employer reporting; provider payment comparisons; Pathways to Excellence; ad hoc requests

*\* Note that Elizabeth Mitchell is a board member of Onpoint Health Data.*

- **MAINE MUNICIPAL ASSOCIATION**

Contact Stephen Gove, Deputy Director and Director Health Trust Services, Maine  
Municipal Employees Health Trust  
Telephone 207-623-8428  
Email [sgove@memun.org](mailto:sgove@memun.org)  
Address 60 Community Drive  
Augusta, ME 04330-9486  
Type of Work Employer reporting; provision of reporting for actuarial consultants

- **NEW HAMPSHIRE OFFICE OF MEDICAID BUSINESS & POLICY**

Contact Andrew Chalsma, Chief, Bureau of Data Systems and Management  
Telephone 603-271-4514  
Email [achalsma@dhhs.state.nh.us](mailto:achalsma@dhhs.state.nh.us)  
Address Office of Medicaid Business and Policy  
New Hampshire Department of Health and Human Services  
129 Pleasant Street Annex  
Concord, NH 03301-3857  
Type of Work Special studies using Medicaid and commercial claims; rate-setting reports;  
web-based reporting; birth and death certificate linkage to claims

- **OFFICE OF MAINECARE SERVICES**

Contact Brenda McCormick, Director, Division of HealthCare Management  
Telephone 207-287-1774  
Email [brenda.mccormick@maine.gov](mailto:brenda.mccormick@maine.gov)  
Address 11 State House Station  
442 Civic Center Drive  
Augusta, ME 04333  
Type of Work Special studies and ad hoc reports using Medicaid claims data

- **DEPARTMENT OF VERMONT HEALTH ACCESS**

Contact Craig Jones, MD, Director of Vermont Blueprint for Health  
Telephone 802-879-5988  
Email [craig.jones@vdh.state.vt.us](mailto:craig.jones@vdh.state.vt.us)  
Address 312 Hurricane Lane  
Williston, VT 05495  
Type of Work Blueprint evaluation (in progress)

- **VERMONT DEPARTMENT OF BANKING INSURANCE SECURITIES & HEALTH CARE ADMINISTRATION**

Contact Dian Kahn, Director, Analysis & Data Management  
Telephone 802-828-2906  
Email [dian.kahn@state.vt.us](mailto:dian.kahn@state.vt.us)  
Address Vermont BISHCA  
Division of Health Care Administration  
City Center  
89 Main Street, Drawer 20  
Montpelier, VT 05620-3601  
Type of Work VHCURES reporting (Onpoint is current vendor)

**5.2.4.** Bidders must provide a full description of credentials and qualifications of staff to be assigned to this project and any proposed subcontractors and consultants, including the relevant credentials, skills, knowledge and experience of the staff and subcontractors or consultants who would be assigned to this project. Bidders must identify the Project Manager and Principal Investigator who may be the same person who will be the primary contact between the Contractor and the State. Bidders must provide a list professional personnel who would be assigned to this project and include titles, credentials, licenses, skills, experience, and knowledge that are relevant to research, use of administrative health data including claims data, analysis and health care/health policy studies. Employing staff or consultants with clinical expertise who are licensed physicians, nurses or other licensed professionals who understand and have experience with research and statistical methods for research in health services, health care administration, health policy and/or public health is an important consideration. (RFP/p.10)

Onpoint has assembled an accomplished team to meet the demands and deliverables required by BISHCA and DVHA. Onpoint’s own team of experienced health services research staff, systems and data analysts, and expert consultants will be joined by subcontractors to provide a robust response to the State’s research and analysis needs. A summary table as well as more detailed descriptions of this proposal’s team members follow (for further details regarding staff and subcontractors’ experience and responsibilities, please see [Appendix I](#)):

**Table 4.** Onpoint Health Data’s Proposal Team

ORGANIZATION	INDIVIDUAL	POSITION	SPECIFIC ROLE/SKILLS
Onpoint Health Data	Karl Finison, MA	Director of Health Services Research	Project lead; research design; statistical methods
	Janice Bourgault	Manager of Data Quality & Applications	BI tool development; quality control
	Amy Kinner, MS	Health Services Researcher	Analysis; reporting; presentations
	Rebecca Symes	Health Data Analyst	Report design and development; analytic tools
	Michael DeLorenzo, PhD	Project Consultant	Provider/health system reporting; statistical methods
	Daniel Mingle, MD, MS	Clinical Consultant	Provider/health system reporting; interpretation of results for clinical relevance
Burns & Associates	Mark Podrazik, MBA	Health Policy Consultant	Medicaid deliverables
Compass Health Analytics	James Highland, PhD, MHSA	Actuarial Consultant	Rate review deliverables; analysis and reporting

## Onpoint Health Data

- **KARL FINISON, MA – DIRECTOR OF HEALTH SERVICES RESEARCH (PROJECT LEAD)**

Karl Finison has been an integral member of Onpoint Health Data’s research team since 1992, earning widespread recognition for his expansive knowledge and incisive analyses. Karl has helmed much of Onpoint Health Data’s research and authored many of our reports. His areas of expertise include statistical analysis, health utilization and costs using administrative claims, hospital inpatient discharge and outpatient reporting, and SAS. Karl has played a leading role in providing annual and other presentations to Maine’s State Employee Health Commission (SEHC) since 1992, planning analyses and participating in responses to ad hoc requests. For this proposal, Karl will serve as project lead and provide key insights into research design and statistical methods.

*Karl received a master’s in physical anthropology from the University of Massachusetts. He also has completed graduate-level training in biostatistics.*

- **JANICE BOURGAULT – MANAGER OF DATA QUALITY & APPLICATIONS**

Janice Bourgault brings many years’ experience working with and analyzing healthcare data sets, including administrative claims data, electronic medical record data, and clinical registry data. Her role at Onpoint focuses primarily on process improvement, quality control, and report design and fulfillment. As part of her quality management role, she oversees all core data quality operations, ensuring timely and reliable claims data. Beyond Janice’s in-depth knowledge of healthcare data, she has strong analytic skills and a deep knowledge of reporting tools. Janice previously worked for a large health system in Maine, overseeing EMR deployment, application support, and reporting. For this proposal, Janice will lead BI tool development and quality control initiatives.

*Janice received a bachelor’s in accounting from Bentley College and is a Certified Professional Coder.*

- **AMY KINNER, MPH – HEALTH SERVICES RESEARCHER**

Amy Kinner has been an integral member of Onpoint since 2009, supporting the analytic needs of large employers and business coalitions and providing expertise in ETG-based cost analysis and HEDIS quality measures. Prior to joining Onpoint, Amy spent four years as a researcher/epidemiologist for a public health consulting firm, where she led health services needs assessments and program evaluation projects. For this proposal, Amy will provide lead analysis as well as reporting and presentations.

*Amy received a bachelor’s in chemistry from Vermont’s Middlebury College and a master’s in health, environment, and development from the University of California, Berkeley, School of Public Health.*

- **REBECCA SYMES — HEALTH DATA ANALYST**

Rebecca Symes is a senior health data analyst and lead SAS programmer for Onpoint, where she has programmed more than 100 HEDIS measures for various clients and serves as the principal data analyst for the annual insurance benefits survey. Rebecca has more than 15 years' experience working with administrative claims data and provider attribution methods as well as a thorough understanding of ETGs and other groupers. She is a lead analyst on developing provider attribution used to profile physician practices. She also has 24 years' experience extracting data and generating reports from the largest healthcare databases in the state of Maine, working as our data manager during the Maine Health Management Coalition's formation and creating the first Maine database of health insurance benefit structures for the Coalition. Rebecca previously worked at Cigna Healthcare when the state of Maine was their client, creating a range of products, including employer-level claims summaries to provider profiles. For this proposal, Rebecca will provide key report design and development as well as analytic tools.

*Rebecca received a bachelor's in agriculture and resource economics from the University of Maine.*

- **MICHAEL DeLORENZO, PHD — PROJECT CONSULTANT**

Dr. Michael DeLorenzo, principal at Population Health Analytics, LLC, works with multi-stakeholder coalitions, provider organizations, and health data organizations involved in system redesign and payment reform. His current work includes health system analytics and measure development for the Maine Health Management Coalition, supporting efforts in ACO development, payment reform, an advanced primary care medical home pilot (for which he developed the provider measurement tools), purchaser reporting, and hospital cost studies. He also is working directly with a hospital system in their transformation to an ACO.

From 2006 through 2010, Michael worked at Health Dialog, his final position being vice-president, Modeling and Provider Measurement, with primary responsibility for the Provider Measurement, Predictive Modeling, and Clinical Development teams. Prior to joining Health Dialog, Michael worked at the Center for Outcomes Research (CORE) at Maine Medical Center under Dr. David Wennberg and in cooperation with Dr. Jack Wennberg's group at the Center for Clinical and Evaluative Sciences at Dartmouth Medical School. Cooperative work with Dartmouth was centered around causes of unwarranted variation in the delivery of care, with the implications for policy, primarily with respect to CMS programs and pilots. Primary research studies at CORE included evaluating the causes and consequences of the intensity of diagnostic testing and therapeutic interventions in the Medicare population as well as injury studies, including the efficacy of trauma centers. Before joining CORE, Michael was a professor with tenure on the faculty of the University of Florida. For this proposal, Michael will consult on statistical methods and the enhancement of provider and health system reporting.

*Michael received his bachelor's and master's from the University of Michigan and his PhD in quantitative genetics with minor areas in statistics and economics from New York's Cornell University.*

- **DANIEL MINGLE, MD, MS — CLINICAL CONSULTANT**

Dr. Daniel Mingle has been a member of the Maine healthcare community since 1980, specializing in healthcare improvement and healthcare informatics. Dan is a regular consultant with Onpoint, providing clinical guidance to staff on projects and workgroups and evaluating the clinical relevance of data and specific reporting approaches. Prior to joining Onpoint, Dan served on the faculty and as assistant medical director of Maine-Dartmouth Family Practice Residency. He also served as director of electronic medical records at MaineGeneral Medical Center, where he helped win and administer federal grant funds for EMR implementation and regional healthcare improvement. Dan was one of nine recipients of the Healthcare Informatics 2008 Innovator Awards. For this proposal, Dan will consult on provider and health system reporting and will interpret results for clinical relevance.

*Dan received a bachelor's in science from Pennsylvania State University, an MD from Jefferson Medical College (Thomas Jefferson University in Philadelphia), and an MS from the Center for Evaluative Clinical Sciences (now the Dartmouth Institute for Health Policy and Clinical Practice) at Dartmouth College. He also has participated in the Hanley-ICL Health Leadership Development Program.*

## Subcontractors

- **BURNS & ASSOCIATES — MARK PODRAZIK, MBA (HEALTH POLICY CONSULTANT)**

Mark Podrazik has more than 13 years' experience in healthcare consulting, specializing in the reimbursement and evaluation components of healthcare programs. Prior to Burns & Associates, Mark was a corporate manager at EP&P Consulting. He has served as project manager on engagements with public programs in 12 states. He currently manages Burns & Associates' engagement with Indiana's Medicaid program, which includes evaluations of their managed care program, Hoosier Healthwise; their care management program, Care Select; and, beginning in 2009, their program for low-income working uninsured, Healthy Indiana Plan. Other evaluations have been for Oklahoma's ESI subsidy program (Insure Oklahoma) and New York's reinsurance subsidy program (Healthy NY). He also recently implemented DRG and Medicare OPPS-based reimbursement systems for the Department of Vermont Health Access. Previously, Mark managed reimbursement engagements for Medicaid programs in Arizona, Georgia, Nevada, and Ohio. For this proposal, Mark will consult on Medicaid deliverables for DVHA.

*Mark received a bachelor's of science in finance and marketing from Syracuse University (Syracuse, New York) and an MBA from Johns Hopkins University (Baltimore, Maryland).*

- **COMPASS HEALTH ANALYTICS — JAMES HIGHLAND, PHD, MHSA (ACTUARIAL CONSULTANT)**

Dr. James Highland is the founder and president of Compass Health Analytics. Jim has worked as a health information systems consultant for the precursor to the consulting firm Accenture, as a consultant at a healthcare think tank, and has worked at Blue Cross and Blue Shield of Massachusetts. Since founding Compass in 1997, Jim has worked extensively in public policy processes that are highly visible and involving parties with divergent interests, providing analysis and advice that navigate processes to successful, defensible conclusions. Jim is a member, at the invitation

of the governor, of Maine's Advisory Council on Health System Development and its payment reform subcommittee.

For this proposal, Jim will consult on BISHCA rate review deliverables as well as provide analysis and reporting.

*Jim holds a Ph.D. in health economics from the Wharton School of the University of Pennsylvania, where he also taught health economics and healthcare financial management. He also holds a master's of health services administration from the University of Michigan with concentrations in finance and information systems and a bachelor's from Northwestern University.*

**5.2.5.** A list of all health insurers, health care facilities and other health care providers with whom the bidder or its directors, owners, employees, or contractors maintains any health related business arrangements. This list shall include a brief description of the nature of any such arrangement. (RFP/p.10)

Onpoint is an independent, nonprofit health data organization governed by a board of directors representing multiple stakeholder organizations, including health insurers, health systems, state agencies, academic organizations, medical societies, certification bodies, and other health data organizations. All board members sign conflict of interest statements each year and are excluded from any discussions where they have any real or perceived interest. See [Table 2](#) or Onpoint’s website for the most recent [board listing](#).

Onpoint’s clients include health insurers, healthcare facilities, and other provider organizations. For these organizations, we perform research and other analytic services utilizing claims data, hospital discharge data, and other data sets. Analysis typically is focused on healthcare service use, cost, and quality information. The following list of clients and deliverables is illustrative of Onpoint’s business arrangements:

- **Anthem Blue Cross Blue Shield of ME** — Provide claims data management and standard reporting-type services (e.g., Onpoint’s Report Card series) on behalf of the Maine Education Association, one of Anthem’s largest self-funded employers
- **MaineHealth** — Provide comparative analysis of service use, cost, and quality using claims data for Maine’s largest health system; subsidiary and affiliated organizations’ are benchmarked against MaineHealth as a whole, other competing health systems, and the state of Maine as a whole
- **OA Centers for Orthopaedics** — Developed comparative cost analysis by ETG, benchmarking large, multidisciplinary orthopaedic practice against other orthopaedic providers

**5.2.6.** Documentation to show proof of the bidder’s financial capacity to undertake the responsibilities required under this contract. (RFP/p.10)

Onpoint Health Data is a private, nonprofit corporation with a 35-year track record of prudent financial management and fiscal stability. The organization is led by an experienced, capable management team with strong financial management backgrounds. President/CEO James Harrison and Director of Finance Anna Dawkins manage all core financial operations and planning responsibilities. Onpoint’s board of directors provides appropriate oversight, including regular review of financial statements and specific analyses. An annual audit is conducted by a qualified certified public accounting firm and results of the audit are reviewed with both management and board members. All standard financial controls and related policies are documented and followed. Any findings or recommendations identified by auditors are addressed in a timely fashion.

Onpoint Health Data’s FY 2009 audited financial statement is included as [Appendix J](#). The balance sheet and income statements reflect a history of steady growth and careful financial management. Over the past five years, revenues have grown 13 percent per year and operating surplus has averaged 6 percent of revenues. The organization has no significant liabilities, cash and investment balances are strong, and assets are replaced regularly to ensure a contemporary operating infrastructure.

**5.2.7.** Documentation that the bidder is free of actual or apparent conflict of interest with respect to provisions of 18 V.S.A. § 9414, Rule 10, Rule H-2009-03, 8 V.S.A § 4089a and Regulation 95-2. (RFP/p.10)

Onpoint Health Data attests that the organization, our employees, and our subcontractors, including immediate family and household members, are free of actual or apparent conflicts of interest pursuant to the provisions cited in the Request for Proposal's sections 5.2.7 and 8.1 – 8.4.

**5.2.8.** Documentation that the bidder will procure and maintain professional liability insurance for any and all services performed under the contract, with minimum coverage of \$1,000,000 per occurrence. (RFP/p.10)

Onpoint Health Data has professional liability coverage of \$1,000,000 per claim. The Certificate of Liability Insurance for Onpoint's current policies and their respective limits is included as [Appendix K](#).

## 5.3 COST PROPOSALS

**5.3.1.** The bidder should offer a cost proposal, distinct from the technical proposal, to include a flat fee estimate of the total cost not to be exceeded for the two separate proposed contracts under Exhibits A and B. All pricing proposed in the bid must remain firm and constant during the entire contract period and any extension. Rates provided must be all inclusive, incorporating all direct and indirect costs, including profit, clerical support, software licensing fees, materials, supplies, managerial support, travel, lodging, meals, and all documents, forms and reproductions thereof. (RFP/p.10)

**5.3.2.** Cost bids must be related to the functions and responsibilities outlined in Exhibits A and B. The cost bid must include number of hours and hourly rates per assigned staff or subcontractor, and indirect costs for each component listed below for Exhibits A and B. (RFP/p.11)

**5.3.2.1.** Separate cost bids must be submitted for the following components of Attachment A in Exhibit A for BISHCA: (1) Standard Analytical and Reporting Series; (2) Health Insurance Rate Review (This deliverable is contingent upon grant funding that has been applied for by the State of Vermont. See [[this link](#)]); (3) Ad Hoc Reports and Special Studies; and (4) Development and Support of In-house Reporting Capability. (RFP/p.11)

**Table 5.** Cost Proposal for BISHCA Deliverables (Exhibit A)

RFP SECTION	BISHCA DELIVERABLE (EXHIBIT A)	YEAR 1 COST	YEAR 1 HOURS	YEAR 2 COST	YEAR 2 HOURS	TOTAL COST	TOTAL HOURS
5.3.2.1.1	Standard Analytical and Reporting Series	\$78,200	496	\$78,200	496	\$156,400	992
5.3.2.1.2	Health Insurance Rate Review	\$138,700	766	\$138,700	766	\$277,400	1,532
5.3.2.1.3	Ad Hoc Reports and Special Studies						
	Ad Hoc Reports (2 each per year)	\$56,800	368	\$56,800	368	\$113,600	736
	Special Studies (1 each per year)	\$56,575	367	\$56,575	367	\$113,150	734
5.3.2.1.4	In-House Reporting Consulting Services	\$130,275	742	\$97,075	550	\$227,350	1,292
	Travel Estimate*	\$9,250		\$7,000		\$16,250	
	<b>BISHCA Total Cost</b>	<b>\$469,800</b>		<b>\$434,350</b>		<b>\$904,150</b>	

\* Travel Estimate covers the costs associated with three on-site visits in Year 1 and two on-site visits in Year 2.

**5.3.2.2.** Separate cost bids must be provided for the following components of Attachment A in Exhibit B for DVHA: (1) Custom Medicaid Studies; (2) Custom Blueprint Studies; and (3) Special reports and studies for other Agency of Human Services departments. (RFP/p.11)

**Table 6.** Cost Proposal for DVHA Deliverables (Exhibit B)

RFP SECTION	DVHA DELIVERABLE (EXHIBIT B)	YEAR 1 COST	YEAR 1 HOURS	YEAR 2 COST	YEAR 2 HOURS	TOTAL COST	TOTAL HOURS
5.3.2.2.1	Custom Medicaid Studies	\$61,225	371	\$61,225	371	\$122,450	742
5.3.2.2.2	Custom Blueprint Studies	\$59,975	371	\$59,975	371	\$119,950	742
5.3.2.2.3	Special Reports and Studies for Other Departments	\$57,475	371	\$57,475	371	\$114,950	742
	Travel Estimate*	\$7,000		\$7,000		\$14,000	
	<b>DVHA Total Cost</b>	<b>\$185,675</b>		<b>\$185,675</b>		<b>\$371,350</b>	

\* Travel Estimate covers the costs associated with two on-site visits per year.

**5.3.3.** Because of the inherent unpredictability of the total workload, the bidder should provide the workload assumptions on which the total cost and unit cost estimations are based. (RFP/p.10)

## Workload Assumptions for BISHCA Deliverables (Exhibit A)

### STANDARD ANALYTICAL & REPORTING SERIES (5.3.2.1.1)

The Standard Analytical & Reporting Series includes annual delivery of the following reports, which we have assumed will follow the existing report design:

- Healthcare Utilization and Expenditure Report (HUER) — New scope to include trending and executive summary
- Onpoint healthcare Report Card — New scope to include executive summary
- Healthcare Information Technology (HIT) Fund report — No new scope
- Medicare Products Summary Report — New scope includes addition of HSA and utilization

### HEALTH INSURANCE RATE REVIEW (5.3.2.1.2)

The Health Insurance Rate Review includes:

- Annual consultation with the State and its actuarial consultant to customize the VHCURES reporting to support rate review and identifying an inventory of insurance product types to be reported to VHCURES
- Annual development and production of trend reports on incurred and paid claims based upon the customization identified with the State. The definition of incurred and paid claims reports was not sufficiently clarified in RFP from an actuarial perspective. Onpoint and Compass Health Analytics assume that estimating cost will not require computations of IBNR. Onpoint does expect that BISHCA may wish to develop claims triangulation reports.
- Annual consultation with the State to identify, inventory, and report insurer carve-out relationships
- Annual development and production of reports for carve-out relationships as directed by the State
- Annual consultation with the State regarding applications and improvements to the VHCURES Master Provider Index (MPI)
- Annual report addressing the current state of the MPI, annual development and production of provider-level ad hoc reporting. The RFP and response to bidder questions were not specific about provider reporting. We are assuming that provider reporting initially means provider types (not specific providers) and will review with BISHCA a phased approach to provider-specific reporting starting with hospitals in Year 1, followed by primary care practices in Year 2. Also in Year 2, options for incorporating specialist reporting will be reviewed (for delivery in subsequent year). We have budgeted 126 hours for provider-level reporting. Given lack of specificity, any hours in excess of 126 would need to be funded additionally at the rates below:
  - Principal: \$250/hour
  - Senior Manager: \$225/hour

- Analyst: \$125/hour
- Data: \$110/hour

#### **AD HOC REPORTS & SPECIAL STUDIES (5.3.2.1.3)**

Annual pricing for ad hoc reports and special studies is \$113,375. This pricing is based on two ad hoc reports at 184 hours each and one special study at 367 hours. It is assumed that a clear scope of work will be agreed upon by both parties prior to work being undertaken.

#### **IN-HOUSE REPORTING CONSULTING SERVICES (5.3.2.1.4)**

Annual pricing for in-house reporting consulting services is \$130,275 in Year 1 and \$97,075 in Year 2. Year 1 pricing includes two initiatives: (1) report, including plan and recommendations, for building in-house reporting capability, and (2) consulting services and training to support development of in-house reporting. Year 2 includes only the second initiative: consulting services and training to support development of in-house reporting.

It is assumed that prior to consulting work being undertaken that a clear scope of work will be agreed upon, including the hours and related cost to be paid to Onpoint and drawn down against the total in-house reporting consulting services allowances. Pricing is based on an hourly rate determined by the complexity of the request and by the level of staff needed to complete the assignment. Hourly rates by staff level follow:

- Principal: \$250/hour
- Senior Manager: \$225/hour
- Analyst: \$125/hour

It also is assumed the consulting services would not include actual licensing, deployment, support, and hosting of a business intelligence tool acquired by the State.

## Workload Assumptions for DVHA Deliverables (Exhibit B)

### CUSTOM MEDICAID STUDIES (5.3.2.2.1), CUSTOM BLUEPRINT STUDIES (5.3.2.2.2), & SPECIAL REPORTS & STUDIES FOR OTHER DEPARTMENTS (5.3.2.2.3)

It has been estimated that each special study would require approximately 371 hours. It is assumed that a clear scope of work will be agreed upon by both parties prior to work being undertaken.

The RFP and response to bidder questions were not specific about provider reporting. If a special study requires provider-level reporting, Onpoint will review and determine whether that will exceed the budgeted 360 hours and, if so, will require additional funding. The budgeted hours also do not contemplate integration of other data sources, including clinical data, although Onpoint has the capability to do so.

■ **5.3.4.** Bidder must specify address where contract payments shall be sent. (RFP/p.11)

Contract payments shall be sent to Onpoint Health Data at the following address:

Onpoint Health Data  
Attn: Accounts Receivable  
P.O. Box 360  
Manchester, ME 04351-0360

## APPENDICES

## APPENDIX A – PROJECT TIMELINE

TASK	2011												2012											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
On-site meetings	✓			✓						✓						✓						✓		
Conference call (two per month)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
<b>BISHCA DELIVERABLES (EXHIBIT A)</b>																								
<b>3 Standard Analytical Reports</b>																								
3.1.1 HUER report and analysis								✓												✓				
3.1.2 Report Card and analysis								✓												✓				
3.1.2 HIT Fund report										✓												✓		
3.1.3 Medicare products report								✓												✓				
<b>4 Health Insurance Rate Review</b>																								
4.1.1 Evaluation/recommendation report								✓																
4.1.2 Trend reports with product type								✓												✓				
4.1.3 Carve-out relationships study								✓																
4.1.4 Carve-out reports								✓												✓				
4.1.5 MPI recommendation report								✓																
4.1.6 Provider reporting								✓												✓				
<b>5 Ad Hoc Reports and Special Studies</b>																								
5.1 One custom study												✓												✓
5.2 Ad hoc reports						✓					✓								✓				✓	
<b>6 In-House Reporting Services</b>																								
6.1 Phased-plan				✓																				
6.2 Consulting/training, BI tool (TBD)																								
<b>DVHA DELIVERABLES (EXHIBIT B)</b>																								
Custom Medicaid study				✓												✓								
Custom Blueprint study								✓												✓				
Other department study or ad hoc report												✓												✓

## APPENDIX B — WORK SAMPLES — STANDARD ANALYSIS & REPORTING

B-1 — Sample HUER Report

B-2 — Sample Report Card

B-3 — Sample HIT Report

B-4 — Sample Medicare Products Summary Report

# Appendix B-1 – Sample HUER Report (1 of 2)

Vermont HealthCare Utilization and Expenditure 2008  
Statewide Total - Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Expenditure Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
3,208,205	267,350	0	Total	324,649	4,504,268	\$979,752,295	\$154,672,384	\$1,134,424,678	16,847.8	\$354
3,208,205	267,350	1	Hospital Inpatient	10,881	13,787	\$159,575,730	\$4,867,243	\$164,442,973	51.6	\$51
3,208,205	267,350	2	Mental/Substance Inpatient	662	1,095	\$6,539,853	\$407,347	\$6,947,199	4.1	\$2
3,208,205	267,350	3	Private Psych Hospital	184	310	\$1,870,104	\$91,233	\$1,961,338	1.2	\$1
3,208,205	267,350	4	Other Hospitals	526	785	\$4,669,748	\$316,114	\$4,985,862	2.9	\$2
3,208,205	267,350	5	Maternity-related and newborns	4,491	4,592	\$20,936,544	\$1,376,717	\$22,313,260	17.2	\$7
3,208,205	267,350	6	Surgical	3,208	3,809	\$85,327,824	\$1,332,628	\$86,660,451	13.5	\$27
3,208,205	267,350	7	Medical	3,453	4,491	\$46,771,511	\$1,750,552	\$48,522,062	16.8	\$15
3,208,205	267,350	8	Hospital Outpatient	164,259	527,390	\$357,040,851	\$41,894,950	\$398,935,802	1,972.7	\$124
3,208,205	267,350	9	Mental/Substance Hospital Outpatient	4,046	6,840	\$2,518,651	\$537,623	\$3,056,274	28.6	\$1
3,208,205	267,350	10	Observation Bed	2,217	2,399	\$15,863,805	\$668,521	\$16,532,326	9.0	\$5
3,208,205	267,350	11	Emergency Room	36,042	47,069	\$36,223,109	\$7,438,266	\$43,661,395	176.1	\$14
3,208,205	267,350	12	Outpatient Surgery	17,967	21,233	\$78,189,708	\$6,368,090	\$84,557,798	79.4	\$26
3,208,205	267,350	13	Outpatient Radiology	46,858	78,937	\$107,415,907	\$8,685,715	\$116,101,622	295.3	\$36
3,208,205	267,350	14	Outpatient Lab	116,907	252,792	\$54,151,465	\$10,539,453	\$64,690,918	945.5	\$20
3,208,205	267,350	15	Hospital-Dispensed Pharmacy	6,857	8,494	\$16,462,386	\$1,548,733	\$18,011,120	31.8	\$6
3,208,205	267,350	16	Outpatient Physical Therapy	7,370	15,995	\$6,988,735	\$1,084,415	\$8,073,150	59.8	\$3
3,208,205	267,350	17	Outpatient Other Therapy	1,787	3,500	\$1,283,187	\$192,034	\$1,475,221	13.1	\$0
3,208,205	267,350	18	Other Outpatient Hospital	60,592	90,111	\$37,943,897	\$4,832,081	\$42,775,978	337.1	\$13
3,208,205	267,350	19	Non-Mental Health Professional Services	243,339	1,741,971	\$270,284,959	\$51,622,219	\$321,807,178	6,515.7	\$100
3,208,205	267,350	20	Physician Services	229,341	1,258,852	\$225,891,432	\$37,680,279	\$263,571,710	4,708.6	\$62
3,208,205	267,350	21	Physician Inpatient Setting	12,336	62,464	\$36,567,741	\$2,465,270	\$39,033,011	233.6	\$12
3,208,205	267,350	22	Physician Outpatient Setting	108,152	280,034	\$73,538,095	\$9,502,806	\$83,040,901	1,047.4	\$26
3,208,205	267,350	23	Physician Office Setting	218,105	867,119	\$106,874,167	\$24,463,209	\$131,337,376	3,243.4	\$41
3,208,205	267,350	24	Physician Other Setting	32,179	49,235	\$8,711,429	\$1,258,994	\$9,970,422	164.2	\$3
3,208,205	267,350	25	Other Professional Services	120,619	483,119	\$44,678,129	\$13,863,923	\$58,542,052	1,807.1	\$18
3,208,205	267,350	26	Nurse Practitioners or Physician Assistants	63,937	116,928	\$14,508,012	\$3,405,546	\$17,913,558	437.4	\$6
3,208,205	267,350	27	Physical Therapists	18,033	127,919	\$11,416,676	\$3,626,428	\$15,043,104	478.5	\$5
3,208,205	267,350	28	Chiropractors	26,302	153,468	\$8,662,819	\$4,090,134	\$12,752,953	574.0	\$4
3,208,205	267,350	29	Podiatrists	6,828	15,065	\$1,691,346	\$504,134	\$2,195,479	56.3	\$1
3,208,205	267,350	30	Other Professional Services	46,442	69,739	\$8,399,276	\$2,237,681	\$10,636,957	260.9	\$3
3,208,205	267,350	31	Non-Hospital Mental Health Professional Services	33,831	189,767	\$17,387,544	\$6,077,789	\$23,465,333	709.8	\$7
3,208,205	267,350	32	Psychiatrists	3,254	14,552	\$1,704,902	\$425,963	\$2,130,865	54.4	\$1
3,208,205	267,350	33	Psychologists	6,493	42,830	\$3,980,229	\$1,489,644	\$5,469,873	160.2	\$2
3,208,205	267,350	34	Social Workers (including MSWs, LICSW, LCSW)	8,212	54,709	\$4,097,593	\$1,039,164	\$5,036,757	204.6	\$2
3,208,205	267,350	35	Other non-hospital Mental	22,502	77,878	\$7,520,216	\$2,201,036	\$9,721,254	290.5	\$3
3,208,205	267,350	37	Pharmacy	232,481	1,767,681	\$155,793,989	\$47,443,242	\$203,237,200	6,611.9	\$63
3,208,205	267,350	38	Pharmacy in pharmacy claims	230,951	1,668,957	\$152,982,631	\$41,945,094	\$194,927,726	6,242.6	\$61
3,208,205	267,350	39	Pharmacy in medical claims	17,291	96,724	\$2,801,329	\$5,498,145	\$8,299,474	369.3	\$3
3,208,205	267,350	40	All Other Services	21,737	28,756	\$19,679,250	\$2,866,943	\$22,546,193	107.6	\$7
3,208,205	267,350	41	Free-standing Ambulatory Surgery Center	122	131	\$165,583	\$18,582	\$184,164	0.5	\$0
3,208,205	267,350	44	Nursing Home	10	21	\$10,320	\$654	\$10,974	0.1	\$0
3,208,205	267,350	45	Home Based Care	3,673	10,973	\$5,829,067	\$385,673	\$6,214,741	41.0	\$2
3,208,205	267,350	46	Durable Medical Equipment	6,712	17,150	\$5,816,469	\$939,976	\$6,556,445	64.1	\$2
3,208,205	267,350	47	Mental Health Clinics	123	481	\$77,292	\$22,586	\$99,877	1.8	\$0
3,208,205	267,350	48	Other	13,379	24,950	\$7,980,519	\$1,499,473	\$9,479,992	93.3	\$3

## Appendix B-1 – Sample HUER Report (2 of 2)

Vermont HealthCare Utilization and Expenditure 2008  
Total By Barre Hospital Service Area- Major Medical Members Under 65

Member Months	Average Members (member months / 12)	Category	Expenditure Category Description	Count of Unique Members Using Service	Count of Visits	Plan Paid	Member Paid	Plan + Member Paid	Visits per 1,000 Members	Plan + Member Paid Per Member Per Month
399,202	33,267	0	Total	42,683	558,649	\$121,300,305	\$18,425,664	\$139,725,970	16,793	\$350
399,202	33,267	1	Hospital Inpatient	1,333	1,676	\$18,666,937	\$552,953	\$19,219,890	60	\$48
399,202	33,267	2	Mental/Substance Inpatient	84	122	\$650,207	\$58,992	\$709,199	4	\$2
399,202	33,267	3	Private Psych Hospital	16	24	\$169,950	\$9,959	\$169,609	1	\$0
399,202	33,267	4	Other Hospitals	73	98	\$490,657	\$49,034	\$539,691	3	\$1
399,202	33,267	5	Maternity-related and newborns	530	539	\$2,416,633	\$170,849	\$2,587,482	16	\$6
399,202	33,267	6	Surgical	391	448	\$9,902,948	\$146,408	\$10,049,256	13	\$25
399,202	33,267	7	Medical	445	567	\$5,700,065	\$176,391	\$5,876,478	17	\$15
399,202	33,267	8	Hospital Outpatient	21,677	73,331	\$46,963,031	\$5,626,783	\$52,499,814	2,204	\$131
399,202	33,267	9	Mental/Substance Hospital Outpatient	551	939	\$260,783	\$58,358	\$319,141	26	\$1
399,202	33,267	10	Observation Bed	344	376	\$2,409,211	\$75,055	\$2,484,266	11	\$6
399,202	33,267	11	Emergency Room	5,201	6,983	\$4,754,384	\$1,012,093	\$5,766,477	210	\$14
399,202	33,267	12	Outpatient Surgery	2,107	2,606	\$10,397,790	\$805,224	\$11,203,014	78	\$28
399,202	33,267	13	Outpatient Radiology	5,985	10,048	\$14,039,614	\$1,082,152	\$15,121,766	302	\$38
399,202	33,267	14	Outpatient Lab	16,381	36,524	\$7,552,124	\$1,432,615	\$8,984,739	1,096	\$23
399,202	33,267	15	Hospital-Dispensed Pharmacy	1,138	1,313	\$2,197,473	\$278,758	\$2,476,230	39	\$6
399,202	33,267	16	Outpatient Physical Therapy	1,307	2,663	\$834,338	\$178,268	\$1,012,606	80	\$3
399,202	33,267	17	Outpatient Other Therapy	261	468	\$157,949	\$30,841	\$188,790	14	\$0
399,202	33,267	18	Other Outpatient Hospital	7,663	11,411	\$4,358,774	\$573,615	\$4,932,389	343	\$12
399,202	33,267	19	Non-Mental Health Professional Services	30,131	207,276	\$32,935,094	\$5,880,178	\$38,815,272	6,231	\$97
399,202	33,267	20	Physician Services	25,221	149,422	\$27,839,395	\$4,292,864	\$32,132,259	4,492	\$80
399,202	33,267	21	Physician Inpatient Setting	1,577	7,880	\$4,508,621	\$262,421	\$4,771,042	237	\$12
399,202	33,267	22	Physician Outpatient Setting	12,345	30,946	\$8,910,062	\$955,549	\$9,865,610	930	\$25
399,202	33,267	23	Physician Office Setting	27,057	104,801	\$13,306,596	\$2,960,575	\$16,267,171	3,150	\$41
399,202	33,267	24	Physician Other Setting	3,910	5,793	\$1,053,783	\$114,319	\$1,168,102	174	\$3
399,202	33,267	25	Other Professional Services	15,772	57,854	\$5,114,689	\$1,690,695	\$6,705,284	1,739	\$17
399,202	33,267	26	Nurse Practitioners or Physician Assistants	7,715	12,686	\$1,478,701	\$359,300	\$1,838,002	381	\$5
399,202	33,267	27	Physical Therapists	2,379	15,598	\$1,202,495	\$407,493	\$1,609,989	469	\$4
399,202	33,267	28	Chiropractors	3,069	17,172	\$1,001,043	\$467,184	\$1,468,226	516	\$4
399,202	33,267	29	Podiatrists	723	1,517	\$164,149	\$46,859	\$211,007	46	\$1
399,202	33,267	30	Other Professional Services	7,413	10,881	\$1,268,301	\$309,759	\$1,578,060	327	\$4
399,202	33,267	31	Non-Hospital Mental Health Professional Services	4,382	23,116	\$2,348,252	\$732,304	\$3,080,555	695	\$8
399,202	33,267	32	Psychiatrists	370	1,706	\$222,922	\$46,303	\$269,225	51	\$1
399,202	33,267	33	Psychologists	854	5,272	\$526,088	\$195,998	\$722,086	158	\$2
399,202	33,267	34	Social Workers (including MSWs, LICSW, LCSW)	968	5,631	\$523,644	\$238,988	\$762,632	169	\$3
399,202	33,267	36	Other non-hospital Mental	2,966	10,607	\$1,066,797	\$247,603	\$1,314,400	316	\$3
399,202	33,267	37	Pharmacy	30,127	216,956	\$16,039,701	\$5,448,045	\$23,487,746	6,522	\$69
399,202	33,267	38	Pharmacy in pharmacy claims	29,907	200,646	\$17,611,791	\$4,577,048	\$22,188,839	6,031	\$56
399,202	33,267	39	Pharmacy in medical claims	2,764	16,310	\$428,349	\$871,038	\$1,299,386	490	\$3
399,202	33,267	40	All Other Services	2,589	3,828	\$2,347,290	\$285,403	\$2,632,693	115	\$7
399,202	33,267	41	Free-standing Ambulatory Surgery Center	4	4	\$23,915	\$415	\$24,330	0	\$0
399,202	33,267	45	Home Based Care	585	1,503	\$714,080	\$42,608	\$756,688	45	\$2
399,202	33,267	46	Durable Medical Equipment	1,053	2,258	\$674,697	\$107,812	\$782,509	68	\$2
399,202	33,267	47	Mental Health Clinics	28	63	\$27,348	\$2,457	\$29,805	2	\$0
399,202	33,267	48	Other	1,243	2,028	\$902,721	\$131,913	\$1,034,634	61	\$3

## Appendix B-2 — Sample Report Card



## ONPOINT HEALTH DATA HEALTHCARE REPORTING SYSTEM

The Onpoint Health Data Healthcare Reporting System was designed to report key demographic, diagnostic, utilization, quality of care, access to primary care and preventive visits, and claims payment measures from administrative eligibility and claims data.

The reporting includes counts, payments, rates, trends, and comparisons to total population (i.e. benchmarks).

Diagnostic, utilization, high cost case sections provide information to assist in determining factors associated with trends in health care cost and variations compared to total population (i.e. benchmarks).

National Committee for Quality Assurance (NCQA), HEDIS (Healthcare Effectiveness Data and Information Set) health care performance measures are reported in three separate sections. These HEDIS measures are based on administrative eligibility and claims data and are used to evaluate quality of care, access to care, preventive visits, and selected procedures. "NCQA National Avg" is the National Committee for Quality Assurance national average reported by health plans.

The reporting system is designed for stratified analysis for employers, products (HMO, POS, Indemnity), geographical areas, practices, and other stratification criteria of interest to clients.

Pharmacy claims are typically provided in a separate administrative file and may be carved out to a pharmacy benefit management (PBM) organization. In some cases, pharmacy claims may be included in the reports if the pharmacy data is linked and in some cases may not be included in the reports if the pharmacy data is not linked.

**TABLE OF CONTENTS**

**Demographics** ..... 1

**Total Payments**

    Total Payments ..... 2

    Total Payments by Type of Contract ..... 3

    Total Payments by Age & Gender ..... 4

    Total Payments by Relationship ..... 5

**Major Disease Category Prevalence & Payments**

    Major Disease Category Prevalence ..... 6

    Payments by Major Disease Category ..... 8

**Utilization by Type of Service** ..... 9

**Payments by Type of Provider** ..... 11

**High Cost Cases**

    High Cost Cases ..... 13

    High Cost Cases by Leading Diagnoses ..... 15

**HEDIS Measures**

    Effectiveness of Care Measures ..... 17

    Access to Care & Preventive Visit Measures ..... 20

    Frequency of Selected Procedures ..... 21

**Preference-Sensitive & High Cost Episodes**

    ETGs - Benchmark ..... 22

## DEMOGRAPHICS

The demographic section of the report provides key member demographic information. This section of the report is based on the administrative eligibility data provided by payers.

Because a proportion of members during the year are not covered for the full year, member months is the standard used for determining membership. The member months form the basis for denominators used in rate calculations throughout the remainder of the report.

Average age includes the contract holder, spouse and dependents. Average members is member months / 12.

DEMOGRAPHICS	2007	2008	% CHANGE	% ABOVE OR BELOW BENCHMARK
Average Number of Contracts	6,647	6,970	5%	
# of Contracts with Spouse or Dependent	4,124	4,358	6%	
Average Contract Size	2.1	2.2	1%	5%
Average Members	14,221	14,992	5%	
Member Months	170,657	179,903	5%	
Average Age	34.4	34.7	1%	-5%
% Female	58%	58%	0%	6%

## TOTAL PAYMENTS

This section includes a summary of claim payments. Payments throughout this report are based on the plan and member (deductible, coinsurance, copay) payments combined. Because benefit structures vary, valid comparison requires combining plan and member payments.

### Total Payments

This section provides Total Payments, Plan Payments, and Member Payments separately. Medical claims are distinguished from Pharmacy claims. In some cases pharmacy data may not be available or linked. Payments Per Member Per Month (PMPM) represent the claim payments / member months.

TOTAL PAYMENTS	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Total Payments	\$44,106,926	\$258	\$50,747,293	\$282	9%	-14%
Medical Plan Payments	\$39,255,872	\$230	\$45,323,319	\$252	10%	-16%
Medical Member Payments	\$4,851,054	\$28	\$5,423,974	\$30	6%	19%
Medical % Paid by Member	11%		11%		0%	0%
Pharmacy Plan Payments						
Pharmacy Member Payments						
Pharmacy % Paid by Member						

## MAJOR DISEASE CATEGORY PREVALENCE & PAYMENTS

Administrative medical claims include ICD-9 diagnostic coding which provide the basis for the information in this section of the report.

### Total Payments by Type of Contract

This section provides payments by contract type (single adult, two adults, family, one adult plus dependents). Per Contract Per Year (PCPY) are provided. These rates can be used to determine contract type differentials often utilized by actuaries.

TYPE OF CONTRACT	2007		2008			
	PAYMENTS	PCPY	PAYMENTS	PCPY	% CHANGE	% ABOVE OR BELOW BENCHMARK
1 Adult	\$13,099,875	\$4,280	\$13,894,284	\$4,401	3%	-10%
2 Adults	\$10,090,848	\$8,958	\$13,594,556	\$10,975	23%	-12%
Family	\$16,889,823	\$9,261	\$18,474,191	\$9,740	5%	-10%
Adult + Dependents	\$3,875,590	\$6,094	\$4,760,797	\$7,029	15%	-11%
All Other	\$150,789	\$0	\$23,465	\$0	0%	-100%

## MAJOR DISEASE CATEGORY PREVALENCE & PAYMENTS

Administrative medical claims include ICD-9 diagnostic coding which provide the basis for the information in this section of the report.

### Total Payments by Age & Gender

This section provides payments and payments PMPM by age and gender groups. This section also includes an age and gender standardized rate which is used to remove the effect of differences in the demographics of a population when making payment PMPM comparisons.

AGE & GENDER	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Total, Age / Sex Adjusted PMPM		\$267		\$291	9%	-11%
Total, All Ages	\$44,106,926	\$258	\$50,747,293	\$282	9%	-14%
Total 0	\$831,799	\$774	\$639,504	\$582	-25%	1%
1-4	\$1,330,855	\$156	\$946,653	\$105	-32%	-33%
5-17	\$3,366,633	\$103	\$3,892,186	\$114	11%	-12%
Male 18-34	\$2,136,318	\$152	\$2,098,115	\$143	-6%	-20%
35-44	\$2,415,421	\$204	\$2,477,258	\$207	2%	-3%
45-54	\$3,535,607	\$259	\$3,718,678	\$260	0%	-19%
55-64	\$3,840,981	\$400	\$5,835,062	\$547	37%	2%
65+	\$1,534,707	\$855	\$1,913,587	\$867	1%	-8%

## MAJOR DISEASE CATEGORY PREVALENCE & PAYMENTS

Administrative medical claims include ICD-9 diagnostic coding which provide the basis for the information in this section of the report.

### Total Payments by Age & Gender (continued)

AGE & GENDER	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Female 18-34	\$6,431,851	\$280	\$7,108,641	\$291	4%	-6%
35-44	\$5,856,698	\$339	\$6,184,578	\$348	3%	-3%
45-54	\$6,235,657	\$296	\$8,313,670	\$382	29%	-13%
55-64	\$5,410,180	\$371	\$6,465,557	\$401	8%	-23%
65+	\$1,178,299	\$820	\$1,153,805	\$675	-18%	2%
Unknown Age & Gender	\$1,919	\$0	\$0	\$0	0%	0%

### Total Payments by Relationship

This section provides payments and payments PMPM by contract holder (employee) compared with covered spouse and/or dependents.

RELATIONSHIP	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Employee	\$25,144,869	\$312	\$29,355,930	\$347	11%	-8%
Spouse / Dependent	\$18,962,057	\$211	\$21,391,363	\$225	7%	-19%

## MAJOR DISEASE CATEGORY PREVALENCE & PAYMENTS

Administrative medical claims include ICD-9 diagnostic coding which provide the basis for the information in this section of the report.

### Major Disease Category Prevalence

The disease prevalence provides information on major diagnostic categories that contribute significantly to healthcare payments. This includes the number of members and the prevalence rate per 1,000 members. Counts and rates for major categories such as heart and circulatory disease are provided as well as more detailed categories such as coronary heart disease or stroke. Prevalence for key chronic diseases such as diabetes and asthma are reported. Select invasive cancers are reported including those with high prevalence and cost that can be reduced through improved screening.

MAJOR DISEASE CATEGORY PREVALENCE	2007		2008			
	MEMBERS WITH CONDITION	RATE PER 1,000	MEMBERS WITH CONDITION	RATE PER 1,000	% CHANGE	% ABOVE OR BELOW BENCHMARK
Injuries, Muscles & Skeletal	5,764	405.3	6,144	409.8	1%	-2%
Back Injury	1,736	122.1	1,884	125.7	3%	-3%
Heart & Other Circulatory Diseases	1,951	137.2	2,117	141.2	3%	-12%
Coronary Heart Disease	199	14.0	212	14.1	1%	-19%
Stroke	71	5.0	68	4.5	-9%	-24%
Congestive Heart Failure	28	2.0	38	2.5	29%	-7%
Cancers	1,541	108.4	1,474	98.3	-9%	-10%
Breast Cancer	69	4.9	81	5.4	11%	-16%
Lung Cancer	9	0.6	11	0.7	16%	-27%
Colorectal Cancer	24	1.7	24	1.6	-5%	19%
Digestive System Diseases	1,783	125.4	1,876	125.1	0%	-1%
Genitourinary System Disorders	2,731	192.0	2,817	187.9	-2%	2%

MAJOR DISEASE CATEGORY PREVALENCE & PAYMENTS (continued)

Major Disease Category Prevalence (continued)

MAJOR DISEASE CATEGORY PREVALENCE	2007		2008			
	MEMBERS WITH CONDITION	RATE PER 1,000	MEMBERS WITH CONDITION	RATE PER 1,000	% CHANGE	% ABOVE OR BELOW BENCHMARK
Respiratory System Disorders	3,627	255.0	3,660	244.1	-4%	-9%
Asthma	553	38.9	583	38.9	0%	6%
Chronic Obstructive Pulmonary Disease (COPD)	87	6.1	86	5.7	-6%	-29%
Mental Disorders	2,614	183.8	2,840	189.4	3%	20%
Depression	1,183	83.2	1,267	84.5	2%	23%
Diseases of the Nervous System & Sense Organs	3,514	247.1	3,657	243.9	-1%	-7%
Nutritional & Metabolic	3,001	211.0	3,161	210.8	0%	-10%
Diabetes	606	42.6	636	42.4	0%	-15%
Dyslipidemia (High Cholesterol)	1,626	114.3	1,696	113.1	-1%	-18%

## MAJOR DISEASE CATEGORY PREVALENCE & PAYMENTS (continued)

### Payments by Major Disease Category

This section provides the payments and payments PMPM for the major diagnostic categories that contribute to health care payments. Pharmacy claims do not contain diagnostic coding and are not included.

MAJOR DISEASE CATEGORY	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Injuries, Muscles & Skeletal	\$8,898,446	\$52	\$9,795,819	\$54	4%	-13%
Heart & Other Circulatory Diseases	\$2,999,851	\$18	\$3,797,033	\$21	20%	-24%
Cancers	\$3,803,863	\$22	\$3,503,375	\$19	-13%	-36%
Digestive System Diseases	\$3,112,860	\$18	\$3,777,674	\$21	15%	-9%
Genitourinary System Disorders	\$2,788,780	\$16	\$2,890,736	\$16	-2%	-21%
Respiratory System Disorders	\$1,493,816	\$9	\$1,818,425	\$10	15%	-22%
Mental Disorders	\$2,541,074	\$15	\$2,803,754	\$16	5%	8%
Diseases of the Nervous System & Sense Organs	\$1,940,689	\$11	\$2,364,778	\$13	16%	-15%
Nutritional & Metabolic	\$1,509,116	\$9	\$1,751,949	\$10	10%	-31%
All Other Medical Claims	\$15,018,431	\$88	\$18,243,749	\$101	15%	-4%

## UTILIZATION BY TYPE OF SERVICE

This section provides counts and rates per 1,000 for the utilization of services. Inpatient use, outpatient emergency department use, standard and advanced diagnostic tests, and professional encounters by specialty of provider are reported.

UTILIZATION BY TYPE OF SERVICE	2007		2008			
	SERVICES	RATE PER 1,000	SERVICES	RATE PER 1,000	% CHANGE	% ABOVE OR BELOW BENCHMARK
<b>Inpatient Hospital</b>						
Discharges	837	58.9	871	58.1	-1%	3%
Inpatient Days	3,287	231.1	3,377	225.3	-3%	1%
<b>Outpatient Service Encounters</b>						
Emergency Department Visits	4,235	297.8	4,447	296.6	0%	11%
Operating Room Procedures	996	70.0	991	66.1	-6%	-16%
<b>Diagnostic Testing</b>						
Standard Imaging	10,091	709.6	10,619	708.3	0%	-5%
Advanced Imaging	2,397	168.5	2,482	165.6	-2%	-4%
Echography	3,489	245.3	4,123	275.0	12%	20%
Laboratory	28,521	2,005.5	30,196	2,014.2	0%	-3%
Colonoscopy	745	52.4	708	47.2	-10%	-12%
Cardiac Testing	2,410	169.5	2,668	178.0	5%	-2%

UTILIZATION BY TYPE OF SERVICE (continued)

UTILIZATION BY TYPE OF SERVICE	2007		2008			
	SERVICES	RATE PER 1,000	SERVICES	RATE PER 1,000	% CHANGE	% ABOVE OR BELOW BENCHMARK
Professional Encounters						
Primary Care	40,457	2,844.8	42,764	2,852.5	0%	-4%
Medical Specialist	23,668	1,664.3	24,638	1,643.4	-1%	-2%
Surgical Specialist	13,422	943.8	15,077	1,005.7	7%	11%
Chiropractic Care / Osteopathic Manip.	13,854	974.2	16,018	1,068.4	10%	-2%
Physical, Speech & Occ. Therapists	21,836	1,535.4	23,765	1,585.2	3%	3%
Mental Health / Substance Abuse	16,258	1,143.2	18,937	1,263.1	10%	26%
All Other Professional	20,640	1,451.3	22,103	1,474.3	2%	38%

## PAYMENTS BY TYPE OF PROVIDER

This section provides payments and payments PPM by type of provider. Hospital inpatient, hospital outpatient, free-standing and other facilities are reported. Payments to professionals are reported by major specialty.

PAYMENTS BY TYPE OF PROVIDER	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Total Payments	\$44,106,926	\$258	\$50,747,293	\$282	9%	-14%
Hospital Inpatient	\$9,266,290	\$54	\$10,689,572	\$59	9%	-15%
Hospital Outpatient	\$12,472,712	\$73	\$14,661,006	\$81	12%	-34%
Freestanding Ambulatory Surgical Center	\$676,505	\$4	\$735,868	\$4	3%	82%
Other Facility	\$2,389,034	\$14	\$2,349,272	\$13	-7%	-16%
Professional Encounters						
Primary Care	\$4,762,318	\$28	\$5,310,811	\$30	6%	2%
Medical Specialist	\$4,190,581	\$25	\$5,031,110	\$28	14%	5%
Surgical Specialist	\$3,592,638	\$21	\$4,253,256	\$24	12%	8%
Chiropractic Care / Osteopathic Manip.	\$984,709	\$6	\$1,083,953	\$6	4%	-1%
Mental Health / Substance Abuse	\$1,119,484	\$7	\$1,351,158	\$8	14%	21%
All Other Professional	\$3,418,141	\$20	\$3,792,413	\$21	5%	17%

PAYMENTS BY TYPE OF PROVIDER (continued)

PAYMENTS BY TYPE OF PROVIDER	2007		2008			
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE	% ABOVE OR BELOW BENCHMARK
Home Health / Ambulance / DME	\$1,185,684	\$7	\$1,455,080	\$8	16%	-5%
Other / Unclassified	\$48,829	\$0	\$33,794	\$0	-34%	-72%
Prescription Drug	\$0	\$0	\$0	\$0	0%	0%

## HIGH COST CASES

A small number of high cost cases often have a significant impact on total payments and trends. This section of the report provides information on high cost cases. High cost cases are defined as those members who incurred \$50,000 or more in combined claims payments for the entire year. An arbitrary cutoff of \$50,000 was used instead of percentiles to facilitate comparisons between years and between populations.

High cost cases are stratified by cost categories, age group, and relationship (contract holder/employee compared with spouses and dependents). The percentage of all members who are high cost cases and the percentage of total payments due to high cost cases are reported.

### High Cost Cases

MEMBERS	2007	2008	
	MEMBERS	MEMBERS	% CHANGE
Average Members	14,221	14,992	5%
High Cost Members	79	87	10%

PAYMENTS	2007		2008		
	PAYMENTS	PMPM	PAYMENTS	PMPM	% CHANGE
Total Payments	\$44,106,926	\$258	\$50,747,293	\$282	15%
High Cost Members' Payments	\$7,722,893	\$8,639	\$9,001,874	\$8,748	17%

HIGH COST PERCENT	2007	2008	
	PCT	PCT	% CHANGE
High Cost Case Payments as a percent of Total Payments	18%	18%	1%
High Cost Case Members as a percent of Total Members	1%	1%	4%

HIGH COST CASES (continued)

HIGH COST CASE DISTRIBUTION CATEGORIES	2007		2008		
	PAYMENTS	MEMBERS	PAYMENTS	MEMBERS	% CHANGE
\$50,000 - \$99,999	\$4,276,915	61	\$4,406,694	62	3%
\$100,000 - \$199,999	\$1,758,447	13	\$2,759,533	21	57%
\$200,000 - \$499,999	\$1,687,531	5	\$825,612	3	-51%
\$500,000+	\$0	0	\$1,010,035	1	0%

HIGH COST CASE BY AGE	2007		2008		
	MEMBERS	% OF TOTAL	MEMBERS	% OF TOTAL	% CHANGE
Total, All Ages	79	100%	87	100%	10%
Total 0-17	8	10%	5	6%	-38%
Total 18-49	31	39%	33	38%	6%
Total 50-64	27	34%	39	45%	44%
Total 65+	13	16%	10	11%	-23%

HIGH COST CASE BY RELATIONSHIP	2007		2008		
	MEMBERS	% OF TOTAL	MEMBERS	% OF TOTAL	% CHANGE
Employee	41	52%	51	59%	24%
Spouse / Dependent	38	48%	36	41%	-5%

## HIGH COST CASES (continued)

### High Cost Cases by Leading Diagnoses

Leading diagnoses for high cost cases are reported based on primary diagnosis on claims. Because a high cost case may have multiple diagnoses during the year, on members are reported based on the diagnoses on their claims regardless of underlying disease. For example, a single member with diabetes and with coronary heart disease, will have claims in both categories. Therefore, the count of members in this section will add to more than the total count of high cost members.

HIGH COST CASES BY LEADING DIAGNOSES	2007		2008		
	MEMBERS WITH CONDITION	TOTAL PAYMENTS	MEMBERS WITH CONDITION	TOTAL PAYMENTS	% CHANGE PAYMENTS
All High Cost Payments		\$7,722,893		\$9,001,874	17%
Injuries, Muscles & Skeletal	57	\$982,786	63	\$851,249	-13%
Heart & Other Circulatory Diseases (Total)	56	\$1,250,565	51	\$1,774,804	42%
Coronary Heart Disease	20	\$674,323	14	\$986,365	46%
Stroke	7	\$69,514	4	\$3,269	-95%
Congestive Heart Failure	9	\$58,587	7	\$18,958	-68%
Cancers (Total)	35	\$1,587,138	36	\$1,381,095	-13%
Lung Cancer	2	\$57,562	4	\$125,743	118%
Breast Cancer	4	\$241,445	9	\$430,045	78%
Colorectal Cancer	3	\$133,696	4	\$256,445	92%
Cervical Cancer	0	\$0	0	\$0	0%
Prostate Cancer	2	\$35,861	0	\$0	-100%

HIGH COST CASES (continued)

High Cost Cases by Leading Diagnoses (continued)

HIGH COST CASES BY LEADING DIAGNOSES	2007		2008		
	MEMBERS WITH CONDITION	TOTAL PLAN PAYMENTS	MEMBERS WITH CONDITION	TOTAL PLAN PAYMENTS	% CHANGE PAYMENTS
Digestive System Diseases	36	\$526,184	38	\$557,485	6%
Genitourinary System Disorders	32	\$298,325	37	\$226,298	-24%
Respiratory System Disorders	47	\$241,242	47	\$348,562	44%
Pregnancy & Newborns	8	\$499,390	8	\$432,073	-13%
Mental Disorders / Substance Abuse	18	\$6,626	20	\$75,444	1,039%
Diseases of the Nervous System & Sense Organs	43	\$192,455	57	\$351,070	82%
Nutritional & Metabolic (Total)	41	\$210,126	42	\$257,680	23%
Diabetes	13	\$20,380	18	\$32,155	58%

## HEDIS MEASURES

Developed by the National Committee for Quality Assurance (NCQA), HEDIS (Healthcare Effectiveness Data and Information Set) is one of the most widely used sets of health care performance measures. NCQA Commercial HMO national averages are also provided for comparison.

### Effectiveness of Care Measures

The following selected HEDIS measures are reported in this section:

#### Comprehensive Diabetes Care (CDC)

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.  
The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a LDL-C screening.

#### Use of Appropriate Medications for People with Asthma (ASM)

The percentage of members 5-56 years of age who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

#### Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The percentage of children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI (i.e. the proportion for whom antibiotics *were not* prescribed).

#### Breast Cancer Screening (BCS)

The percentage of women 42-51 and 52-69 years of age who had a mammogram to screen for breast cancer.

#### Cervical Cancer Screening (CCS)

The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

#### Cholesterol Management for Patients with Cardiovascular Conditions (CMC)

The percentage of members 18-75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) or who had a diagnosis of ischemic heart disease, who had a LDL screening.

#### Use of Imaging Studies for Low Back Pain (LBP)

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT Scan within 28 days of the diagnosis). A high score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did *not* occur).



HEDIS MEASURES (continued)

Effectiveness of Care Measures (continued)

EFFECTIVENESS OF CARE	2007		2008				
	DISTINCT MEMBERS	PCT	DISTINCT MEMBERS	PCT	% CHANGE	% ABOVE OR BELOW BENCHMARK	NCQA NATIONAL AVG
Diabetes Care-HbA1c testing, 18-75	434	89%	474	88%	-1%	0%	88%
Diabetes Care-LDL testing, 18-75	402	82%	457	85%	3%	3%	84%
Appropriate Meds for Asthmatics, 5-56	194	93%	212	93%	0%	0%	92%
Appropriate Tx for Children with URI, 3m-18y	252	88%	238	86%	-1%	1%	84%
Breast Cancer Screening, 42-51	1,033	77%	1,071	76%	-1%	-1%	66%
Breast Cancer Screening, 52-69	1,303	83%	1,491	84%	1%	0%	72%
Cervical Cancer Screening, 21-64	2,890	78%	3,053	78%	0%	2%	82%
Cholesterol Mgmt for Cardio Cond, 18-75	116	85%	129	83%	-3%	6%	88%
Imaging Studies for Low Back Pain, 18-50	304	79%	344	84%	6%	1%	75%

## HEDIS MEASURES (continued)

### HEDIS Access to Care & Preventive Visit Measures

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34). The percentage of members 3-6 years of age who received one or more well-child visits with a primary care physician.

Adolescent Well-Care Visits (AWC). The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a primary care physician or an OB/GYN practitioner.

Children and Adolescents' Access to Primary Care Practitioners (CAP). The percentage of members who had a visit with a primary care practitioner. The report provides measures for children 25-months to 6 years of age and for adolescents 12-19 years of age.

Adults' Access to Preventive/Ambulatory Health Services (AAP). The percentage of members who had an ambulatory or preventive care visits. Report shows the rate for members 45-64 years of age.

ACCESS / AVAILABILITY OF CARE	2007		2008				
	DISTINCT MEMBERS	PCT	DISTINCT MEMBERS	PCT	% CHANGE	% ABOVE OR BELOW BENCHMARK	NCQA NATIONAL AVG
Well-Child Visits, 3-6	454	77%	515	80%	4%	5%	68%
Adolescent Well-Care Visits, 12-21	871	43%	890	43%	-1%	11%	42%
Childrens' Access to PCPs, 25Mths-6y	697	92%	739	93%	1%	1%	89%
Adolescents' Access to PCPs, 12-19	1,337	89%	1,390	91%	2%	2%	87%
Adult Access to Health Services, Total 45-64	3,533	95%	3,785	96%	2%	0%	95%
Adult Access to Health Services, Female 45-64	2,194	96%	2,333	97%	1%	0%	
Adult Access to Health Services, Male 45-64	1,339	92%	1,452	94%	2%	0%	

HEDIS MEASURES (continued)

**Frequency of Selected Procedures**

This measure summarizes the utilization of frequently performed procedures that often show wide geographical variation and have generated concern regarding potentially inappropriate utilization. Many of these procedures have also been referred to as preference-sensitive indicating that for some medical conditions, there are significant tradeoffs among available options and the importance of informed decision-making based on patient's values and preferences. NCQA HEDIS reports frequency and rates for each procedure by selected age groups. For this report, the HEDIS age groups that reflect highest volume in the commercial population were selected for reporting.

FREQUENCY OF SELECTED PROCEDURES	2007		2008				
	PROCEDURES	RATE PER 1,000	PROCEDURES	RATE PER 1,000	% CHANGE	% ABOVE OR BELOW BENCHMARK	NCQA NATIONAL AVG
Myringotomy, 0-4	24	29.9	11	13.1	-56%	-34%	50.0
Tonsillectomy, 0-9	16	9.4	7	3.9	-58%	-34%	9.9
Angioplasty (PTCA), Female, 45-64	4	1.3	0	0.0	-100%	-100%	3.8
Angioplasty (PTCA), Male, 45-64	10	5.2	11	5.3	2%	-14%	8.3
Cardiac Catheterization, Female, 45-64	8	2.7	11	3.5	29%	-42%	11.2
Cardiac Catheterization, Male, 45-64	17	8.8	22	10.6	20%	-24%	14.3
Coronary Artery Bypass Graft, Female, 45-64	2	0.7	0	0.0	-100%	-100%	1.8
Coronary Artery Bypass Graft, Male, 45-64	4	2.1	3	1.4	-30%	-7%	3.4
Cholecystectomy, Closed, Female, 45-64	19	6.4	18	5.7	-11%	-16%	7.1
Cholecystectomy, Closed, Male, 30-64	14	7.2	11	5.3	-27%	1%	3.0
Prostatectomy, 45-64	5	1.5	9	2.6	71%	38%	

HEDIS MEASURES (continued)

Frequency of Selected Procedures (continued)

FREQUENCY OF SELECTED PROCEDURES	2007		2008				
	PROCEDURES	RATE PER 1,000	PROCEDURES	RATE PER 1,000	% CHANGE	% ABOVE OR BELOW BENCHMARK	NCQA NATIONAL AVG
Back Surgery, Female, 45-64	14	4.7	16	5.1	8%	19%	6.2
Back Surgery, Male, 45-64	12	6.2	17	8.2	32%	52%	6.2
Lumpectomy, 45-64	14	4.7	14	4.4	-6%	-38%	6.8
Mastectomy, 45-64	4	1.3	4	1.3	-6%	-33%	1.7
Non-Obstetric D & C, 45-64	10	3.4	13	4.1	22%	22%	2.9
Abdominal Hysterectomy, 45-64	18	6.1	23	7.3	20%	21%	5.9
Vaginal Hysterectomy, 45-64	15	5.0	11	3.5	-31%	34%	3.5

## PREFERENCE-SENSITIVE & HIGH COST EPISODES

Onpoint Health Data uses Ingenix Episode Treatment Groups\* to group administrative claims data into episodes of illness. ETGs are used in utilization and cost analyses, physician profiling, quality assessment, disease and case management. The illness classification and episode building methodology yields clinically homogeneous episodes of care, regardless of treatment location or duration. ETGs combine inpatient, outpatient, ancillary, and pharmacy claims to build a comprehensive treatment episode. Onpoint Health Data has identified through analysis and clinical review, ETGs that closely corresponded to conditions identified as preference-sensitive. Based on this work, selected preference-sensitive and high cost ETGs are reported in this section. The report includes the count of episodes, payment per episode and total payments.

Only full clean episodes as defined in the ETG grouping are included and outlier episodes are excluded. With these exclusions, the report may under-report the total volume of episodes incurred during the period. It is intended to demonstrate the relative differences in payments per episode.

**ETGs - Benchmark**

EPISODE TREATMENT GROUP NAME	2007-2008		
	EPISODE COUNTS	PAYMENT PER EPISODE	TOTAL PAYMENTS
Joint Degeneration (Spine)	6,318	\$2,009	\$12,690,873
Joint degeneration, localized, with surgery - neck & back	265	\$16,733	\$4,434,273
Joint degeneration, localized, w/o surgery - neck & back	6,053	\$1,364	\$8,256,600
Other Minor Orthopedic Disorders - Neck & Back	26,917	\$462	\$12,430,627
Joint Derangement (Knee)	1,865	\$3,323	\$6,197,724
Joint derangement, with surgery - knee & lower leg	690	\$7,200	\$4,967,687
Joint derangement, w/o surgery - knee & lower leg	1,175	\$1,047	\$1,230,037

PREFERENCE-SENSITIVE & HIGH-COST EPISODES (continued)

ETGs - Benchmark (continued)

EPISODE TREATMENT GROUP NAME	2007-2008		
	EPISODE COUNTS	PAYMENT PER EPISODE	TOTAL PAYMENTS
Benign Neoplasm of Female Genital Tract	4,165	\$3,713	\$15,465,830
Benign neoplasm of female genital tract, with surgery	856	\$10,789	\$9,235,118
Benign neoplasm of female genital tract, w/o surgery	3,309	\$1,883	\$6,230,712
Malignant Neoplasm of Breast, with Surgery	67	\$42,162	\$2,824,859
Coronary Artery Disease, with AMI	130	\$41,532	\$5,399,217
Heart Disease without AMI	3,845	\$3,211	\$12,347,604
Coronary artery disease, w/o AMI, with coronary artery bypass graft	18	\$18,237	\$328,272
Coronary artery disease, w/o AMI, with angioplasty	121	\$18,019	\$2,180,264
Coronary artery disease, w/o AMI, with cardiac catheterization	183	\$16,179	\$2,960,690
Ischemic heart disease, except CHF, w/o AMI	3,523	\$1,952	\$6,878,378

PREFERENCE-SENSITIVE & HIGH-COST EPISODES (continued)

ETGs - Benchmark (continued)

EPISODE TREATMENT GROUP NAME	2007-2008		
	EPISODE COUNTS	PAYMENT PER EPISODE	TOTAL PAYMENTS
Hernias	2,688	\$3,817	\$10,260,932
Hernias, except hiatal, with surgery	1,397	\$6,602	\$9,222,935
Hernias, except hiatal, w/o surgery	1,291	\$804	\$1,037,997
Simple Cholelithiasis	908	\$6,309	\$5,728,255
Cholelithiasis, simple, with surgery	551	\$9,422	\$5,191,396
Cholelithiasis, simple, w/o surgery	357	\$1,504	\$536,859
Tonsillitis, Adenoiditis, or Pharyngitis	34,151	\$265	\$9,042,750
Otitis Media, without Major Surgery	23,052	\$228	\$5,248,860



Reliable data. Informed decisions. Strategic advantage.

16 Association Drive  
PO Box 360  
Manchester, ME 04351  
207 623-2555  
207 622-7086 FAX

[www.OnpointHealthData.org](http://www.OnpointHealthData.org)

## Appendix B-3 – Sample HIT Report

Database: VHCURES medical and pharmacy claims for Vermont residents only												
Time Period: 6 selected data periods												
Paid/Incurred Basis: Paid												
Pharmacy Claims Included: Yes												
1/28/2010												
Comprehensive Major Medical												
Year	Qtr	Payercode	Insurer	Member Months (A)	Average Members (B)	Total Paid Medical Claims (C)	Total Plan Paid Medical Claims	Total Member Paid Medical Claims	Total Paid Pharmacy Claims (D)	Total Plan Paid Pharmacy Claims	Total Member Paid Pharmacy Claims	Total Paid Plan+Member Medical and Pharmacy Claims (C)+(D)
YEAR	QTR	PAYERCO	COMPANY	COM_MM	COM_AVG	COM_MED_TOT	COM_MED_PLAN	COM_MED_MEM	COM_RX_TOT	COM_RX_PLAN	COM_RX_MEM	COM_TOT_PAID
2008	-1	1	Total	3,915,382	326,282	\$ 996,964,684	\$ 874,487,985	\$ 122,476,699	\$ 223,240,596	\$ 176,401,055	\$ 46,839,541	\$ 1,220,205,280
2008	1	1	Total	985,010	328,337	\$ 242,245,556	\$ 204,620,631	\$ 37,624,925	\$ 68,942,092	\$ 52,447,181	\$ 16,494,911	\$ 311,187,648
2008	2	1	Total	980,155	326,718	\$ 256,170,442	\$ 222,484,007	\$ 33,686,435	\$ 56,550,786	\$ 44,858,960	\$ 11,691,826	\$ 312,721,228
2008	3	1	Total	979,724	326,575	\$ 244,731,728	\$ 217,503,601	\$ 27,228,126	\$ 49,824,312	\$ 40,180,629	\$ 9,643,683	\$ 294,556,040
2008	4	1	Total	970,493	323,498	\$ 253,816,959	\$ 229,879,746	\$ 23,937,213	\$ 47,923,405	\$ 38,914,286	\$ 9,009,120	\$ 301,740,364
2008	-1	VTC0125	Connecticut General Life Insurance Cor	1,103,629	91,969	\$ 266,926,959	\$ 229,543,227	\$ 37,383,732	\$ 40,314,970	\$ 29,921,004	\$ 10,393,965	\$ 307,241,929
2008	1	VTC0125	Connecticut General Life Insurance Cor	278,052	92,684	\$ 65,804,558	\$ 54,486,578	\$ 11,317,980	\$ 10,070,793	\$ 6,994,800	\$ 3,075,993	\$ 75,875,350
2008	2	VTC0125	Connecticut General Life Insurance Cor	278,173	92,724	\$ 67,716,871	\$ 57,643,754	\$ 10,073,117	\$ 9,942,707	\$ 7,297,023	\$ 2,645,684	\$ 77,659,578
2008	3	VTC0125	Connecticut General Life Insurance Cor	276,091	92,030	\$ 64,864,004	\$ 56,532,404	\$ 8,331,599	\$ 9,854,572	\$ 7,465,563	\$ 2,389,009	\$ 74,718,576
2008	4	VTC0125	Connecticut General Life Insurance Cor	271,313	90,438	\$ 68,541,527	\$ 60,880,491	\$ 7,661,036	\$ 10,446,898	\$ 8,163,617	\$ 2,283,280	\$ 78,988,425
2008	-1	VTC0802	Blue Cross Blue Shield of Vermont	1,113,832	92,819	\$ 345,915,538	\$ 306,258,539	\$ 39,656,999	\$ 54,295,305	\$ 47,492,582	\$ 6,802,723	\$ 400,210,843
2008	1	VTC0802	Blue Cross Blue Shield of Vermont	278,239	92,746	\$ 84,616,537	\$ 71,465,017	\$ 13,151,520	\$ 22,648,403	\$ 18,854,632	\$ 3,793,771	\$ 107,264,941
2008	2	VTC0802	Blue Cross Blue Shield of Vermont	277,445	92,482	\$ 86,051,222	\$ 75,362,466	\$ 10,688,756	\$ 14,328,804	\$ 12,836,156	\$ 1,492,648	\$ 100,380,026
2008	3	VTC0802	Blue Cross Blue Shield of Vermont	277,780	92,593	\$ 84,579,312	\$ 76,158,287	\$ 8,421,025	\$ 10,316,375	\$ 9,437,719	\$ 878,656	\$ 94,895,688
2008	4	VTC0802	Blue Cross Blue Shield of Vermont	280,368	93,456	\$ 90,668,466	\$ 83,272,769	\$ 7,395,697	\$ 7,001,723	\$ 6,364,075	\$ 637,647	\$ 97,670,189
2008	-1	VTC0818	MVP Health Insurance Company	66,304	5,525	\$ 13,404,477	\$ 11,730,691	\$ 1,673,786	\$ 3,699,770	\$ 2,638,657	\$ 1,061,112	\$ 17,104,247
2008	1	VTC0818	MVP Health Insurance Company	13,964	4,655	\$ 2,476,161	\$ 2,114,570	\$ 361,592	\$ 751,014	\$ 499,126	\$ 251,888	\$ 3,227,175
2008	2	VTC0818	MVP Health Insurance Company	16,749	5,583	\$ 3,251,761	\$ 2,824,204	\$ 427,557	\$ 835,962	\$ 597,744	\$ 238,219	\$ 4,087,723
2008	3	VTC0818	MVP Health Insurance Company	17,413	5,804	\$ 3,669,578	\$ 3,229,736	\$ 439,842	\$ 970,900	\$ 696,474	\$ 274,426	\$ 4,640,479
2008	4	VTC0818	MVP Health Insurance Company	18,178	6,059	\$ 4,006,977	\$ 3,562,181	\$ 444,796	\$ 1,141,893	\$ 845,313	\$ 296,580	\$ 5,148,870
2008	-1	VTC0830	The Vermont Health Plan	327,621	27,302	\$ 86,050,721	\$ 69,738,359	\$ 16,312,362	\$ 20,370,302	\$ 15,555,539	\$ 4,814,762	\$ 106,421,023
2008	1	VTC0830	The Vermont Health Plan	81,858	27,286	\$ 20,692,593	\$ 15,540,944	\$ 5,151,649	\$ 10,046,241	\$ 7,344,346	\$ 2,701,895	\$ 30,738,834
2008	2	VTC0830	The Vermont Health Plan	82,228	27,409	\$ 22,003,429	\$ 17,155,784	\$ 4,847,644	\$ 5,144,122	\$ 4,020,801	\$ 1,123,321	\$ 27,147,551
2008	3	VTC0830	The Vermont Health Plan	82,394	27,465	\$ 21,393,479	\$ 17,702,194	\$ 3,691,285	\$ 3,234,940	\$ 2,592,694	\$ 642,246	\$ 24,628,420
2008	4	VTC0830	The Vermont Health Plan	81,141	27,047	\$ 21,961,220	\$ 19,339,437	\$ 2,621,783	\$ 1,944,998	\$ 1,597,698	\$ 347,300	\$ 23,906,218
2008	-1	VTC0831	MVP Health Plan, Inc.	244,256	20,355	\$ 146,609,386	\$ 138,783,248	\$ 7,826,139	\$ 16,028,540	\$ 11,979,289	\$ 4,049,251	\$ 162,637,926
2008	1	VTC0831	MVP Health Plan, Inc.	62,065	20,688	\$ 34,901,220	\$ 32,933,132	\$ 1,968,088	\$ 4,173,853	\$ 2,981,667	\$ 1,192,186	\$ 39,075,072
2008	2	VTC0831	MVP Health Plan, Inc.	61,032	20,344	\$ 40,809,427	\$ 38,584,095	\$ 2,225,332	\$ 3,606,179	\$ 2,672,208	\$ 933,971	\$ 44,415,606
2008	3	VTC0831	MVP Health Plan, Inc.	60,214	20,071	\$ 36,307,745	\$ 34,446,928	\$ 1,860,817	\$ 4,038,023	\$ 3,092,291	\$ 945,733	\$ 40,345,769
2008	4	VTC0831	MVP Health Plan, Inc.	60,945	20,315	\$ 34,590,994	\$ 32,819,093	\$ 1,771,901	\$ 4,210,485	\$ 3,233,123	\$ 977,362	\$ 38,801,479

## Appendix B-4 — Sample Medicare Products Summary Report

Paid Claims Report: Annual Medicare Summary  
 T002  
 Time Period: CY07, CY08, quarterly  
 Paid/Incurred Basis: Paid  
 Pharmacy Included: Yes

				Medicare Supplement									
Calendar Year	Calendar Qtr	Payercode	Payer Name	Age Category	Member Months	Average Months	Plan Paid Medical	Member Paid Medical	Total Paid Medical	Plan Paid Pharmacy	Member Paid Pharmacy	Total Paid Pharmacy	Total Paid Medical and Pharmacy
2008 Total		-1	Statewide Total	Total	64,632	7,069.3	11,763,245.92	15,366.44	11,778,612.36	64,615,051.30	22,807,827.05	107,422,878.35	119,201,490.71
2008 Total		-1	Statewide Total	0 - 17	-	-	-	-	-	-	-	-	-
2008 Total		-1	Statewide Total	18 - 44	273	22.8	37,395.58	-	37,395.58	12,442.94	50,652.51	63,095.45	100,491.03
2008 Total		-1	Statewide Total	45 - 64	4,219	351.6	887,606.14	515.60	888,121.74	4,502,969.98	1,204,499.88	5,757,469.86	6,645,591.60
2008 Total		-1	Statewide Total	65 +	80,340	6,695.0	10,838,244.20	14,850.84	10,853,095.04	80,049,638.38	21,552,674.66	101,602,313.04	112,455,408.08
2008 Total	VTC0802		Blue Cross Blue Shield of Vermont	Total	64,739	7,061.6	11,741,345.79	15,366.44	11,756,712.23	10,031,793.56	4,702,680.46	14,734,474.02	26,491,186.25
2008 Total	VTC0802		Blue Cross Blue Shield of Vermont	18 - 44	273	22.8	37,395.58	-	37,395.58	8,436.84	46,834.87	55,271.71	92,667.29
2008 Total	VTC0802		Blue Cross Blue Shield of Vermont	45 - 64	4,219	351.6	887,606.14	515.60	888,121.74	476,065.82	205,836.65	681,902.47	1,570,024.21
2008 Total	VTC0802		Blue Cross Blue Shield of Vermont	65 +	80,247	6,687.3	10,816,344.07	14,850.84	10,831,194.91	9,547,290.90	4,450,008.94	13,997,299.84	24,828,494.75
2008 1	VTC0802		Blue Cross Blue Shield of Vermont	Total	21,690	7,230.0	3,337,082.75	5,129.07	3,342,211.82	5,086,813.22	2,524,256.21	7,611,069.43	10,933,281.25
2008 1	VTC0802		Blue Cross Blue Shield of Vermont	18 - 44	63	21.0	10,201.35	-	10,201.35	8,384.81	17,213.64	25,598.45	35,799.60
2008 1	VTC0802		Blue Cross Blue Shield of Vermont	45 - 64	1,122	374.0	259,871.52	46.76	259,918.28	288,244.93	91,267.94	359,512.87	619,431.15
2008 1	VTC0802		Blue Cross Blue Shield of Vermont	65 +	20,505	6,835.0	3,067,009.88	5,082.31	3,072,092.19	4,810,183.48	2,415,774.63	7,225,958.11	10,298,050.30
2008 2	VTC0802		Blue Cross Blue Shield of Vermont	Total	21,320	7,106.7	2,931,065.40	3,210.04	2,934,275.44	2,711,735.52	1,057,878.80	3,769,614.32	6,703,889.76
2008 2	VTC0802		Blue Cross Blue Shield of Vermont	18 - 44	66	22.0	6,638.40	-	6,638.40	7.75	1,153.74	1,161.49	7,799.89
2008 2	VTC0802		Blue Cross Blue Shield of Vermont	45 - 64	1,088	362.7	205,377.77	162.17	205,539.94	108,235.87	65,050.82	173,286.69	378,826.63
2008 2	VTC0802		Blue Cross Blue Shield of Vermont	65 +	20,166	6,722.0	2,719,049.23	3,047.87	2,722,097.10	2,603,491.90	991,674.24	3,595,166.14	6,317,263.24
2008 3	VTC0802		Blue Cross Blue Shield of Vermont	Total	20,983	6,894.3	2,698,220.83	3,934.18	2,703,155.01	1,456,451.35	642,014.06	2,098,465.41	4,801,620.42
2008 3	VTC0802		Blue Cross Blue Shield of Vermont	18 - 44	73	24.3	12,298.23	-	12,298.23	-	-	-	12,298.23
2008 3	VTC0802		Blue Cross Blue Shield of Vermont	45 - 64	1,013	337.7	212,922.07	239.88	213,161.95	50,154.11	18,797.01	68,951.12	282,113.07
2008 3	VTC0802		Blue Cross Blue Shield of Vermont	65 +	19,897	6,632.3	2,474,000.53	3,694.30	2,477,694.83	1,406,297.24	623,217.05	2,029,514.29	4,507,209.12
2008 4	VTC0802		Blue Cross Blue Shield of Vermont	Total	20,746	6,915.3	2,773,976.81	3,093.15	2,777,069.96	776,793.47	478,531.39	1,255,324.86	4,032,394.82
2008 4	VTC0802		Blue Cross Blue Shield of Vermont	18 - 44	71	23.7	8,257.60	-	8,257.60	44.28	28,467.49	28,511.77	36,765.37
2008 4	VTC0802		Blue Cross Blue Shield of Vermont	45 - 64	996	332.0	209,434.78	66.79	209,501.57	49,430.91	30,720.88	80,151.79	289,653.36
2008 4	VTC0802		Blue Cross Blue Shield of Vermont	65 +	19,679	6,559.7	2,566,284.43	3,026.36	2,559,310.79	727,318.28	419,343.02	1,146,661.30	3,705,972.09

## APPENDIX C — WORK SAMPLES — HEALTH INSURANCE RATE REVIEWS

C-1 — Hospital Variation in Payments Adjusted for Patient Mix

C-2 — Triangulation Report



STATE OF MAINE  
BUREAU OF HUMAN RESOURCES

# Healthy Times

Employee Health & Benefits Newsletter – Winter 2010

## STATE EMPLOYEE HEALTH COMMISSION

### CO-CHAIRS:

Brett Hoskins  
Alicia Kellogg

### MEMBERS:

John Bloemendaal  
Lauren Carrier  
Becky Greene  
Carol Harris  
Tom Hayden  
Richard Hodgdon  
Kandi Jenkins  
Scott Kilcollins  
Jan Lachapelle  
John Leavitt  
Michael Mitchell  
Steve Moore  
Cheryl Moreau  
Ed Mouradian  
Carl Parker  
Kimberly Proffitt  
E. James Soucie  
J. Sam Teel  
Will Towers  
Freeman Wood

### EXECUTIVE DIRECTOR: (EX-OFFICIO)

Frank Johnson

### STAFF:

Tanya Plante

### EDITOR/LAYOUT:

Patrick E. Paradis

### CONTRIBUTORS:

Bill McPeck  
Guida Libby  
Jane Paxton  
Earle Pease  
Heather Sargent-Plante

## HOSPITAL COSTS

Did you know that a colonoscopy in one Maine hospital can cost the health plan as much as 8 times more than the same procedure in another Maine hospital? Does it make sense that a gall bladder removal can be three times more costly in Hospital A compared to Hospital B? Why is there a nearly 60% difference in what the plan pays Maine hospitals for the same market basket of common procedures?

These questions have been troubling the State Employee Health Commission for several years. After examining claims for the past five years the Commission has found that there are significant differences in both the volume of certain procedures and the amount paid for those services. For example, a member of the State employee plan living in central Aroostook County is twice as likely to have an advanced imaging procedure (MRI or CT scan) than a member living in Cumberland County. Additionally, the average payment for these procedures varies greatly. The lowest payment for a CT scan of the head was \$329 while the highest payment for that procedure was \$1,235 – nearly four times more.

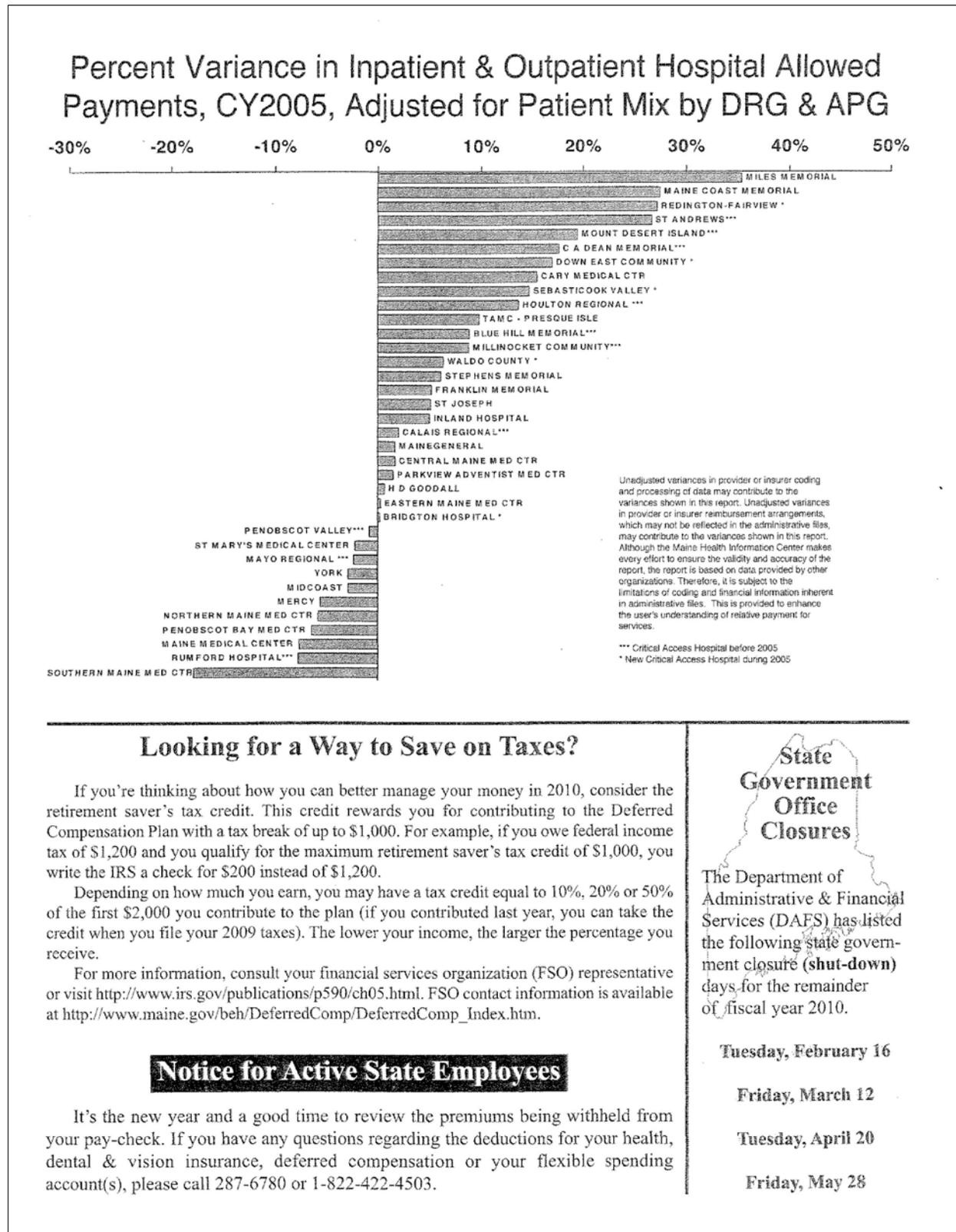
This issue of the newsletter includes a graph that shows the payment variation in Maine hospitals for a series of common procedures that are performed in all Maine hospitals. The vertical line at “0” is the state average. Everything to the right of that line is above the state average and everything to the left is below the state average. This graph is a clear illustration of the significant variance in payments among Maine hospitals.

So what can the Commission do to reduce this huge variation? One of the things under consideration is how to include comparative payments in the design for hospital benefits. Since 2006 the State employee plan has offered incentives for members to seek care from hospitals that meet certain patient safety and clinical quality standards. In the last newsletter issue we explained how hospital tiering has contributed to improved hospital performance. The Commission is now looking to introduce incentives to encourage members to seek care from high quality and efficient hospitals.

In order to continue providing a comprehensive health benefits package the Commission must slow the growth of health care spending in the State employee plan. One of many strategies to consider is linking costs to the tiered hospital benefit. More information will be forthcoming as the Commission examines its options for 2010 and beyond.

*See page 3 for graph information*

## Appendix C-1 — Hospital Variation in Payments Adjusted for Patient Mix (1 of 2)



### Looking for a Way to Save on Taxes?

If you're thinking about how you can better manage your money in 2010, consider the retirement saver's tax credit. This credit rewards you for contributing to the Deferred Compensation Plan with a tax break of up to \$1,000. For example, if you owe federal income tax of \$1,200 and you qualify for the maximum retirement saver's tax credit of \$1,000, you write the IRS a check for \$200 instead of \$1,200.

Depending on how much you earn, you may have a tax credit equal to 10%, 20% or 50% of the first \$2,000 you contribute to the plan (if you contributed last year, you can take the credit when you file your 2009 taxes). The lower your income, the larger the percentage you receive.

For more information, consult your financial services organization (FSO) representative or visit <http://www.irs.gov/publications/p590/ch05.html>. FSO contact information is available at [http://www.maine.gov/beh/DeferredComp/DeferredComp\\_Index.htm](http://www.maine.gov/beh/DeferredComp/DeferredComp_Index.htm).

### Notice for Active State Employees

It's the new year and a good time to review the premiums being withheld from your pay-check. If you have any questions regarding the deductions for your health, dental & vision insurance, deferred compensation or your flexible spending account(s), please call 287-6780 or 1-822-422-4503.

### State Government Office Closures

The Department of Administrative & Financial Services (DAFS) has listed the following state government closure (shut-down) days for the remainder of fiscal year 2010.

Tuesday, February 16

Friday, March 12

Tuesday, April 20

Friday, May 28

## Appendix C-2 – Triangulation Report

INCMON	FEB03	MAR03	APR03	MAY03	JUN03	JUL03	AUG03	SEP03	OCT03	NOV03	DEC03	JAN04	FEB04	MAR04	APR04	MAY04	JUN04	JUL04
200104	908.54	8,951.23	941.07		925.21	110.87						360.00		81.50		652.24		
200105	352.15	7,664.97	128.74	2,700.68	448.59	1,471.42	-697.37	87.06	302.68					79.65				110.58
200106	204.37	7,002.96	-30.17	486.40	635.34	772.68		2,056.69	119.20	133.56			393.75	5,420.40				
200107	455.52	6,691.36	-2,376.73	504.96	-256.82	292.28	2,355.96	88.44		143.49	252.29			768.50			47.06	
200108	-1,595.78	-12,655.43	2,032.94	208.41	35.45	25,312.02	434.36	127.33	9.00	79.92				126.08				
200109	223.76	779.20	389.92	24,007.26	-3,214.25	-1,308.36	-6.40	327.23	6,272.60	609.91	38.99	-38.99		-100.34	25.45		-561.81	-47.06
200110	3,425.41	4,452.27	-1,261.90	2,143.96	8,351.55	4,472.56	558.90	2,467.38	-1.90	345.58	2,296.39	-3,548.73	-219.36	531.67	-144.95		-48,637.49	481.94
200111	-3,158.81	-777.02	-350.57	1,539.86	1,960.15	13,315.63	399.35	916.37	3,883.93	80.14	734.01	10,469.61	170.00	-3,605.17	-24.24		131.12	663.53
200112	22,811.08	837.56	474.63	4,952.49	401.71	3,474.31	477.13	667.33	-2,815.15	4,297.04	-125.11	436.13	-660.18	-317.65	-18.40		-190.24	
200201	23,189.39	1,142.92	3,440.39	-2,600.66	31,916.68	4,838.26	117.17	962.99	658.64	-233.50	167.46	541.63		-59.95		122.10		
200202	15,908.86	3,429.73	1,644.19	728.77	-6,361.62	731.21	3,895.47	952.26	-1,538.51	329.81	-667.89	384.87	1.60	1,289.73	305.46	1,331.17	5,974.36	
200203	-3,619.94	10,622.85	-182.44	10,744.07	9,021.88	1,442.04	56.35	-1,782.88	4,785.55	466.13	396.88	551.18	-64.02		-105.02	10.00	5,386.51	
200204	14,631.30	20,679.24	9,443.96	2,642.61	3,055.32	1,603.73	-1,795.97	-418.43	1,444.47	19,319.65	-2,984.88	-346.52	-6.64	9,947.41	-37.06	414.45		
200205	10,558.91	11,305.06	11,112.89	2,453.48	7,205.45	6,776.20	1,309.30	-146.12	-5,628.45	531.20	-831.68	1,248.34	3,947.95	-562.10	196.65	7.35	-1,608.38	-250.67
200206	15,112.14	8,710.38	8,751.58	2,656.40	2,804.43	4,422.32	6,273.29	3,653.71	1,364.73	-3,140.69	-1,079.42	36.80	303.69	143.52	-1,006.42	167.99	599.02	557.83
200207	37,318.72	569.14	1,998.59	1,276.26	3,934.61	15,363.70	-2,722.39	2,950.92	-665.05	7,341.29	-2,257.50	1,409.08	-145.64	-280.63	322.99	25.00	903.71	14.83
200208	33,286.57	35,531.88	20,809.39	6,044.57	3,679.89	4,946.78	3,905.20	5,332.52	6,315.93	-164.60	-2,468.04	1,817.13	484.44	-1,065.89	782.82	1,221.79	255.76	700.76
200209	47,087.46	43,943.42	34,744.35	3,271.45	17,616.69	27,361.69	4,060.02	5,732.55	-45,981.41	-1,665.46	-997.56	2,155.28	-377.17	-2,806.66	145.12	652.39	261.40	-91.21
200210	184,299.76	104,966.52	102,291.67	20,963.65	126,087.12	5,085.57	6,458.44	8,034.07	1,803.69	6,909.22	2,807.46	2,435.85	301.85	8,359.31	-633.24	417.19	257.01	679.27
200211	254,397.33	113,367.06	51,668.53	14,311.74	22,990.82	18,550.07	-38,884.66	4,438.67	3,502.93	2,466.28	4,714.34	2,017.13	-338.81	-4,639.06	343.65	6,586.82	-527.10	748.62
200212	631,560.28	109,070.09	337,150.26	80,150.76	16,590.22	12,150.16	31,504.06	-16,148.35	17,626.53	1,722.17	7,446.55	2,060.07	-17,540.41	338.89	-1,344.78	231.08	-6,464.18	214.80
200301	2,670,920.20	879,691.10	455,864.70	172,042.67	31,389.52	36,168.59	31,181.99	10,597.57	6,152.16	14,408.86	1,631.55	7,441.84	2,579.64	137.12	116.95	-12.58	317.95	3,394.78
200302	2,192,031.23	2,631,369.03	652,365.94	235,333.91	94,339.77	32,604.60	23,306.21	5,980.37	2,184.95	-231.56	8,769.12	4,980.92	487.11	419.78	1,455.19	70.17	390.37	-3,564.66
200303		2,568,880.38	3,001,757.31	963,555.99	215,704.47	86,199.43	37,649.88	63,322.45	4,881.67	13,731.75	17,975.58	2,747.97	-1,719.46	3,462.87	-167,633.06	3,542.96	948.71	274.16
200304			2,589,915.38	2,946,683.05	608,152.94	405,428.98	75,250.37	67,998.21	19,350.30	10,073.89	6,836.17	9,752.99	-843.84	3,727.28	4,032.67	2,530.31	1,271.49	1,855.10
200305				2,516,309.02	3,059,240.06	723,587.53	217,770.55	71,721.65	132,414.95	8,526.84	5,805.62	68,072.57	-3,785.55	10,590.26	20,342.10	-17,607.59	2,557.43	2,940.27
200306					2,578,142.82	3,599,610.70	553,357.77	406,715.29	106,151.83	70,027.64	48,153.44	11,344.42	13,210.11	13,558.56	3,485.55	23,148.07	9,979.07	1,747.26
200307						2,762,392.87	3,381,371.46	533,328.98	122,893.47	46,498.94	22,593.75	8,701.34	15,921.95	2,947.99	7,967.25	11,109.64	4,888.13	5,957.20
200308							2,337,812.88	3,266,822.47	335,958.97	323,836.48	138,697.77	57,389.23	24,094.79	57,404.34	7,629.59	9,546.51	9,286.26	3,176.96
200309								2,820,905.00	3,071,345.01	290,150.17	201,207.87	64,537.81	39,594.24	76,134.02	15,477.17	19,287.64	1,281.00	2,129.69
200310									2,683,429.56	3,469,473.70	866,502.67	282,902.30	175,788.94	89,698.02	29,211.11	8,428.32	13,919.98	6,936.21
200311										1,891,259.15	3,317,877.02	760,231.73	200,999.03	68,018.67	53,785.00	80,935.75	10,127.96	19,544.83
200312											3,069,721.75	2,875,802.35	411,133.11	231,569.13	71,948.60	73,464.38	21,249.92	31,080.51
200401												2,883,562.41	3,015,320.61	908,439.77	173,619.14	105,287.51	67,579.50	14,711.92
200402													2,349,461.44	3,406,191.68	441,337.08	127,650.12	130,577.63	59,150.58
200403														3,464,475.54	3,881,947.03	578,749.20	171,289.38	149,038.87
200404															2,795,968.44	3,270,830.96	900,424.84	250,739.82
200405																2,601,570.39	3,756,018.78	790,144.74
200406																	3,232,770.65	3,544,329.35
200407																		3,057,229.03
200408																		
200409																		

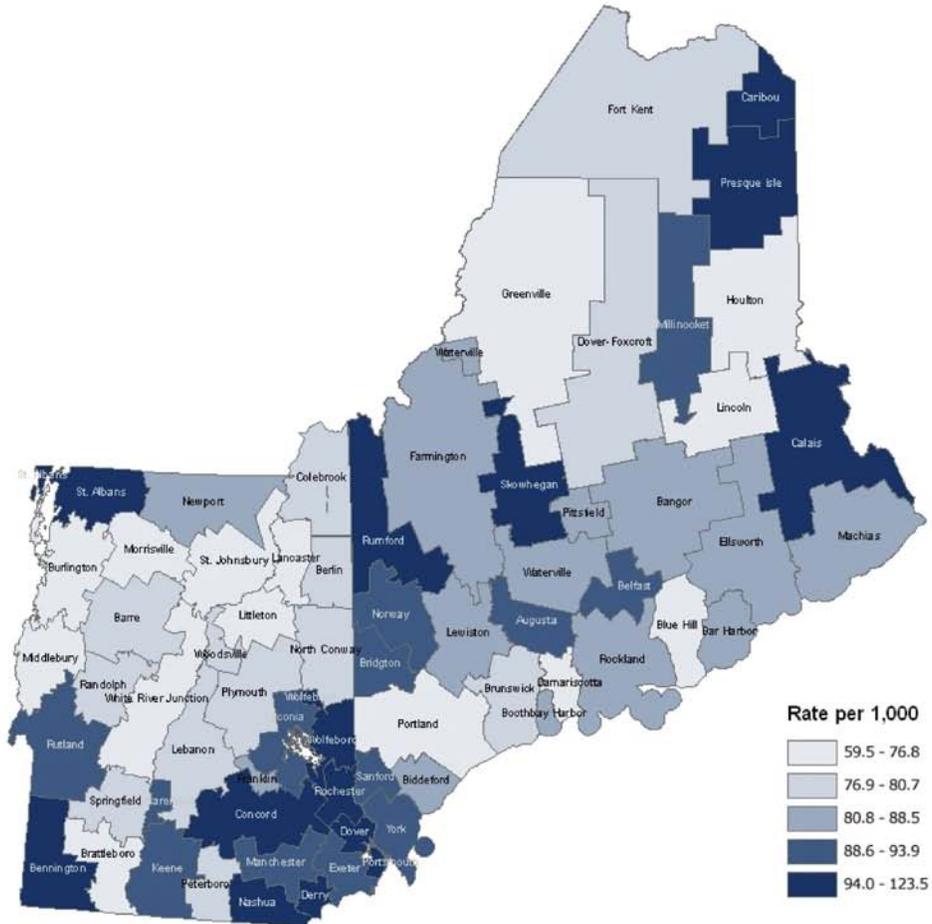
## APPENDIX D — WORK SAMPLES — SPECIAL STUDIES & AD HOC REPORTING

D-1 — Tri-State Variation Report

## Appendix D-1 – Tri-State Variation Report (1 of 4)

**Figure 1.** Computerized Tomography (CT)

Rates per 1,000 members. Commercially insured under age 65. Adjusted for age and gender. 2008 claims data.



## Appendix D-1 – Tri-State Variation Report (2 of 4)

**Table Set 1.** Computerized Tomography (CT)

Rates per 1,000 members. Commercially insured under age 65. Adjusted for age and gender. 2008 claims data.

VERMONT COMPUTERIZED TOMOGRAPHY (CT)					
HOSPITAL SERVICE AREA	AVERAGE MEMBERS	SERVICES	ADJ. RATE PER 1,000	95% LCL	95% UCL
Barre	33,616	2,731	79.2	76.3	82.3
Bennington	14,683	1,540	100.4	95.5	105.6
Brattleboro	12,263	781	59.5	55.4	63.9
Burlington	91,200	5,885	65.6	63.9	67.3
Middlebury	14,166	921	63.3	59.3	67.5
Morrisville	10,195	814	76.8	71.6	82.2
Newport	8,472	788	86.7	80.8	93.0
Randolph	5,985	507	79.5	72.7	86.7
Rutland	27,358	2,627	91.0	87.5	94.5
Springfield	11,261	963	80.4	75.4	85.7
St. Albans	17,384	1,663	95.8	91.2	100.5
St. Johnsbury	9,243	692	71.2	66.0	76.8
White River Junction	16,082	1,122	66.5	62.7	70.5

NEW HAMPSHIRE COMPUTERIZED TOMOGRAPHY (CT)					
HEALTH ANALYSIS AREA	AVERAGE MEMBERS	SERVICES	ADJ. RATE PER 1,000	95% LCL	95% UCL
Berlin	5,277	423	79.6	72.1	87.5
Claremont	6,262	574	93.3	85.8	101.2
Colebrook	1,528	125	76.9	64.0	91.6
Concord	58,755	5,410	94.3	91.8	96.8
Derry	22,887	2,112	96.2	92.2	100.4
Dover	22,938	2,249	104.4	100.1	108.8
Exeter	32,637	2,912	92.4	89.0	95.8
Franklin	7,007	599	85.2	78.5	92.3
Keene	20,889	1,909	90.4	86.4	94.5
Laconia	21,893	2,026	91.1	87.2	95.1
Lancaster	2,815	199	68.8	59.6	79.1
Lebanon	30,168	2,291	77.6	74.4	80.8

## Appendix D-1 – Tri-State Variation Report (3 of 4)

NEW HAMPSHIRE COMPUTERIZED TOMOGRAPHY (CT)					
HEALTH ANALYSIS AREA	AVERAGE MEMBERS	SERVICES	ADJ. RATE PER 1,000	95% LCL	95% UCL
Littleton	6,289	464	71.4	65.0	78.2
Manchester	77,605	6,881	92.0	89.9	94.2
Nashua	63,233	6,041	98.4	96.0	101.0
North Conway	6,179	495	77.6	70.9	84.8
Peterborough	13,645	1,058	80.7	75.9	85.7
Plymouth	10,555	842	79.1	73.8	84.6
Portsmouth	12,565	1,230	97.5	92.1	103.1
Rochester	15,799	1,668	107.4	102.3	112.6
Wolfeboro	9,588	912	94.0	88.0	100.3
Woodsville	2,265	178	77.9	66.8	90.2

MAINE COMPUTERIZED TOMOGRAPHY (CT)					
HOSPITAL SERVICE AREA	AVERAGE MEMBERS	SERVICES	ADJ. RATE PER 1,000	95% LCL	95% UCL
Augusta	30,668	2,931	93.3	90.0	96.8
Bangor	55,610	4,938	88.2	85.8	90.7
Bar Harbor	5,202	463	85.0	77.4	93.1
Belfast	7,179	717	92.7	86.0	99.7
Biddeford	35,318	2,999	84.8	81.8	87.9
Blue Hill	4,178	300	65.2	58.0	73.0
Boothbay	2,671	240	81.0	71.1	92.0
Bridgton	8,179	774	91.4	85.1	98.1
Brunswick	32,505	2,646	79.7	76.7	82.8
Calais	3,535	474	123.2	112.3	134.8
Caribou	4,877	616	123.5	114.0	133.7
Damariscotta	5,670	428	71.1	64.5	78.1
Dover-Foxcroft	6,821	583	79.2	72.9	86.0
Ellsworth	10,150	941	87.3	81.8	93.0
Farmington	12,030	1,030	82.2	77.2	87.3
Fort Kent	4,511	381	79.8	72.0	88.2
Greenville	862	66	66.5	51.4	84.6

## Appendix D-1 – Tri-State Variation Report (4 of 4)

MAINE COMPUTERIZED TOMOGRAPHY (CT)					
HOSPITAL SERVICE AREA	AVERAGE MEMBERS	SERVICES	ADJ. RATE PER 1,000	95% LCL	95% UCL
Houlton	5,063	409	74.9	67.8	82.6
Lewiston	57,653	5,054	88.5	86.1	91.0
Lincoln	5,170	365	68.3	61.5	75.7
Machias	4,581	417	83.4	75.6	91.8
Millinocket	2,395	229	89.1	78.0	101.5
Norway	10,344	945	89.5	83.9	95.4
Pittsfield	5,462	489	88.5	80.9	96.7
Portland	158,275	11,340	74.1	72.8	75.5
Presque Isle	8,471	868	98.8	92.4	105.6
Rockland	21,024	1,836	82.6	78.8	86.4
Rumford	4,494	438	94.6	86.0	103.9
Sanford	17,539	1,610	93.0	88.5	97.6
Skowhegan	9,949	972	95.4	89.5	101.6
Waterville	30,645	2,478	81.2	78.0	84.4
York	28,706	2,582	90.3	86.9	93.9

## APPENDIX E — WORK SAMPLES — IN-HOUSE REPORTING TRAINING

Figure 2. Screen Capture of NH CHIS Online Reporting Tool

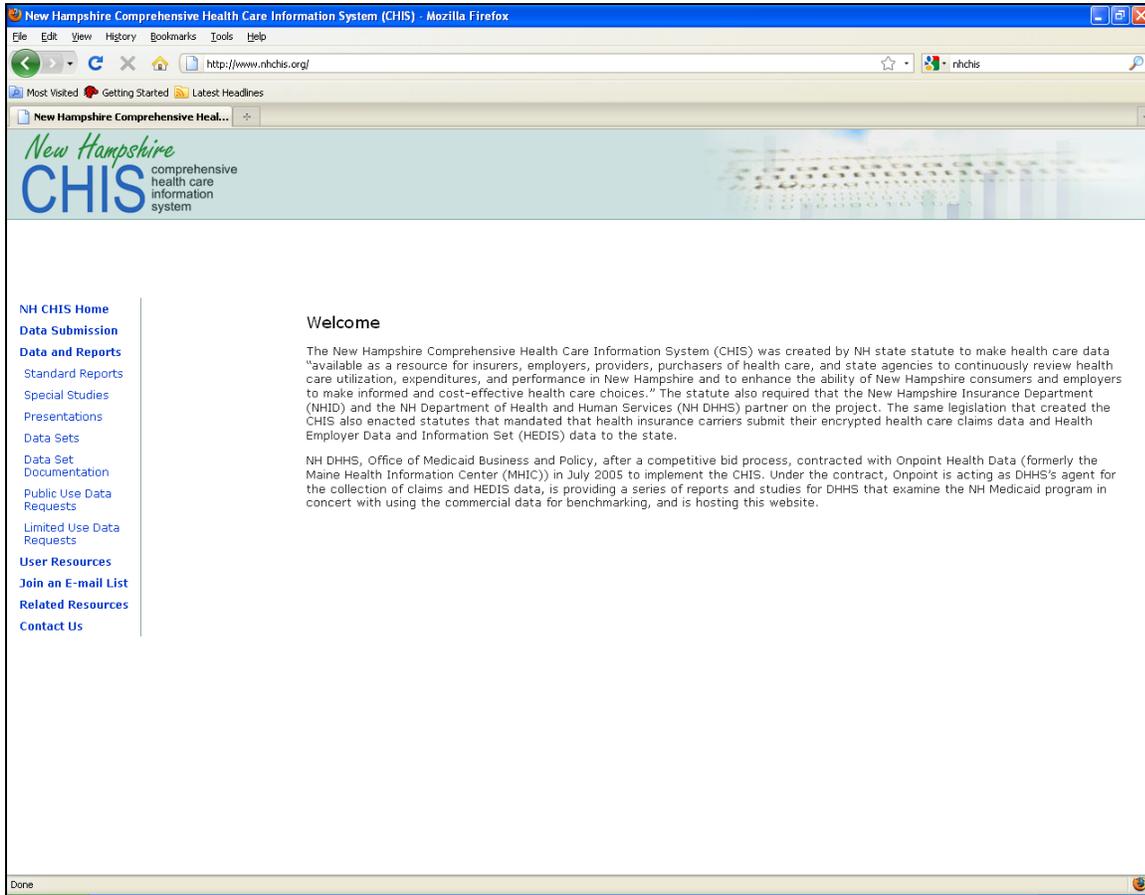


Figure 3. Screen Capture of NH CHIS Online Reporting Tool

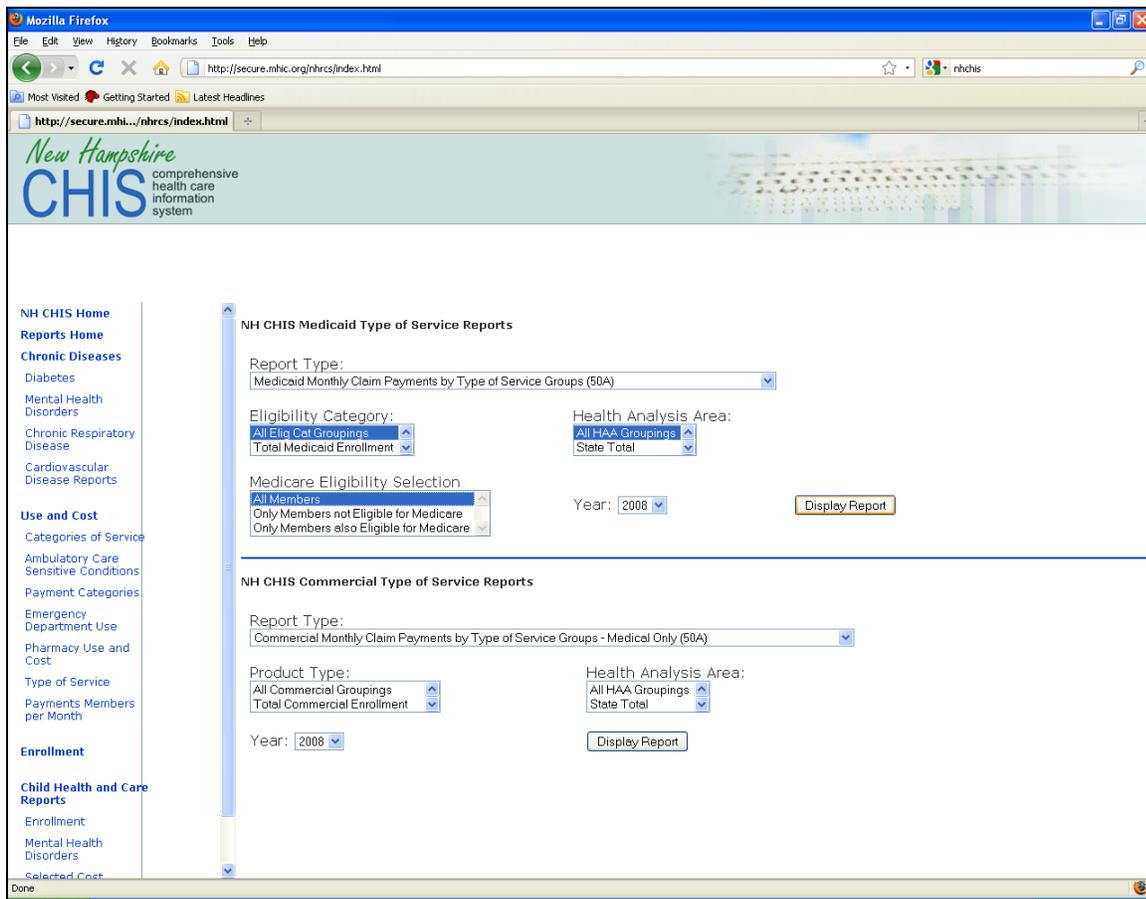


Figure 4. Screen Capture of NH CHIS Online Reporting Tool

Crystal Report Viewer - Mozilla Firefox  
 File Edit View History Bookmarks Tools Help  
 https://reports.nhchis.org/businessobjects/enterprise115/viewrpt.cwr?id=27022&nit=java:connect&promptx=0=200801&promptxc1=200812&prom  
 nhchis

Crystal Report Viewer  
 Business Objects

Preview

New Hampshire Medicaid Monthly Claim Payments by Type of Service Groups  
 Year and Month: January 2008 - December 2008  
 Geographical Area: Health Analysis Area  
**All Medicaid members including those dually eligible for Medicare are contained in this report.**

Eligibility Group	Geographical Area	Type of Service Group	Total Claim Payments	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08
Total Medicaid Enrollment	State Total	MEMBER MONTHS	1,332,412	107,998	108,783	109,593	109,871	110,643	110,814	111,263	111,789	112,262	113,007
Total Medicaid Enrollment	State Total	Totals	\$946,313,437	\$93,163,583	\$75,359,829	\$82,045,868	\$79,576,306	\$78,589,080	\$72,760,811	\$77,071,754	\$77,392,845	\$80,050,929	\$85,371,642
Total Medicaid Enrollment	State Total	Inpatient	\$62,840,811	\$5,120,134	\$4,948,094	\$5,448,220	\$4,804,122	\$4,232,977	\$4,787,510	\$5,681,279	\$5,928,414	\$5,540,926	\$6,350,533
Total Medicaid Enrollment	State Total	Outpatient	\$80,114,217	\$7,758,685	\$6,950,642	\$7,657,144	\$7,810,512	\$7,364,344	\$6,102,191	\$6,286,379	\$5,991,101	\$6,065,824	\$6,576,046
Total Medicaid Enrollment	State Total	Facility	\$169,815,492	\$13,916,653	\$12,013,577	\$13,660,380	\$13,045,688	\$12,741,487	\$11,097,208	\$11,889,911	\$13,228,422	\$17,333,563	\$18,795,697
Total Medicaid Enrollment	State Total	Professional	\$86,437,940	\$8,014,207	\$7,287,961	\$7,749,669	\$7,833,351	\$7,686,013	\$6,928,832	\$6,689,560	\$7,559,006	\$7,253,867	\$7,064,858
Total Medicaid Enrollment	State Total	Home/Amb/DME	\$183,588,261	\$18,914,505	\$17,688,970	\$18,803,868	\$17,889,004	\$16,728,806	\$14,926,659	\$15,203,814	\$10,725,174	\$12,491,267	\$14,045,273
Total Medicaid Enrollment	State Total	Pharmacy	\$81,174,054	\$6,832,785	\$6,332,294	\$6,670,025	\$6,782,525	\$6,979,948	\$6,519,951	\$6,559,666	\$6,596,908	\$6,724,435	\$7,223,381
Total Medicaid Enrollment	State Total	Other	\$26,971,646	\$898,266	\$821,918	\$924,163	\$980,480	\$1,167,896	\$1,034,392	\$2,831,185	\$5,474,758	\$3,503,178	\$3,094,327
Total Medicaid Enrollment	State Total	Unknown	\$37,194,289	\$2,465,863	\$1,965,931	\$2,377,231	\$2,452,805	\$3,146,632	\$3,542,259	\$3,854,459	\$3,804,687	\$3,362,281	\$3,579,121
Total Medicaid Enrollment	State Total	Institutional Care*	\$189,412,587	\$17,687,895	\$15,937,819	\$17,102,810	\$16,177,881	\$16,936,012	\$16,317,773	\$16,553,888	\$16,559,242	\$16,257,887	\$16,897,259
Total Medicaid Enrollment	State Total	Dental*	\$18,783,130	\$1,574,679	\$1,362,921	\$1,653,358	\$1,799,941	\$1,804,967	\$1,504,034	\$1,522,780	\$1,525,133	\$1,517,861	\$1,785,147
Total Medicaid Enrollment	Berlin	MEMBER MONTHS	28,292	2,362	2,355	2,378	2,381	2,374	2,368	2,348	2,347	2,337	2,353
Total Medicaid Enrollment	Berlin	Totals	\$21,426,843	\$1,897,813	\$1,847,791	\$1,885,514	\$1,791,228	\$1,741,496	\$1,590,328	\$1,750,356	\$1,731,893	\$1,850,634	\$1,821,895
Total Medicaid Enrollment	Berlin	Inpatient	\$1,311,854	\$99,477	\$92,927	\$167,186	\$136,996	\$80,249	\$68,167	\$72,662	\$109,632	\$214,700	\$58,699
Total Medicaid Enrollment	Berlin	Outpatient	\$2,793,915	\$316,442	\$265,587	\$245,128	\$219,004	\$213,036	\$202,268	\$260,001	\$213,903	\$187,631	\$223,627
Total Medicaid Enrollment	Berlin	Facility	\$5,435,407	\$487,979	\$432,379	\$439,934	\$425,528	\$368,778	\$339,564	\$404,777	\$427,978	\$480,403	\$544,397
Total Medicaid Enrollment	Berlin	Professional	\$1,847,113	\$169,355	\$135,639	\$159,472	\$176,019	\$152,483	\$143,156	\$155,113	\$151,371	\$155,953	\$151,281
Total Medicaid Enrollment	Berlin	Home/Amb/DME	\$1,443,801	\$111,333	\$98,479	\$134,108	\$111,627	\$122,311	\$108,549	\$120,222	\$123,645	\$131,907	\$123,602
Total Medicaid Enrollment	Berlin	Pharmacy	\$1,847,304	\$152,413	\$135,665	\$159,592	\$153,792	\$154,005	\$147,508	\$142,495	\$148,544	\$155,959	\$168,415
Total Medicaid Enrollment	Berlin	Other	\$120,567	\$6,852	\$10,496	\$16,572	\$15,987	\$11,217	\$9,205	\$9,611	\$8,115	\$6,423	\$11,267
Total Medicaid Enrollment	Berlin	Unknown	\$620,296	\$37,390	\$29,013	\$42,534	\$50,351	\$137,196	\$83,677	\$38,123	\$40,020	\$40,307	\$38,228
Total Medicaid Enrollment	Berlin	Institutional Care*	\$5,693,674	\$506,138	\$460,495	\$490,658	\$468,670	\$479,054	\$460,952	\$482,006	\$480,392	\$453,736	\$475,628
Total Medicaid Enrollment	Berlin	Dental*	\$312,813	\$28,434	\$27,110	\$30,330	\$33,254	\$23,166	\$27,282	\$29,147	\$28,293	\$23,615	\$26,811
Total Medicaid Enrollment	Berlin	MEMBER MONTHS	36,185	2,875	2,871	2,891	2,891	2,940	2,947	2,956	2,942	2,980	2,961
Total Medicaid Enrollment	Claremont	Totals	\$29,345,540	\$2,761,878	\$2,411,831	\$2,601,077	\$2,581,917	\$2,414,353	\$2,151,074	\$2,487,750	\$2,421,957	\$2,362,098	\$2,593,268
Total Medicaid Enrollment	Claremont	Inpatient	\$1,974,215	\$223,740	\$160,588	\$187,667	\$155,408	\$136,972	\$98,142	\$179,189	\$136,318	\$186,239	\$255,949
Total Medicaid Enrollment	Claremont	Outpatient	\$2,745,699	\$293,591	\$229,974	\$263,391	\$278,633	\$249,493	\$193,544	\$214,558	\$217,230	\$205,459	\$225,680
Total Medicaid Enrollment	Claremont	Facility	\$4,709,378	\$430,864	\$377,239	\$413,657	\$426,602	\$388,025	\$333,514	\$412,403	\$349,404	\$384,118	\$440,990

Footnotes: SCHIP, SLMB, OMB are omitted. Eligibility category is determined on the last day of the month.  
 Where applicable, zip codes included in the Area definitions can be found at: [http://www.nhchis.org/Misc/Files/zipcode\\_crosswalk.pdf](http://www.nhchis.org/Misc/Files/zipcode_crosswalk.pdf)  
 Other area is out-of-state placements, border state zip codes, or invalid NH zip codes.

## APPENDIX F — WORK SAMPLES — CUSTOM MEDICAID STUDIES

F-1 — CHIP Brief

F-2 — Chronic Respiratory Diseases Brief

F-3 — Birth Certificate Linkage

F-4 — Primary Care Received by NH Medicaid Members by Practice Setting



**Children's Health Insurance Programs  
in New Hampshire**  
*Access, Prevention, Health Status, Care Management,  
Utilization and Payments, State Fiscal Year 2008*  
**Issue Brief – October 2009**

This Issue Brief presents key findings of a recent study that evaluated a variety of health care measures to compare children up to the age of 18 enrolled in New Hampshire Medicaid, the State Children's Health Insurance Program (SCHIP), and commercial health insurance plans in NH using data collected through the Comprehensive Health Care Information System (NH CHIS) claims database. The study will be used to better inform program and policy decisions. Most significantly, the study found that:

- Children enrolled in NH Medicaid generally do as well or better than their counterparts nationally in accessing and utilizing care, despite the fact that national comparison measures are based on managed care programs and NH Medicaid is fee-for-service. Children enrolled in NH SCHIP generally do better than children enrolled in commercial plans.
- Children's health status was evaluated by applying Clinical Risk Groups (CRG) to the claims data. A higher risk score indicates poorer health status. Medicaid had the highest average CRG risk score, while SCHIP was lower and commercial was lowest.
- Payment rates for children enrolled in NH Medicaid were significantly higher than for children enrolled in SCHIP or CHIS commercial. However, after applying certain exclusions and standardizing for differences in age and health status, the payment rate for children per member per month was lower in NH Medicaid compared with SCHIP and NH CHIS commercial.
- Children enrolled in NH Medicaid in the poorest households had the poorest health and highest utilization and payments compared with children in households with the highest adjusted household income.

The study updates the State Fiscal Year (SFY) 2007 report released in December 2008 on New Hampshire children's health insurance. Nearly all findings were similar between the current and previous studies. However, the SFY2008 study contains additional statistics that assess the health status of children in NH as well as the poverty level of children enrolled in NH Medicaid, and its impact on utilization and payments.

**Introduction**

Children who have health insurance are more likely to have a usual source of health care, access preventive and other needed health services, and have improved social and emotional development. Having health insurance coverage does not guarantee that all children access care appropriately. Length of enrollment in a health care plan can im-

part continuity of care. Prevalence of chronic disease (such as asthma or mental health disorders) can influence the amount, type, and cost of care a child receives.

The results of this study suggest that New Hampshire children had higher rates of access to primary care practitioners and well-child visits compared to national benchmarks; however, the results also indicated that some children did not receive these services, especially adolescents. Rates of utilization for other than primary care services were highest for children enrolled in Medicaid, lower for SCHIP, and lowest for NH CHIS commercial.

**Data Sources**

New Hampshire Medicaid, SCHIP, and NH CHIS commercial eligibility and claims data from services incurred in State Fiscal Year 2008 were used for this study to calculate quality, access to care, and utilization measures, and to assess health status. Where available the study compared these measures to national Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks available from the National Committee for Quality Assurance (NCQA). These measures are used by most health plans to monitor their performance. Severely disabled children covered by Medicaid were excluded from the study.

**Enrollment and Disenrollment**

Analysis of enrollment data suggested that some children in New Hampshire have possible problems with continuity of insurance coverage. One in four children enrolled at the start of the study in Medicaid, and half of the children enrolled in SCHIP, disenrolled during the year.

**Child Disenrollment and Re-enrollment by Plan Type, SFY2008**

	Medicaid	SCHIP
Members with enrollment in July 2006	67,062	7,286
% Disenrolled from plan during year	28%	50%
% Re-enrolled of those disenrolled	23%	11%

Twenty-three percent of the children who disenrolled from Medicaid re-enrolled later in the year compared to 11% in SCHIP. Discontinuity in plan enrollment may have had an impact on access to care, well-child visits or use of preventive services, and utilization of other services for children.

**Health Status**

The 3M Health Systems Clinical Risk Grouper (CRG) was used to evaluate the health status of children. A higher

NH Department of Health and Human Services, Office of Medicaid Business and Policy, 129 Pleasant St, Concord, NH 03301, www.dhhs.nh.gov

## Appendix F-1 – CHIP Brief (2 of 4)

CRG score indicates poorer health. Among continuously enrolled members, Medicaid (0.658) had the highest average CRG risk score, while SCHIP (0.495) was lower and CHIS commercial (0.446) was lowest. The finding that health status was poorest for children enrolled in Medicaid, better for SCHIP, and best for CHIS commercial was consistent for each of the past three state fiscal years.

### Average CRG Risk Score by State Fiscal Year and Plan Type, Members Continuously Enrolled

State Fiscal Year (SFY)	Medicaid	SCHIP	NH CHIS Commercial
SFY2006	0.708	0.518	0.463
SFY2007	0.696	0.506	0.479
SFY2008	0.658	0.495	0.446

One in four children on Medicaid was not healthy based on CRG scores. Although Medicaid covers fewer children than the CHIS commercial population, Medicaid covered a higher proportion (twice as many) of children with significant chronic diseases in multiple organ systems than CHIS commercial. Additionally, children enrolled in Medicaid were least likely to be non-users of health care services (6.8%) compared with children enrolled in SCHIP (14.8%) and CHIS commercial (20.9%) plans.

### Access to Primary Care Practitioners

Children in SCHIP had higher rates of accessing primary care practitioners than children in Medicaid or NH CHIS commercial plans. Children in SCHIP also accessed a primary care practitioner sooner after enrollment compared with children in Medicaid or NH CHIS commercial plans. Compared to national rates, NH Medicaid and SCHIP had higher rates while CHIS commercial was similar to national commercial rates.

### Percent of Children With Access to Primary Care Practitioner by Plan Type, SFY2008

New Hampshire			
Age Group	Medicaid	SCHIP	NH CHIS Commercial
0-11 mos	98.2%	NA	95.2%
12-24 mos	97.5%	96.1%	94.5%
25 mos-6 yrs	88.9%	93.3%	89.4%
7-11 yrs	85.9%	91.8%	86.9%
12-18 yrs	90.9%	95.7%	89.8%
National Managed Care Plan Data			
Age Group	Medicaid	Commercial	
12-24 mos	93.4%	96.9%	
25 mos-6 yrs	84.3%	89.4%	
7-11 yrs	85.8%	89.5%	
12-19 yrs	82.6%	86.9%	

NA: SCHIP does not cover children under the age of one

### Well-Child Visits

The study results indicate that not all children in New Hampshire had well-child visits consistent with guidelines for preventive care. Rates of well-child visits were higher

in SCHIP and NH CHIS commercial compared to Medicaid.

For each plan type, well-child visit rates decreased as age increased. Where national comparison data were available, NH Medicaid was higher than national Medicaid managed care rates (this despite the fact that NH does not have a managed care plan). SCHIP and CHIS commercial rates were also higher than the national commercial rates.

### Percent of Children With a Well-Child Visit to a Primary Care Practitioner by Plan Type, SFY2008

New Hampshire			
Age Group	Medicaid	SCHIP	NH CHIS Commercial
16-35 months	88.9%	95.4%	89.0%
3-6 years	69.9%	82.7%	77.7%
7-11 years	55.0%	63.0%	61.3%
12-18 years	50.4%	57.3%	55.4%
National Managed Care Plan Data*			
Age Group	Medicaid	Commercial	
3-6 years	65.3%	67.8%	
12-21 years	42.0%	41.8%	

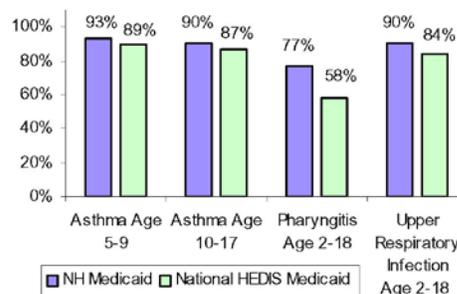
Note: SCHIP does not cover children under the age of one. The SCHIP column is a combination of Medicaid and SCHIP for the 185-300% of federal poverty level group.

\*2006 NCOA HEDIS reporting year on 2007 data.

### Effectiveness of Care Management

The study results of measures for effectiveness of care indicate that children enrolled in NH Medicaid are consistently receiving more effective care than children in Medicaid managed care plans nationally. The use of appropriate medications to control persistent asthma, appropriate testing for pharyngitis, and no inappropriate use of antibiotics for upper respiratory infections (URIs) were measured.

### Comparison of Appropriate Medication for Children Enrolled in Medicaid to National Medicaid Rates, SFY2008

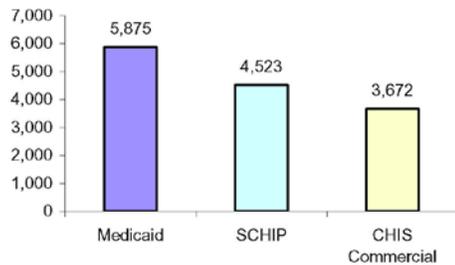


## Appendix F-1 – CHIP Brief (3 of 4)

### Prevalence and Utilization for Mental Health Disorders

The mental health disorder prevalence rate for children enrolled in Medicaid (21.6%) was similar to the prevalence rate for SCHIP (20.0%) but higher than the prevalence rate for NH CHIS commercial (11.7%). For children with a mental health disorder, the psychotherapy visit rate was significantly higher in Medicaid (5,875 per 1,000 members) compared to SCHIP (4,523 per 1,000 members) or NH CHIS commercial (3,672 per 1,000 members).

#### Psychotherapy Visit Rates per 1,000 Members With a Mental Health Disorder by Plan Type, SFY2008

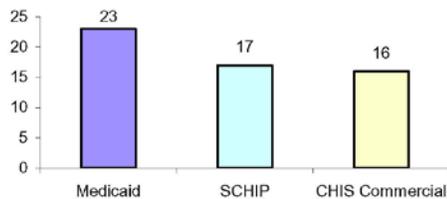


Children enrolled in Medicaid with a mental health disorder diagnosis had higher use rates of all mental health services than CHIS commercial.

### Hospital Utilization

Excluding newborns and infants (age 0–11 months), and standardizing for differences in health status (CRG) and age, the inpatient hospitalization rate for Medicaid (23.3 per 1,000 members) was significantly higher than the SCHIP rate (16.6 per 1,000 members) or the NH CHIS commercial rate (15.8 per 1,000 members).

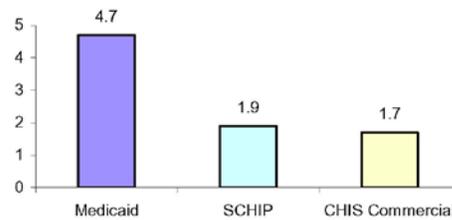
#### Inpatient Standardized Utilization Rates per 1,000 Members, Excluding Infants, SFY2008



For five selected Ambulatory Care Sensitive conditions (those where inpatient hospitalization rates are influenced by rates of appropriate ambulatory care, i.e., asthma, dehydration, bacterial pneumonia, urinary tract infections, and gastroenteritis), the inpatient hospitalization rate for children enrolled in Medicaid (4.7 per 1,000 members) was

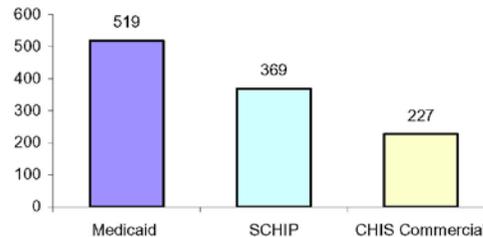
higher than the SCHIP rate (1.9 per 1,000 members) and almost triple the rate for NH CHIS commercial (1.7 per 1,000 members).

#### Ambulatory Care Sensitive Condition Inpatient Utilization Rates per 1,000 Members, Excluding Infants, SFY2008



The rate for ED visits, standardized for differences in health status (CRG) and age, for children enrolled in Medicaid (519 per 1,000 members) was more than double the rate for children enrolled in NH CHIS commercial (227 per 1,000 members). Children enrolled in SCHIP also had a higher rate (369 per 1,000 members) compared to NH CHIS commercial.

#### Outpatient Emergency Department Visit Rates per 1,000 Members, SFY2008

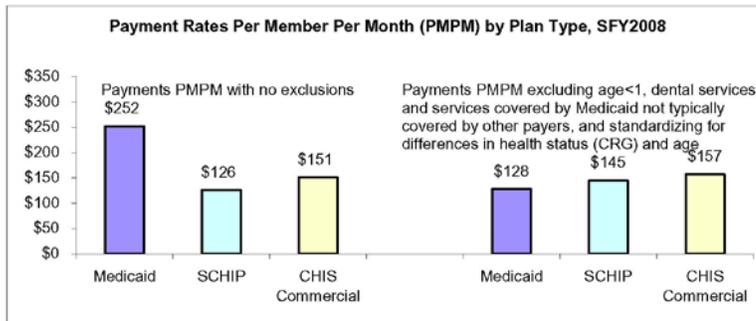


For conditions for which an alternative setting of care is likely to be more appropriate (e.g., upper respiratory infection, ear infection, bronchitis), the outpatient ED use rate for children enrolled in NH Medicaid (240 per 1,000 members) was higher than SCHIP (114 per 1,000 members) and NH CHIS commercial (58 per 1,000 members).

### Payments

During SFY2008 the payment rate for Medicaid (\$252 PMPM) was higher than SCHIP (\$126 PMPM) and CHIS commercial (\$151 PMPM), before any standardization or adjustment to make the PMPMs more comparable. This reflected higher utilization and higher prevalence of disease in the Medicaid population, that SCHIP does not cover infants, the health status (based on CRG) of children enrolled in Medicaid is poorer than children enrolled in SCHIP or CHIS commercial, and Medicaid pays for services typically not covered by commercial plans.

## Appendix F-1 – CHIP Brief (4 of 4)



had a payment rate (\$167 PMPM) that was nearly 1.5 times higher than the rate for children in households with the highest adjusted household income (\$116 PMPM).

### Limitations

This study is based primarily on administrative claims data collected for the purpose of making

financial payments. While it can be an efficient and less costly method to report on health care utilization and payments, administrative claims data may under-report some diagnostic conditions or services.

Differences in utilization and payment measures among Medicaid, SCHIP, and NH CHIS commercial may be influenced by differences in the health status of the children covered or differences in the insurance plan delivery model and benefit structure.

### Discussion and Next Steps

Children enrolled in NH Medicaid are consistently receiving more effective care than children in Medicaid managed care plans nationally. However, NH children enrolled in Medicaid had poorer health status and higher inpatient and emergency department utilization than children enrolled in SCHIP or CHIS commercial plans. Payment rates per member per month were lower in NH Medicaid than SCHIP or CHIS commercial after certain exclusions and adjustments. Within Medicaid, poverty was a strong predictor of health status, utilization, and payment rates.

Several additional studies addressing topics in more depth are under way or planned, including the following:

- characteristics of children in Medicaid who did not receive a well-child visit;
- birth certificate claims linkage and associated outcomes and cost; and
- evaluation of coexisting mental disorders and multiple medication use for children with mental disorders.

However, when excluding special services specific to Medicaid, newborns and infants (age 0–11 months), and standardizing for differences in health status (CRG) and age, the payment rate for children per member per month (PMPM) was lower in Medicaid (\$128 PMPM) compared with SCHIP (\$145 PMPM) or NH CHIS commercial (\$157 PMPM).

### Poverty Level

The relative health status (based on CRG risk scores) of children enrolled in Medicaid indicates that children with continuous enrollment in the poorest households (0% FPL) had the poorest health as indicated by a higher average clinical risk score (0.812) compared with children in households with the highest adjusted household income (134%–184% FPL) whose average CRG risk score was 0.580.

### Medicaid Utilization and Payments Comparison by Poverty Level, SFY2008

Measure	Poverty Level (FPL)			
	0%	1%–99%	100%–133%	134%–184%
Inpatient Hospitalization Rate per 1,000	38	30	26	20
Outpatient ED Visits per 1,000	676	623	529	477
Office-Clinic Visits per 1,000	3,414	3,430	3,447	3,512
Payments PMPM after exclusions	\$167	\$148	\$127	\$116

Children on Medicaid in the poorest households had significantly higher utilization of inpatient hospitalization and ED services than children in households with the highest adjusted household income. In contrast, office-clinic visit rates increased slightly as household income increased. Children enrolled in Medicaid in the poorest households

### About the New Hampshire Comprehensive Health Care Information System

The New Hampshire Comprehensive Health Care Information System (NH CHIS) is a joint project between the New Hampshire Department of Health and Human Services (NH DHHS) and the New Hampshire Insurance Department (NHID). The NH CHIS was created by state statute (RSA 420-G:11-a) to make health care data “available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.” For more information about the CHIS please visit [www.nhchis.org](http://www.nhchis.org) or [www.nh.gov/nhchis](http://www.nh.gov/nhchis).

NH Department of Health and Human Services, Office of Medicaid Business and Policy, 129 Pleasant St, Concord, NH 03301, [www.dhhs.nh.gov](http://www.dhhs.nh.gov)

## Appendix F-2 – Chronic Respiratory Diseases Brief (1 of 2)



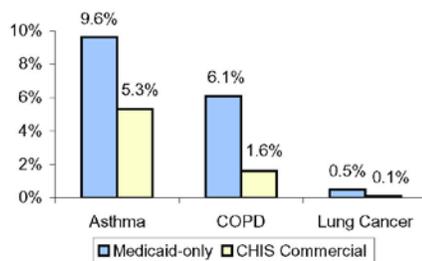
### Chronic Respiratory Diseases in NH Issue Brief – June 2008

Chronic respiratory diseases are major contributors to mortality, disability, and medical cost. While death rates nationally for other major diseases (heart, cancer, and stroke) have declined, chronic respiratory disease death rates increased by 53% between 1980 and 2003.

This report provides a detailed evaluation of the prevalence, utilization, and costs associated with chronic respiratory diseases, together with geographic variation observed in this study. The study used New Hampshire (NH) Medicaid and Comprehensive Health Care Information System (CHIS) commercial administrative eligibility and claims data for services rendered during calendar year (CY) 2005 to evaluate three chronic respiratory diseases: asthma, chronic obstructive pulmonary disease (COPD), and lung cancer.

Medicaid members who are also eligible for Medicare are referred to as dual eligibles. Because Medicare is the primary payer and Medicaid does not cover all of the costs for these members, their claims experience is incomplete. In addition, the commercial group comprises a relatively small number of elderly and disabled members. Therefore, while the complete report includes findings for both the dual eligible and Medicaid-only populations, this Brief focuses on Medicaid-only members.

**Prevalence of Chronic Respiratory Diseases in New Hampshire, CY2005**



#### Asthma

Medicaid-only members (those not also enrolled in Medicare) had an asthma prevalence rate (9.6%) that was 1.8 times the CHIS commercial member rate (5.3%). For children age 0-18, the Medicaid-only prevalence rate (8.5%) was 1.3 times higher than the CHIS commercial rate (6.3%). Among adults age 19-

64, the Medicaid-only prevalence rate (13.4%) was 2.7 times the CHIS commercial rate (4.9%). For every age group the Medicaid-only prevalence rate was higher than the CHIS commercial prevalence rate.

About half of the NH Medicaid members with asthma were children, while only one-third of CHIS commercial members with asthma were children. This variation is likely due to the fact that NH Medicaid comprises a much larger percentage of children than the commercial population.

The highest rate of asthma prevalence was found in the physically disabled eligibility group (17%).

#### COPD

During CY2005, Medicaid-only members had a COPD prevalence rate (6.1%) that was 3.8 times the CHIS commercial member rate (1.6%). Twice as many females as males in Medicaid were diagnosed with COPD, whereas the gender breakdown among the CHIS commercial group was nearly equal. The highest rate of COPD prevalence in Medicaid-only involved the physically disabled (18.5%) and elderly (16.9%).

#### Lung Cancer

The prevalence rate of lung cancer (0.5%) in Medicaid-only was five times the rate in CHIS commercial (0.1%). Prevalence rates of lung cancer increased with age for both the Medicaid and CHIS commercial populations.

There were more Medicaid-only females (55) with lung cancer than males (40), but the prevalence rate was three times higher for males (0.9%) compared to females (0.3%). The highest prevalence of lung cancer was among the physically disabled (2.1%) and elderly (0.9%).

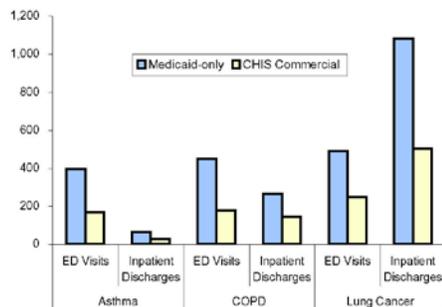
#### Utilization and Costs

Standardization for age differences was made in the comparison of Medicaid to commercial population rates. For all three chronic respiratory diseases studied, the age-standardized Medicaid-only outpatient Emergency Department (ED) and inpatient use rates were double the CHIS commercial rates. Office-clinic use for Medicaid-only members with asthma was 5% lower than commercial, while Medicaid-only office-clinic use for COPD and lung cancer was 17% and 26% higher, respectively, than the CHIS commercial group.

## Appendix F-2 — Chronic Respiratory Diseases Brief (2 of 2)

Despite relatively lower payments per service in Medicaid compared to CHIS commercial, the age-standardized payment rates per member per month for Medicaid-only were higher for members with asthma or COPD compared to CHIS commercial. Higher hospital use rates for ED or inpatient services among Medicaid members is a factor in these differences.

### Age-Standardized Respiratory Disease Utilization, per 1,000 members, CY2005



It should be noted that these payment rates are based only on those claims involving a respiratory diagnosis or respiratory medications. Members with chronic respiratory diseases often have multiple coexisting conditions that contribute to utilization and payments. Medicaid members with COPD, lung cancer, and asthma had high prevalence rates of coexisting conditions (e.g., heart disease, diabetes, mental disorders) and a significant number resided in nursing facilities during the year. For example, Medicaid members with COPD incurred \$102 million in payments during CY2005, of which only \$16.4 million was specific to COPD, other respiratory diagnoses or respiratory medications. Coexisting conditions were less prevalent in the commercial population with these diseases.

### Geographic Variation

Disease prevalence and utilization rates were evaluated by the location of the member's residence. Medicaid prevalence rates of asthma and COPD were higher in northern and more rural New Hampshire regions compared to the southern part of the state. For members with asthma or COPD, a pattern of high outpatient ED

use was found in the northern and more rural New Hampshire regions compared to the southern border towns. This pattern was found in both the Medicaid and CHIS commercial populations (and is consistent with the prior NH CHIS study for CY2005 outpatient ED use).

### Limitations

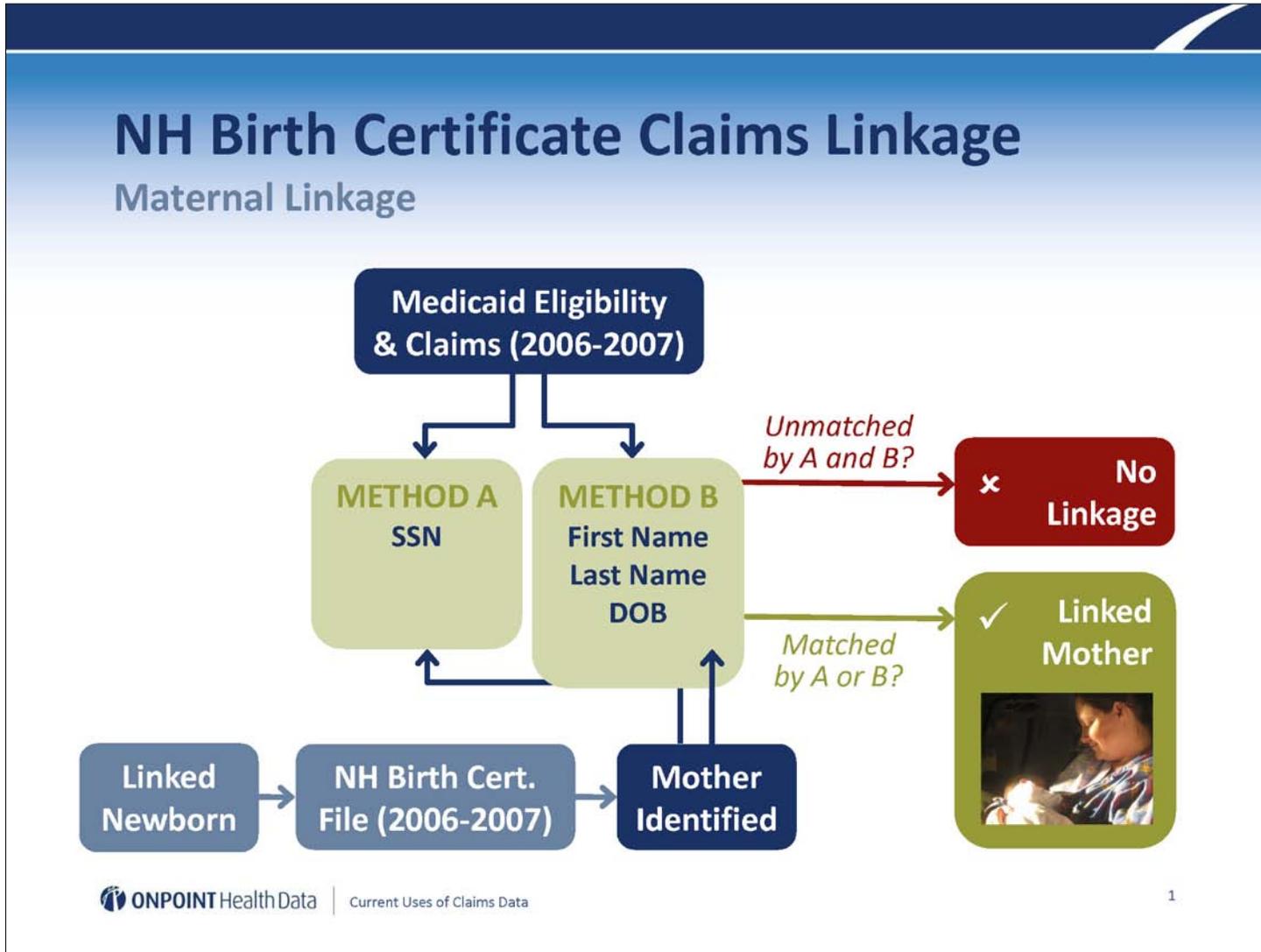
Claims and eligibility data are constructed primarily for administrative purposes, which poses some limitations. Other information, especially diagnoses, may be under-reported. Variances in provider or insurer claims coding, data processing, or reimbursement arrangements may also contribute to the variances shown in this report. Additionally, many members are covered by other third parties, in particular those who are dually eligible for both Medicare and Medicaid (while their Medicaid experience is fully represented, these members will have limited claims experience from other parties and may be under-reported in this analysis).

### Conclusion

This study demonstrated that chronic respiratory diseases were much more prevalent in the NH Medicaid population than the commercial population, and that members with chronic respiratory diseases contribute significantly to utilization and costs. Medicaid outpatient ED and inpatient admissions were at higher rates than CHIS commercial. Finally, members with chronic respiratory diseases in Medicaid had complex medical problems as indicated by high rates of coexisting respiratory diseases, other serious medical conditions, and mental disorders.

#### About the New Hampshire Comprehensive Health Care Information System

The New Hampshire Comprehensive Health Care Information System (NH CHIS) is a joint project between the New Hampshire Department of Health and Human Services (NH DHHS) and the New Hampshire Insurance Department (NHID). The NH CHIS was created by state statute (RSA 420-G:11-a) to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices." For more information about the CHIS please visit [www.nhchis.org](http://www.nhchis.org) or [www.nh.gov/nhchis](http://www.nh.gov/nhchis).



Appendix F-3 – Birth Certificate Linkage (2 of 2)

## NH Medicaid Birth Certificate – Claims

Logistic Regression, Odds Ratios Newborn Cost; DRAFT

Characteristics Birth Certificate	High Cost >\$10,000 During 1 <sup>st</sup> Year
Extreme Prematurity (<33 weeks)	24.7*
Congenital Abnormality	9.3*
Low Birth Weight	1.9*

Characteristics Medicaid Claims	High Cost >\$10,000 During 1 <sup>st</sup> Year
Income < 100% FPL	1.5*
Drug Dependence	6.8*
Mental Health Disorder	2.3*


Current Uses of Claims Data
2

## Appendix F-4 – Primary Care Received by NH Medicaid Members by Practice Setting

**Table 11. Percentage of Members with Appropriate Diabetes Care**

*Note: 95% confidence intervals (CI) in parentheses*

Measure	Measurement Based on NH CHIS Administrative Claims Data						National 2007 NCQA Medicaid Managed Care HEDIS Data
	Hospital- based	DHC	FQHC/LAL	RHC	Office- based	NH Medicaid with PC Total	
Eye Exam	52.8% (47.0-58.6)	59.9% (52.3-67.5)	50.5% (43.6-57.3)	48.0% (36.0-60.0)	48.0% (43.6-52.3)	51.1% (48.3-53.8)	51.4%
HbA1c	81.5% (77.0-86.1)	84.9% (79.2-90.5)	85.6% (80.7-90.4)	77.3% (67.2-87.5)	80.1% (76.6-83.6)	81.8% (79.7-84.0)	78.0%
LDL	73.3% (68.1-78.4)	79.7% (73.3-86.0)	77.5% (71.8-83.2)	68.0% (56.8-79.2)	72.1% (68.2-76.0)	74.0% (71.6-76.5)	71.1%
Nephropathy	83.8% (79.5-88.1)	83.7% (77.9-89.5)	86.9% (82.3-91.6)	76.0% (65.7-86.3)	84.4% (81.2-87.5)	84.1% (82.1-86.1)	74.6%

*Differences between primary care settings and the total were not statistically significant*

Overall, NH Medicaid beneficiaries with diabetes who are receiving primary care at all settings are more likely to have attention paid to kidney disease (nephropathy) (76% in RHCs to 87% in FQHCs compared to 75% nationally) and, with the exception of RHCs, to get HbA1c tests and their serum cholesterol checked than Medicaid members nationally.

**Comparison of Primary Care Received by NH Medicaid Members by Practice Setting, CY 2006**  
Office of Medicaid Business and Policy, NH Department of Health and Human Services, May 2009

24

## APPENDIX G — WORK SAMPLES — CUSTOM BLUEPRINT STUDIES

G-1 — Blueprint Pilot Evaluation Design

G-2 — Medical Home Intervention Pilot

G-3 — Pathways to Excellence Blue Ribbon Website

G-4 — Primary Care Study

G-5 — Hospital Payment Variation Analysis for Maine Health Management Coalition

G-6 — Assessment of PCP Practice Observed and Expected Episode Costs

G-7 — Sample Provider Services Assessment System - ETG Detail

## Appendix G-1 – Blueprint Pilot Evaluation Design

**Table 1.** Blueprint Pilot Evaluation Design

POPULATION	ST. JOHNSBURY HSA		BURLINGTON HSA	
	BASELINE PRE-INTERVENTION 7/1/07 – 6/30/08	YEAR 1 INTERVENTION 7/1/08 – 6/30/09	BASELINE PRE-INTERVENTION 10/1/07 – 9/30/08	YEAR 1 INTERVENTION 10/1/08 – 9/30/09
Blueprint Participants				
Community Controls				
Non-Community Controls selected randomly				

## Appendix G-2 – Medical Home Intervention Pilot

**Table 3  
Medical Payments by Age Group for Healthy Futures and Matched Control  
Group Members**

Study Group	Age Group	Study Members	Pre	Transition	Post 1	Post 2	Pre PMPM	Transition PMPM	Post 1 PMPM	Post 2 PMPM
Healthy Futures	0-17	47	\$45,538	\$23,098	\$14,118	\$23,537	\$86.25	\$42.30	\$26.90	\$43.59
Healthy Futures	18-39	41	\$19,550	\$35,375	\$35,396	\$58,721	\$42.87	\$77.07	\$78.83	\$132.85
Healthy Futures	40-49	57	\$74,424	\$95,834	\$67,845	\$85,425	\$115.74	\$146.99	\$103.74	\$133.69
Healthy Futures	50-59	63	\$72,233	\$145,106	\$104,728	\$131,396	\$97.22	\$199.87	\$145.46	\$182.50
Healthy Futures	60 and over	38	\$155,831	\$57,029	\$204,375	\$242,610	\$375.50	\$144.01	\$526.74	\$701.19
Healthy Futures	All Ages	244	\$367,577	\$356,442	\$426,461	\$541,694	\$131.98	\$128.26	\$154.74	\$201.60
Other Winthrop	0-17	44	\$28,471	\$28,769	\$44,851	\$18,436	\$56.72	\$57.08	\$86.42	\$36.95
Other Winthrop	18-39	44	\$40,333	\$67,587	\$40,942	\$46,605	\$91.58	\$141.40	\$88.24	\$117.69
Other Winthrop	40-49	56	\$67,910	\$136,704	\$93,369	\$171,483	\$102.89	\$212.94	\$144.09	\$271.76
Other Winthrop	50-59	67	\$124,920	\$70,381	\$60,210	\$101,954	\$163.72	\$90.00	\$117.46	\$135.94
Other Winthrop	60 and over	33	\$53,885	\$78,171	\$62,822	\$62,152	\$144.85	\$220.79	\$185.88	\$219.62
Other Winthrop	All Ages	244	\$315,518	\$379,613	\$332,193	\$400,631	\$113.13	\$137.99	\$121.37	\$156.58
Catchment Area	0-17	45	\$18,578	\$54,886	\$23,762	\$40,184	\$32.76	\$104.94	\$44.87	\$80.69
Catchment Area	18-39	43	\$37,991	\$68,141	\$37,387	\$37,179	\$80.32	\$141.37	\$81.45	\$90.90
Catchment Area	40-49	57	\$93,905	\$56,016	\$52,754	\$35,725	\$148.35	\$86.31	\$78.62	\$54.88
Catchment Area	50-59	64	\$172,731	\$76,045	\$99,465	\$74,134	\$226.38	\$102.35	\$136.25	\$102.98
Catchment Area	60 and over	35	\$118,255	\$35,949	\$57,825	\$152,235	\$290.58	\$92.89	\$164.61	\$449.07
Catchment Area	All Ages	244	\$439,471	\$291,038	\$271,213	\$339,456	\$157.97	\$104.54	\$98.12	\$129.71
Southern Augusta H.S.A.	0-17	45	\$19,591	\$23,460	\$36,285	\$21,398	\$38.95	\$44.94	\$68.46	\$42.96
Southern Augusta H.S.A.	18-39	41	\$34,366	\$42,133	\$28,414	\$31,587	\$74.87	\$91.99	\$63.28	\$83.56
Southern Augusta H.S.A.	40-49	57	\$121,983	\$96,801	\$117,700	\$86,953	\$187.38	\$146.45	\$179.97	\$106.44
Southern Augusta H.S.A.	50-59	65	\$252,304	\$134,086	\$125,381	\$112,113	\$335.06	\$180.47	\$168.52	\$150.69
Southern Augusta H.S.A.	60 and over	36	\$97,226	\$175,341	\$239,129	\$167,354	\$240.66	\$446.16	\$617.90	\$489.34
Southern Augusta H.S.A.	All Ages	244	\$525,470	\$471,820	\$546,908	\$399,403	\$189.70	\$169.60	\$167.87	\$164.15

Pre = 1/1/97 – 12/31/97  
 Transition = 1/1/98 – 12/31/98  
 Post 1 = 1/1/99 – 12/31/99  
 Post 2 = 1/1/2000 – 12/31/2000



## Appendix G-3 – Pathways to Excellence Blue Ribbon Website (1 of 2)

MHMC - Understanding Patient Safety Ratings - Mozilla Firefox

http://www.mhmc.info/ratings-explained/patient-safety/

Maine Health Management Coalition

Maine Doctor Ratings | Maine Hospital Ratings | Major Surgery Ratings | How Do I Get Quality Care?

Optional: Search within 10 miles of zip code View Results

### Maine Hospital Ratings

#### Hospital Ratings Explained

[Return to Hospital Ratings](#)

[Patient Experience ratings explained](#) | [Patient Safety ratings explained](#) | [Select Clinical Quality ratings explained](#)

#### Understanding Patient Safety Ratings

**Were do the facts come from?**

*Medication Safety:* Hospitals fill in surveys and send to MHMC. Medication Spotlight ribbons and pies are from data that hospitals reported on their 2009 Survey.

*National Survey:* The Leapfrog Group provides MHMC with the facts. Leapfrog ribbons are from data that hospitals reported through September 30, 2009.

**How Often Are the Facts Updated?**

*Medication Safety:* Annually. Hospitals have the option to update one time during year.

*National Survey:* Annually. Hospitals have the option of providing updates every month.

**How Does MHMC Turn the Facts Into Ratings?**

**Blue Ribbon for Medication Safety:**

MHMC - Understanding Patient Safety Ratings - Mozilla Firefox

http://www.mhmc.info/ratings-explained/patient-safety/

#### How Does MHMC Turn the Facts Into Ratings?

**Blue Ribbon for Medication Safety:**

**Ratings Levels**

Points 1 2 3 4

Hospitals receive a blue ribbon when they have a score equal to or greater than 2.5. This score is calculated by averaging the combined points received in the Medication Safety and National Survey measurement areas.

- ✓ Prevent Medication Errors
- ✓ Appropriate ICU Staffing
- ✓ Steps to Avoid Harm
- ✓ High Risk Treatment

Bars for the four Leapfrog survey "leaps" rolled into an aggregate MHMC pie as follows:

- ✓ 4 bars = 4 points
- ✓ 3 bars = 3 points
- ✓ 2 bars = 2 points
- ✓ 1 bar = 1 point
- ✓ N/A = not included in numerator or denominator

Pies are calculated by totaling the points of the four leaps and dividing that number by the total number of leaps required to be

## Appendix G-3 – Pathways to Excellence Blue Ribbon Website (2 of 2)

[Maine Doctor Ratings](#)
[Maine Hospital Ratings](#)
[Major Surgery Ratings](#)
[How Do I Get Quality Care?](#)

Optional: Search  within 10 miles  of  zip code

### Maine Hospital Ratings

Blue Ribbons Sort by: [Highest Rated](#) [Name](#) [City](#)

[view Specialty Hospitals >>](#)

[Hospital Ratings Explained](#)  
page last updated Oct 2009

[Patient Experience ratings explained](#) [Patient Safety ratings explained](#)

	<a href="#">Patient Experience ratings explained</a>	<a href="#">Patient Safety ratings explained</a>	HEART ATTACK	HEART FAILURE	PNEUMONIA	SURGICAL INFECTION
<b>Mid Coast Hospital</b> 123 Medical Center Drive, <b>Brunswick</b> 04011 · <a href="#">view map</a>						
<b>Mercy Hospital</b> 144 State Street, <b>Portland</b> 04101 · <a href="#">view map</a>						
<b>Southern Maine Medical Center</b> 1 Medical Center Drive, <b>Biddeford</b> 04005 · <a href="#">view map</a>						

[Maine Doctor Ratings](#)
[Maine Hospital Ratings](#)
[Major Surgery Ratings](#)
[How Do I Get Quality Care?](#)

Optional: Search  within 10 miles  of  zip code

### Maine Hospital Ratings

#### Hospital Ratings Explained

[Return to Hospital Ratings](#)

[Patient Experience ratings explained](#) [Patient Safety ratings explained](#) [Select Clinical Quality ratings explained](#)

#### Understanding Patient Experience Ratings

**Where do the facts come from?**

The U.S. Department of Health and Human Services collects hospital performance information through the efforts of the Centers for Medicare & Medicaid Services (CMS) [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov). Ribbons and pies are from data that hospitals reported between January, 2008 and December 2008.

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national, standardized survey of hospital patients. HCAHPS (pronounced "H-caps") was created to publicly report the patient's perspective of hospital care. The survey asks a random sample of recently discharged patients about important aspects of their hospital experience.

HCAHPS was developed by a partnership of public and private organizations. Development of the survey was funded by the Federal government, specifically the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ).

For more on HCAHPS information, please see Information for Professionals on this website, or visit the official HCAHPS website: [www.hcahpsonline.org](http://www.hcahpsonline.org).

## Appendix G-4 – Primary Care Study

**Table 7.** Primary Care Visits During Year by Age (CAP) - One-Year Measure

PRACTICE TYPE	AGE	2006 MEMBERS CONTINUOUSLY ENROLLED	WITH ANY VISIT 2006	% WITH VISIT
State Total	0-11M	700	687	98.1%
State Total	12-24M	3,622	3,517	97.1%
State Total	25M-6Y	14,528	12,921	88.9%
Hospital	0-11M	122	121	99.2%
Hospital	12-24M	666	666	100.0%
Hospital	25M-6Y	2,501	2,496	99.8%
DHC	0-11M	145	145	100.0%
DHC	12-24M	699	699	100.0%
DHC	25M-6Y	2,510	2,503	99.7%
FQHC	0-11M	109	107	98.2%
FQHC	12-24M	448	446	99.6%
FQHC	25M-6Y	1,450	1,442	99.5%
RHC	0-11M	40	38	95.0%
RHC	12-24M	252	233	92.5%
RHC	25M-6Y	854	729	85.4%
OfficeBased	0-11M	264	263	99.6%
OfficeBased	12-24M	1,412	1,406	99.6%
OfficeBased	25M-6Y	5,544	5,458	98.5%
No Primary Care Attribution/Unknown	0-11M	20	13	65.0%
No Primary Care Attribution/Unknown	12-24M	145	67	46.2%
No Primary Care Attribution/Unknown	25M-6Y	1,669	293	17.6%

**Table 8.** Primary Care Visits During Year by Age (CAP) - Two-Year Measure

PRACTICE TYPE	AGE	MEMBERS CONTINUOUSLY ENROLLED 2005-2006	WITH ANY VISIT 2005-2006	% WITH VISIT
State Total	07-11Y	9413	7796	82.8%
State Total	12-18Y	11786	10337	87.7%
Hospital	07-11Y	1675	1606	95.9%
Hospital	12-18Y	2090	2088	99.9%
DHC	07-11Y	1812	1716	94.7%
DHC	12-18Y	2245	2230	99.3%

PRACTICE TYPE	AGE	MEMBERS CONTINUOUSLY ENROLLED 2005-2006	WITH ANY VISIT 2005-2006	% WITH VISIT
FQHC	07-11Y	803	758	94.4%
FQHC	12-18Y	1051	1048	99.7%
RHC	07-11Y	635	499	78.6%
RHC	12-18Y	797	715	89.7%
OfficeBased	07-11Y	4083	3823	93.6%
OfficeBased	12-18Y	4959	4827	97.3%
No Primary Care Attribution/Unknown	07-11Y	2080	1000	48.1%
No Primary Care Attribution/Unknown	12-18Y	2734	1517	55.5%

**Table 9.** Adult Access to Primary Care Providers (AAP) – One-Year Measure

PRACTICE TYPE	AGE	MEMBERS CONTINUOUSLY ENROLLED 2006	WITH ANY VISIT 2006	% WITH VISIT
State Total	20-44	8,824	7,773	88%
State Total	45-64	3,491	3,228	92%
State Total	65+	577	523	91%
Hospital	20-44	1,618	1,605	99%
Hospital	45-64	679	679	100%
Hospital	65+	59	59	100%
DHC	20-44	1,329	1,318	99%
DHC	45-64	387	387	100%
DHC	65+	95	95	100%
FQHC	20-44	1,312	1,300	99%
FQHC	45-64	485	485	100%
FQHC	65+	61	61	100%
RHC	20-44	356	352	99%
RHC	45-64	177	177	100%
RHC	65+	17	17	100%
OfficeBased	20-44	2,960	2,937	99%
OfficeBased	45-64	1,395	1,394	100%
OfficeBased	65+	269	269	100%
No Primary Care Attribution/Unknown	20-44	1,249	261	21%
No Primary Care Attribution/Unknown	45-64	368	106	29%
No Primary Care Attribution/Unknown	65+	76	22	29%

**Table 10.** Well Child Visits in First 15 Months of Life (W15)

PRACTICE TYPE	NUMBER OF VISITS	MEMBERS AGE 15 MONTHS IN 2006, CE 13+ MONTHS	MEMBERS WITH VISIT DURING FIRST 15 MONTHS	% WITH NUMBER OF VISITS
State Total	0	3,230	89	2.8%
State Total	1	3,230	70	2.2%
State Total	2	3,230	106	3.3%
State Total	3	3,230	206	6.4%
State Total	4	3,230	369	11.4%
State Total	5	3,230	604	18.7%
State Total	6+	3,230	1,786	55.3%
Hospital	0	590	13	2.2%
Hospital	1	590	8	1.4%
Hospital	2	590	25	4.2%
Hospital	3	590	48	8.1%
Hospital	4	590	82	13.9%
Hospital	5	590	99	16.8%
Hospital	6+	590	315	53.4%
DHC	0	630	6	1.0%
DHC	1	630	8	1.3%
DHC	2	630	17	2.7%
DHC	3	630	49	7.8%
DHC	4	630	79	12.5%
DHC	5	630	145	23.0%
DHC	6+	630	326	51.8%
FQHC	0	384	1	0.3%
FQHC	1	384	3	0.8%
FQHC	2	384	16	4.2%
FQHC	3	384	32	8.3%
FQHC	4	384	56	14.6%
FQHC	5	384	59	15.4%
FQHC	6+	384	217	56.5%
RHC	0	222	12	5.4%
RHC	1	222	24	10.8%
RHC	2	222	13	5.9%
RHC	3	222	11	5.0%
RHC	4	222	16	7.2%
RHC	5	222	31	14.0%
RHC	6+	222	115	51.8%

OfficeBased	0	1,242	16	1.3%
OfficeBased	1	1,242	18	1.5%
OfficeBased	2	1,242	24	1.9%
OfficeBased	3	1,242	54	4.4%
OfficeBased	4	1,242	121	9.7%
OfficeBased	5	1,242	244	19.7%
OfficeBased	6+	1,242	765	61.6%
No Primary Care Attribution/Unknown	0	162	41	25.3%
No Primary Care Attribution/Unknown	1	162	9	5.6%
No Primary Care Attribution/Unknown	2	162	11	6.8%
No Primary Care Attribution/Unknown	3	162	12	7.4%
No Primary Care Attribution/Unknown	4	162	15	9.3%
No Primary Care Attribution/Unknown	5	162	26	16.1%
No Primary Care Attribution/Unknown	6+	162	48	29.6%

**Table 11.** Well Child Visits (Modified HEDIS Measure W34)

PRACTICE TYPE	AGE	2006 MEMBERS CONTINUOUSLY ENROLLED	2006 MEMBERS WITH AT LEAST ONE VISIT 2006	% WITH AT LEAST ONE VISIT CURRENT YEAR
State Total	16-35M	6,562	5,120	78.0%
State Total	3-6Y	15,012	9,420	62.7%
State Total	7-11Y	17,238	8,130	47.2%
Hospital	16-35M	1,145	1,017	88.8%
Hospital	3-6Y	2,306	1,791	77.7%
Hospital	7-11Y	2,283	1,420	62.2%
DHC	16-35M	1,134	963	84.9%
DHC	3-6Y	2,318	1,756	75.8%
DHC	7-11Y	2,519	1,487	59.0%
FQHC	16-35M	691	607	87.8%
FQHC	3-6Y	1,313	966	73.6%
FQHC	7-11Y	1,144	684	59.8%
RHC	16-35M	386	303	78.5%
RHC	3-6Y	813	487	59.9%
RHC	7-11Y	860	394	45.8%
OfficeBased	16-35M	2,352	2121	90.2%
OfficeBased	3-6Y	5,319	4,202	79.0%
OfficeBased	7-11Y	5,917	3,917	66.2%
No Primary Care Attribution/Unknown	16-35M	854	109	12.8%
No Primary Care Attribution/Unknown	3-6Y	2,943	218	7.4%
No Primary Care Attribution/Unknown	7-11Y	4,515	228	5.1%

**Table 12.** Adolescent Well-Care Visits (AWC)

PRACTICE TYPE	AGE	2006 MEMBERS CONTINUOUSLY ENROLLED	2006 MEMBERS WITH AT LEAST ONE VISIT 2006	% WITH AT LEAST ONE VISIT CURRENT YEAR
State Total	12-18Y	17,208	7,867	45.7%
Hospital	12-18Y	2,535	1,446	57.0%
DHC	12-18Y	2,658	1,603	60.3%
FQHC	12-18Y	1,323	730	55.2%
RHC	12-18Y	980	444	45.3%
OfficeBased	12-18Y	6,120	3,469	56.7%
No Primary Care Attribution/Unknown	12-18Y	3,592	175	4.9%

## Appendix G-5 — Hospital Payment Variation Analysis for Maine Health Management Coalition

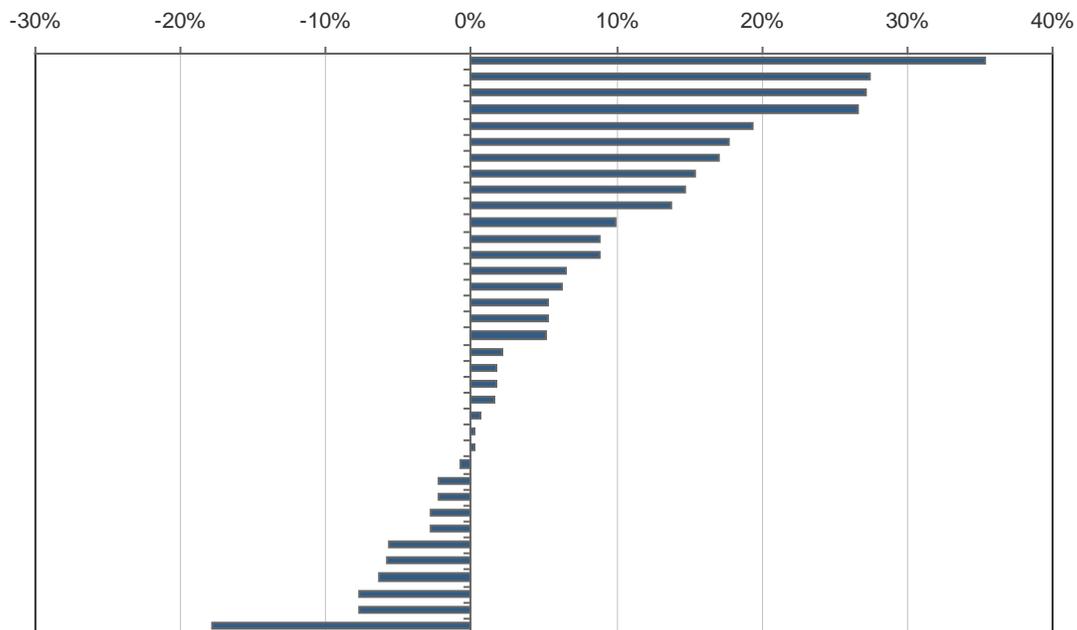
The Maine Health Management Coalition requested evaluation of variability in payments to Maine hospitals. Over several years, Onpoint provided risk-adjusted measurement of payments to Maine hospitals for inpatient and outpatient services.

Onpoint met with representatives (CFOs and others) from Maine hospitals to review data sources and methods. DRGs were used to case-mix adjust inpatient data. APC and APG groupers were evaluated for outpatient data and with grouper experts at 3M. APG was selected for case-mix adjusting outpatient hospital data.

Statewide Maine commercial claims data was used to determine payments. Payments were aggregated to the inpatient discharge and outpatient visit level. Professional fees were excluded and adjustments made for bundled claims. Results were reported for each Maine hospital for inpatient, outpatient, and combined. Additional analyses evaluated the relationship between hospital size, Medicaid/Medicare mix, and payment variance.

For selected DRGs, average Maine payments were compared to those of another state (New Hampshire) using the same methodology. Methods and results were presented to the board of the Maine Health Management Coalition.

Table 13. Variation Above/Below State Average in Payments to 36 Maine Hospitals for Inpatient and Outpatient Care, Adjusted for Patient Mix, Commercial Population



## Appendix G-6 — Assessment of PCP Practice Observed and Expected Episode Costs

### By PTE Star Rating, By Selected Episode Treatment Group (ETG) Categories

**Time Period:** Illness episodes between January 2006 and December 2007 (24 months)

**Data Source:** MHMC Database

**Episode Categories:** Lower-cost-routine episodes w/o IP, all other episodes w/o IP, blended lower-cost routine and other non IP episodes

**Episode Type:** Closed or full-year episodes

**Physician Group:** 3-star, 2-star, 1-star, or 0-star PCP Practices identified in 2008 PTE analysis

STARS	PTE PHYSICIAN PRACTICE	REFERENCE: PTE MEMBERS COUNT	LOWER-COST-ROUTINE EPISODE CATEGORY WITHOUT AN INPATIENT STAY						
			PRACTICE OBSERVED			EXPECTED		DIFFERENCE	
			NUMBER OF CLOSED EPISODES	ACTUAL TOTAL PAID	PAID PER EPISODE	EXPECTED TOTAL PAID FOR MIX OF ETGS**	PAID PER EPISODE	DOLLARS PAID/EPISODE (POS >EXPECT NEG <EXPECT)	PERCENT (POS >EXPECT NEG <EXPECT)
	GRAND TOTAL	113,983	193,996	\$27,237,102	\$140.40	\$27,306,267	\$140.76	-\$0.36	-0.3%
All 3-Star PTE Practices		71,902	127,125	\$17,740,337	\$139.55	\$17,887,300	\$140.71	-\$1.16	-0.8%
3	AAA	97	98	\$13,431	\$137.05	\$13,758	\$140.39	-\$3.34	-2.4%
3	BBB	158	259	\$34,279	\$132.35	\$37,465	\$144.65	-\$12.30	-8.5%
3	CCC	153	265	\$39,388	\$148.63	\$37,667	\$142.14	\$6.49	4.6%
3	DDD	1,371	2,527	\$363,337	\$143.78	\$362,119	\$143.30	\$0.48	0.3%
3	EEE	25	45	\$6,705	\$148.99	\$6,147	\$136.60	\$12.39	9.1%
3	FFF	31	37	\$4,453	\$120.36	\$5,255	\$142.02	-\$21.66	-15.3%
3	GGG	198	334	\$46,180	\$138.26	\$48,283	\$144.56	-\$6.30	-4.4%
3	HHH	114	148	\$21,204	\$143.27	\$20,791	\$140.48	\$2.80	2.0%
3	JJJ	1,375	4,401	\$468,902	\$106.54	\$612,379	\$139.15	-\$32.60	-23.4%
3	KKK	32	45	\$5,874	\$130.54	\$6,455	\$143.45	-\$12.91	-9.0%

STARS	PTE PHYSICIAN PRACTICE	REFERENCE: PTE MEMBERS COUNT	LOWER-COST-ROUTINE EPISODE CATEGORY WITHOUT AN INPATIENT STAY						
			PRACTICE OBSERVED			EXPECTED		DIFFERENCE	
			NUMBER OF CLOSED EPISODES	ACTUAL TOTAL PAID	PAID PER EPISODE	EXPECTED TOTAL PAID FOR MIX OF ETGS**	PAID PER EPISODE	DOLLARS PAID/EPISODE (POS >EXPECT NEG <EXPECT)	PERCENT (POS >EXPECT NEG <EXPECT)
3	LLL	303	879	\$104,139	\$118.47	\$122,082	\$138.89	-\$20.41	-14.7%

STARS	PTE PHYSICIAN PRACTICE	REFERENCE: PTE MEMBERS COUNT	ALL OTHER EPISODES WITHOUT AN INPATIENT STAY						
			PRACTICE OBSERVED			EXPECTED		DIFFERENCE	
			NUMBER OF CLOSED EPISODES	ACTUAL TOTAL PAID	PAID PER EPISODE	EXPECTED TOTAL PAID FOR MIX OF ETGS**	PAID PER EPISODE	DOLLARS PAID/EPISODE (POS >EXPECT NEG <EXPECT)	PERCENT (POS >EXPECT NEG <EXPECT)
	GRAND TOTAL	113,983	242,882	\$189,839,028	\$781.61	\$190,158,965	\$782.93	-\$1.32	-0.2%
	All 3-Star PTE Practices	71,902	151,730	\$115,605,365	\$761.92	\$118,094,488	\$778.32	-\$16.40	-2.1%
3	AAA	97	122	\$83,963	\$688.22	\$139,891	\$1,146.64	-\$458.42	-40.0%
3	BBB	158	343	\$204,893	\$597.36	\$294,425	\$858.38	-\$261.03	-30.4%
3	CCC	153	407	\$267,184	\$656.47	\$373,602	\$917.94	-\$261.47	-28.5%
3	DDD	1,371	3,603	\$2,157,927	\$598.93	\$2,983,324	\$828.01	-\$229.09	-27.7%
3	EEE	25	64	\$67,307	\$1,051.68	\$91,797	\$1,434.32	-\$382.65	-26.7%
3	FFF	31	66	\$29,197	\$442.38	\$39,144	\$593.09	-\$150.71	-25.4%
3	GGG	198	603	\$288,047	\$477.69	\$387,744	\$643.02	-\$165.33	-25.7%
3	HHH	114	276	\$131,994	\$478.24	\$176,134	\$638.17	-\$159.93	-25.1%

STARS	PTE PHYSICIAN PRACTICE	REFERENCE: PTE MEMBERS COUNT	ALL OTHER EPISODES WITHOUT AN INPATIENT STAY						
			PRACTICE OBSERVED			EXPECTED		DIFFERENCE	
			NUMBER OF CLOSED EPISODES	ACTUAL TOTAL PAID	PAID PER EPISODE	EXPECTED TOTAL PAID FOR MIX OF ETGS**	PAID PER EPISODE	DOLLARS PAID/EPISODE (POS >EXPECT NEG <EXPECT)	PERCENT (POS >EXPECT NEG <EXPECT)
3	JJJ	1,375	1,967	\$911,775	\$463.54	\$1,156,251	\$587.82	-\$124.29	-21.1%
3	KKK	32	76	\$85,092	\$1,119.63	\$106,608	\$1,402.73	-\$283.10	-20.2%
3	LLL	303	454	\$173,253	\$381.61	\$219,176	\$482.77	-\$101.15	-21.0%

STARS	PTE PHYSICIAN PRACTICE	REFERENCE: PTE MEMBERS COUNT	BLENDED LOWER-COST-ROUTINE AND OTHER NON-INPATIENT-STAY EPISODES						
			PRACTICE OBSERVED			EXPECTED		DIFFERENCE	
			NUMBER OF CLOSED EPISODES	ACTUAL TOTAL PAID	PAID PER EPISODE	EXPECTED TOTAL PAID FOR MIX OF ETGS**	PAID PER EPISODE	DOLLARS PAID/EPISODE (POS >EXPECT NEG <EXPECT)	PERCENT (POS >EXPECT NEG <EXPECT)
	GRAND TOTAL	113,983	436,878	\$217,076,129	\$496.88	\$217,465,232	\$497.77	-\$0.89	-0.2%
	All 3-Star PTE Practices	71,902	278,855	\$133,345,702	\$478.19	\$135,981,788	\$487.64	-\$9.45	-1.9%
3	AAA	97	220	\$97,395	\$442.70	\$153,649	\$698.40	-\$255.70	-36.6%
3	BBB	158	602	\$239,172	\$397.30	\$331,890	\$551.31	-\$154.02	-27.9%
3	CCC	153	672	\$306,572	\$456.21	\$411,269	\$612.01	-\$155.80	-25.5%
3	DDD	1,371	6,130	\$2,521,264	\$411.30	\$3,345,442	\$545.75	-\$134.45	-24.6%
3	EEE	25	109	\$74,012	\$679.01	\$97,944	\$898.57	-\$219.56	-24.4%
3	FFF	31	103	\$33,650	\$326.70	\$44,399	\$431.05	-\$104.35	-24.2%
3	GGG	198	937	\$334,227	\$356.70	\$436,027	\$465.34	-\$108.64	-23.3%

STARS	PTE PHYSICIAN PRACTICE	REFERENCE: PTE MEMBERS COUNT	BLENDED LOWER-COST-ROUTINE AND OTHER NON-INPATIENT-STAY EPISODES						
			PRACTICE OBSERVED			EXPECTED		DIFFERENCE	
			NUMBER OF CLOSED EPISODES	ACTUAL TOTAL PAID	PAID PER EPISODE	EXPECTED TOTAL PAID FOR MIX OF ETGS**	PAID PER EPISODE	DOLLARS PAID/EPISODE (POS >EXPECT NEG <EXPECT)	PERCENT (POS >EXPECT NEG <EXPECT)
3	HHH	114	424	\$153,199	\$361.32	\$196,925	\$464.44	-\$103.13	-22.2%
3	JJJ	1,375	6,368	\$1,380,677	\$216.81	\$1,768,630	\$277.74	-\$60.92	-21.9%
3	KKK	32	121	\$90,966	\$751.79	\$113,063	\$934.40	-\$182.61	-19.5%
3	LLL	303	1,333	\$277,392	\$208.10	\$341,258	\$256.01	-\$47.91	-18.7%

# Appendix G-7 – Sample Provider Services Assessment System – ETG Detail



## Sample Provider Services Assessment System - ETG Detail

ETG Episodes from Incurred claims Jan 2005 - Dec 2007

Profited Provider Group

See NOTES tab for Provider types and ETGs

Use the dropdown arrows in any field to Filter on that field. Select (Alt) to release the Filter.  
Filters may be combined or customized, but use caution to return unwanted Filters to (All).  
Filters in use will have a blue dropdown arrow, and sort data alphabetically for selection.

PROVIDER SPECIALTY	EPISODE TREATMENT GROUP FOR SELECTED MARKET	BLADET OF TREATMENT	PROVIDER	COUNTY	TOTAL EPISODES	SCORE	LOST DAYS					IDENTITY PAYMENTS					INITIAL VISITS (FIRST 21 DAYS)					CONTINUING CARE (AFTER 21 DAYS)							
							EPISODES WITH LOST DAYS	TOTAL LOST DAYS	MEDIAN LOST DAYS	PCT FIRM HMO	PCT FIRM PPO	TOTAL IDENTIFY PAYS	MEDIAN IDENTIFY PAYS	PCT DIFF FIRM HMO	PCT DIFF FIRM PPO	EPISODES WITH INITIAL VISITS	TOTAL VISITS	MEDIAN VISITS	PCT DIFF FIRM HMO	PCT DIFF FIRM PPO	PROVIDER PAID VISITS	PCT DIFF FIRM HMO	PCT DIFF FIRM PPO	EPISODES WITH CONTINUING VISITS	TOTAL VISITS	MEDIAN VISITS	PCT DIFF FIRM HMO	PCT DIFF FIRM PPO	
Hospitals	719 -Oth maj joint inflam, wo surg	TOTAL, THIS ETG			56		2	366	97.3	0.0%	0	6,853	3,506	0.0%	2	2	0.0%	278	0.0%	66	494	43,298	8	0.0%	614	0.0%			
Hospitals	721 -Joint degen, local, w surg	TOTAL, THIS ETG			36		34	13,747	309	0.0%	34	1,790,563	26,646	0.0%	17	52	2	0.0%	172	0.0%	36	476	534,950	20	0.0%	12,732	0.0%		
Hospitals	722 -Joint degen, local, wo surg	TOTAL, THIS ETG			153		93	3,062	229	0.0%	94	2,983,406	20,322	0.0%	40	144	3	0.0%	325	0.0%	153	2509	370,697	10	0.0%	13,725	0.0%		
Hospitals	731 -Ct fx/dls, upper extrem wo sur	TOTAL, THIS ETG			48		20	16,205	60	0.0%	21	69,518	2,286	0.0%	43	120	4	3	0.0%	580	0.0%	48	354	42,817	5	0.0%	461	0.0%	
Hospitals	734 -Ct fx/dls, lower extrem wo sur	TOTAL, THIS ETG			34		19	1265	55	0.0%	19	220,690	2,750	0.0%	29	95	3	0.0%	675	0.0%	34	200	18,870	5	0.0%	357	0.0%		
Hospitals	742 -Joint derangement, w surg	TOTAL, THIS ETG			63		56	7897	94	0.0%	56	440,199	4,236	0.0%	46	159	3	0.0%	532	0.0%	63	1036	100,000	15	0.0%	6,715	0.0%		
Hospitals	743 -Joint derangement, wo surg	TOTAL, THIS ETG			59		30	3390	79	0.0%	29	503,537	2,650	0.0%	41	135	3	0.0%	352	0.0%	59	548	99,222	7	0.0%	666	0.0%		
Hospitals	746 -Minor orthopedic trauma	TOTAL, THIS ETG			547		142	17,767	48	0.0%	147	1,181,561	2,307	0.0%	410	1538	3	0.0%	442	0.0%	547	3915	335,103	5	0.0%	476	0.0%		
Hospitals	748 -Bursitis & tendinitis, wo surg	TOTAL, THIS ETG			175		24	3,942	55	0.0%	27	342,738	3,545	0.0%	90	280	3	0.0%	167	0.0%	175	1285	11,321	6	0.0%	566	0.0%		
Hospitals	749 -Oth minor orthopedic disorders	TOTAL, THIS ETG			59		14	3,704	139	0.0%	16	433,140	9,808	0.0%	25	69	2	0.0%	332	0.0%	59	356	33,034	4	0.0%	445	0.0%		
Hospitals	719 -Oth maj joint inflam, wo surg	Medical Center	Northern		5	10.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospitals	721 -Joint degen, local, w surg	Medical Center	Northern		5	4.2	5	2,745	574	86.4%	5	19,116	24,364	16.7%	3	5	790	2	0.0%	230	-38.3%	5	211	11,633	39	95.0%	14,615	14.8%	
Hospitals	722 -Joint degen, local, wo surg	Medical Center	Northern		32	6.7	14	3,018	80.5	64.9%	10	295,338	10,090	90.3%	2	6	995	3	0.0%	297	-8.3%	32	482	46,635	10	0.0%	1,283	5.6%	
Hospitals	731 -Ct fx/dls, upper extrem wo sur	Medical Center	Northern		5	6.3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospitals	734 -Ct fx/dls, lower extrem wo sur	Medical Center	Northern		4	2.5	1	45	45	100.0%	1	3,663	3,043	12.2%	2	10	181	5	66.7%	905	24.1%	4	31	2,014	3	-40.4%	426	19.4%	
Hospitals	742 -Joint derangement, w surg	Medical Center	Northern		7	3.2	4	802	185.3	44.2%	4	47,171	8,919	19.5%	5	17	4,595	3	0.0%	848	78.4%	7	96	72,418	10	-10.0%	8,524	-19.8%	
Hospitals	743 -Joint derangement, wo surg	Medical Center	Northern		11	5.7	5	699	60	24.1%	5	184,622	2,601	-1.9%	8	20	1,807	3	0.0%	729	-34.8%	11	146	9,678	8	14.3%	561	-5.7%	
Hospitals	746 -Minor orthopedic trauma	Medical Center	Northern		31	2.5	15	1,769	47	2.4%	15	145,289	2,019	-3.2%	24	112	11,855	4	55.3%	400	-9.5%	31	892	24,136	9	80.0%	6,715	-47.7%	
Hospitals	748 -Bursitis & tendinitis, wo surg	Medical Center	Northern		5	5.0	1	26	26	92.3%	1	961	961	-72.9%	2	7	859	4	40.0%	419	14.4%	5	53	5,940	7	16.7%	1,204	10.5%	
Hospitals	749 -Oth minor orthopedic disorders	Medical Center	Northern		1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospitals	722 -Joint degen, local, wo surg	Hospital	Coastal		3	6.7	2	553	276.3	20.7%	2	69,739	34,870	71.6%	1	2	224	2	-33.3%	224	-30.9%	3	33	2,563	6	-40.0%	419	-64.2%	
Hospitals	734 -Ct fx/dls, lower extrem wo sur	Hospital	Coastal		3	6.8	1	114	164	166.7%	1	2,915	2,915	27.6%	3	6	891	2	-33.3%	81	-89.2%	3	18	756	5	31.1%	212	-18.8%	
Hospitals	742 -Joint derangement, w surg	Hospital	Coastal		5	8.0	5	141	35	36.4%	3	7,785	2,568	1.4%	3	6	1,799	3	0.0%	631	-9.1%	5	17	1,063	6	20.0%	280	6.6%	
Hospitals	743 -Joint derangement, wo surg	Hospital	Coastal		5	8.3	5	633	7	-24.5%	5	36,992	3,305	-26.7%	3	8	2,077	2	-33.3%	477	-10.3%	5	57	3,084	9	-37.9%	6,118	-8.0%	
Hospitals	746 -Minor orthopedic trauma	Hospital	Coastal		1	8.0	0	0	0	0	0	36	36	-98.6%	1	1	55	1	-50.0%	155	-56.0%	1	3	4,989	3	-37.9%	4,989	649.0%	
Hospitals	748 -Bursitis & tendinitis, wo surg	Hospital	Coastal		1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospitals	749 -Oth minor orthopedic disorders	Hospital	Coastal		2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospitals	719 -Oth maj joint inflam, wo surg	Hospital	Coastal		2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	690 -Oth minor skin trauma	TOTAL, THIS ETG			41		3	300	20	0.0%	4	12,264	1,542	0.0%	25	68	52	0.0%	369	0.0%	41	131	14,348	2	0.0%	304	0.0%		
Rehabilitation Ctrs.	719 -Oth maj joint inflam, wo surg	TOTAL, THIS ETG			56		6	972	45.5	0.0%	6	106,921	6,755	0.0%	40	246	37,532	6	0.0%	923	0.0%	56	326	39,471	5	0.0%	568	0.0%	
Rehabilitation Ctrs.	722 -Joint degen, local, wo surg	TOTAL, THIS ETG			66		32	10,483	224	0.0%	39	1,682,510	26,760	0.0%	10	44	7,890	5	0.0%	793	0.0%	66	765	121,452	7	0.0%	1,388	0.0%	
Rehabilitation Ctrs.	746 -Minor orthopedic trauma	TOTAL, THIS ETG			206		63	5,609	21.5	0.0%	64	266,078	1,213	0.0%	78	220	344,843	3	0.0%	666	0.0%	206	2,001	262,019	4	0.0%	238	0.0%	
Rehabilitation Ctrs.	748 -Bursitis & tendinitis, wo surg	TOTAL, THIS ETG			84		8	1,987	88.1	0.0%	10	380,764	4,641	0.0%	76	268	64,618	5	0.0%	881	0.0%	84	602	70,090	4	0.0%	507	0.0%	
Rehabilitation Ctrs.	690 -Oth minor skin trauma	Employee Health Center	Cumberland		3	1.7	1	62	62	200.0%	1	8,538	8,538	408.1%	1	5	781	5	100.0%	781	111.4%	3	18	1,009	2	0.0%	344	15.1%	
Rehabilitation Ctrs.	719 -Oth maj joint inflam, wo surg	Employee Health Center	Cumberland		4	5.0	4	50	0	0.0%	4	2,132	2,132	47.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	746 -Minor orthopedic trauma	Employee Health Center	Cumberland		39	6.7	6	92	11	-39.5%	6	7,007	793	-34.6%	29	129	18,405	4	-20.2%	608	-29.8%	39	257	28,128	5	23.0	508	-1.8%	
Rehabilitation Ctrs.	748 -Bursitis & tendinitis, wo surg	Employee Health Center	Cumberland		14	5.0	0	0	0	0.0%	10	426	6,663	5	0.0%	712	1,200	-53.3%	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	722 -Joint degen, local, wo surg	Health Associates	Androscoggin		1	10.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	719 -Oth maj joint inflam, wo surg	Conditioning Clinic	Androscoggin		1	2.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	748 -Minor orthopedic trauma	Conditioning Clinic	Androscoggin		1	7.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	690 -Oth minor skin trauma	Managed Care	Androscoggin		10	5.0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation Ctrs.	690 -Oth minor skin trauma	Managed Care	Cumberland		18	6.7	1	20	20	0.0%	1	1,662	1,662	-32.9%	11	25	4,273	2	0.0%	267	-27.6%	18	66	6,704	2	0.0%	302	-1.6%	
Rehabilitation Ctrs.	690 -Oth minor skin trauma	Managed Care	Kennebec		1	5.0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	690 -Oth minor skin trauma	Managed Care	Oxford		1	3.3	0	0	0	0.0%	1	2,026	2,026	26.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Rehabilitation Ctrs.	690 -Oth minor skin trauma	Managed Care	Penobscot		8	5.8	1	16	16	100.0%	1	1,159	1,159	28.0%	5	17	2,502	3	0.0%	508	52.5	42.2%	1	23	2,543	3	25.0%	258	-2.1%
Rehabilitation Ctrs.	719 -Oth maj joint inflam, wo surg	Managed Care																											



Sample Provider Services Assessment System - ETG Detail

ETG Episodes from incurred claims Jan 2005 - Dec 2007

Profiled Provider Group

See NOTES tab for Provider types and ETGs

Use the dropdown arrows in any field to filter on that field. Select (All) to release the filter. Filters may be combined or customized, but use caution to return unwanted filters to (All). Filters in use will have a blue dropdown arrow, and sort data alphabetically for selection

PROVIDER SPECIALTY	EPISODE TREATMENT GROUP FOR SELECTED MARKET BASKET OF TREATMENT	PROVIDER	COUNTY	TOTAL EPISODES	SCORE	LOST DAYS				INDENTIFY PAYMENTS				INITIAL VISITS (FIRST 21 DAYS)				CONTINUING CARE (AFTER 21 DAYS)				PROVIDER PCT DIFF FROM MED						
						EPISODES WITH LOST DAYS	TOTAL LOST DAYS	MEDIAN LOST DAYS	PCT DIFF FROM MED	INDENTIFY PCT DIFF FROM MED	EPISODES WITH INITIAL VISITS	TOTAL VISITS	MEDIAN VISITS	PCT DIFF FROM MED	PROVIDER PCT DIFF FROM MED	EPISODES WITH CONTINUING VISITS	TOTAL VISITS	MEDIAN VISITS		PCT DIFF FROM MED								
Ortho/Plastic/Hand Surg	734 - C1 fx/cls, lower extrem w/ sur	TOTAL, THIS ETG		49		54	4083	40.5	0.0%	35	276,594	2,882	0.0%	41	120	35,506	3	0.0%	862	0.0%	49	250	24,994	3	0.0%	559	0.0%	
Ortho/Plastic/Hand Surg	742 - Joint disengagement, w/ surg	TOTAL, THIS ETG		69		53	5460	55	0.0%	53	416,469	2,334	0.0%	37	129	63,150	3	0.0%	562	0.0%	69	1301	546,622	14	0.0%	7360	0.0%	
Ortho/Plastic/Hand Surg	743 - Joint disengagement, w/ surg	TOTAL, THIS ETG		88		181	6390	62	0.0%	39	631,025	3,608	0.0%	32	89	14,759	2	0.0%	395	0.0%	88	1668	68,622	4	0.0%	1613	0.0%	
Ortho/Plastic/Hand Surg	744 - Oth major ortho trauma, w/ surg	TOTAL, THIS ETG		38		28	2885	64	0.0%	29	176,888	5,593	0.0%	32	113	136,070	3	0.0%	3,327	0.0%	38	617	147,054	9	0.0%	1639	0.0%	
Ortho/Plastic/Hand Surg	746 - Minor orthopedic trauma	TOTAL, THIS ETG		103		53	8776	71.5	0.0%	54	575,743	3,914	0.0%	56	174	29,217	3	0.0%	437	0.0%	103	741	72,337	5	0.0%	454	0.0%	
Ortho/Plastic/Hand Surg	748 - Bursitis & tendinitis, w/ surg	TOTAL, THIS ETG		96		43	9137	96	0.0%	45	1,272,772	10,663	0.0%	38	34	5,013	2	0.0%	223	0.0%	96	486	60,359	3	0.0%	439	0.0%	
Ortho/Plastic/Hand Surg	749 - Oth minor orthopedic disorders	TOTAL, THIS ETG		52		38	4885	201.5	0.0%	18	483,686	14,933	0.0%	3	3	629	1	0.0%	63	0.0%	52	141	24,486	3	0.0%	310	0.0%	
Ortho/Plastic/Hand Surg	722 - Joint degen, local, w/ surg	AAA	Penobscot	1	2.5	0		0		0				1					197	15.6%	1	20	3,608	20	344.4%	3,608	322.1%	
Ortho/Plastic/Hand Surg	743 - Joint disengagement, w/ surg	AAA	Penobscot	1	-	1	370	370	100.0%	1	65,106	65,106	146.8%	0					1	7.8	10.9%	1	7.8	10.9%	11	42.4%	10,797	175.0%
Ortho/Plastic/Hand Surg	749 - Oth minor orthopedic disorders	AAA	Penobscot	1	5.0	1	156	156	32.5%	1	8,649	8,649	-42.1%	0					1	7	4.57%	7	133.3%	4,571	1177.3%			
Ortho/Plastic/Hand Surg	746 - Minor orthopedic trauma	BBB	York	1	3.8	0		0		0				3					0	0.7%	1	11	792	11	120.0%	792	74.6%	
Ortho/Plastic/Hand Surg	729 - C1 fx/cls, upper extrem	CCC	York	1	10.0	0		0		0				1					0	-97.4%	1	2	35	2	-33.3%	95	-60.8%	
Ortho/Plastic/Hand Surg	748 - Bursitis & tendinitis, w/ surg	CCC	York	1	10.0	1	52	52	-46.9%	1	1,723	1,723	-81.8%	0					1	2	286	2	-31.5%	286	-34.8%			
Ortho/Plastic/Hand Surg	722 - Joint degen, local, w/ surg	DDD	Kennebec	4	6.3	2	137	68.5	-81.0%	2	13,643	6,521	-64.1%	0					4	24	5,689	5	0.0%	1,590	97.0%			
Ortho/Plastic/Hand Surg	729 - C1 fx/cls, upper extrem	DDD	Kennebec	1	1.5	0		0		0				1	6				816	-64.1%	1	2	82	2	-81.1%	82	-73.8%	
Ortho/Plastic/Hand Surg	730 - C1 fx/cls, upper extrem w/ surg	DDD	Kennebec	1	2.5	1	477	477	960.0%	1	23,476	23,476	414.6%	1	4	2,812	4	0.0%	2,812	-58.5%	1	43	4,532	43	636.7%	4,532	692.4%	
Ortho/Plastic/Hand Surg	731 - C1 fx/cls, upper extrem w/ sur	DDD	Kennebec	3	9.2	2	6	3	-93.3%	2	171	85	-96.3%	3	7	2,923	2	-33.3%	972	11.3%	3	9	577	3	-25.0%	143	-67.6%	
Ortho/Plastic/Hand Surg	733 - C1 fx/cls, lower extrem w/ surg	DDD	Kennebec	4	7.5	3	236	57	-14.9%	3	14,615	3,055	-24.9%	4	36	5,595	4	0.0%	960	177.6%	4	26	14,409	4	-12.5%	215	-52.5%	
Ortho/Plastic/Hand Surg	734 - C1 fx/cls, lower extrem w/ sur	DDD	Kennebec	4	4.2	2	56	28	-50.9%	2	3,880	2,340	2.0%	2	6	2,986	3	0.0%	1,493	73.2%	4	6	2,538	3	0.0%	424	24.9%	
Ortho/Plastic/Hand Surg	742 - Joint disengagement, w/ surg	DDD	Kennebec	13	3.3	10	790	59	7.3%	11	85,205	3,600	-42.1%	10	39	28,446	3	0.0%	543	-3.4%	13	260	140,027	15	7.1%	10,480	45.9%	
Ortho/Plastic/Hand Surg	743 - Joint disengagement, w/ surg	DDD	Kennebec	4	1.5	1	695	626	89.9%	1	59,690	59,690	-647.6%	1	4	697	4	100.0%	687	74.0%	4	29	1,315	1	-8.0%	460	-39.7%	
Ortho/Plastic/Hand Surg	744 - Oth major ortho trauma, w/ surg	DDD	Kennebec	2	5.8	2	47	23.5	-63.3%	2	5,825	2,825	-46.0%	2	6	10,146	1	0.0%	5,073	52.5%	2	28	1,874	14	-20.0%	937	-42.8%	
Ortho/Plastic/Hand Surg	746 - Minor orthopedic trauma	DDD	Kennebec	3	6.7	1	20	20	72.0%	1	1,005	1,005	-74.3%	3	9	1,905	3	0.0%	633	44.9%	3	15	1,481	4	-20.0%	315	-31.1%	
Ortho/Plastic/Hand Surg	748 - Bursitis & tendinitis, w/ surg	DDD	Kennebec	2	10.0	1	25	25	74.5%	2	8,204	3,302	-70.9%	0					2	4	545	2	-33.3%	273	-37.9%			

## APPENDIX H — WORK SAMPLES — SPECIAL REPORTS & STUDIES

H-1 — NH Children in Out-of-Home Placement

## Appendix H-1 – NH Children in Out-of-Home Placement (1 of 2)



### Children in Out-of-Home Placement in New Hampshire: Health and Health Care Issue Brief – February 2009

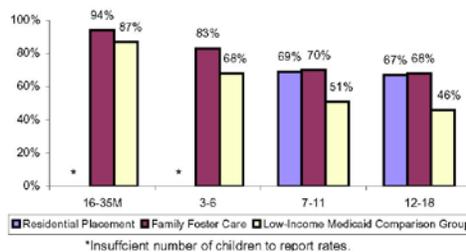
According to a report by the Urban Institute, more than 800,000 children in the United States spend time in foster care each year as a result of abuse and neglect. Foster children are at particularly high risk for physical and mental health problems stemming from not only the maltreatment they have experienced but also the separation from their homes and families, and the continuing disruptions to their daily lives.

This Issue Brief summarizes key findings of a recent study that evaluated a variety of health care measures to compare children between the ages of 1 and 18 in out-of-home placement to other low-income children enrolled in New Hampshire Medicaid during state fiscal year (SFY) 2007. Children in out-of-home placement includes those in either residential placement or family foster care. This study assessed their placement history, health status, access to care, disease prevalence, utilization, and health care payments.

#### Study Population

For SFY2007, 262 children in residential placement, 1,082 in family foster care, and 71,319 in the low-income Medicaid comparison group were studied. Children in residential placement were more likely to be adolescents (78%), compared with children in family foster care (37%) or the low-income group (34%). Children in residential placement were more likely to be male (59%) compared with family foster care (50%) or the low-income comparison group (51%).

#### Well-Child Visits by Age and Study Group, SFY2007



#### Access to Primary Care

Almost all children in out-of-home placement had access to primary care during the study period. Children in out-of-home placement were more likely to have had at least one visit with a primary care practitioner and more likely to have a well-child or adolescent well care

visit compared with the low-income comparison group and with both the national Medicaid and commercial managed care rates. Despite this, some children in out-of-home placement did not receive a well-child preventive visit, and the likelihood of not having a well-child preventive visit increased with the age of the child.

#### Disease Prevalence

Compared to the low-income Medicaid comparison group, children in out-of-home placement had higher prevalence of nutritional or metabolic disorders, mental disorders and mental retardation, epilepsy, convulsions, blindness, and congenital anomalies. Children in residential placement had higher prevalence of digestive and genito-urinary conditions, skin problems, musculoskeletal disorders, abdominal pain, and injuries.

#### Utilization

The rate of inpatient hospitalization was higher in children in residential placement (259 per 1,000 members) and family foster care (66 per 1,000 members) than the low-income comparison group (27 per 1,000 members). This pattern was consistent over all age groups and by gender. The rate of outpatient emergency department visits was higher in children in residential placement (1,358 per 1,000 members) and family foster care (657 per 1,000 members) than the low-income comparison group (560 per 1,000 members).

Injuries, respiratory illnesses, and mental disorders accounted for 61% of the outpatient emergency department visits incurred by children in out-of-home placement. The rate of use of dental services in children in residential placement (2,820 services per 1,000 members) was higher than children in family foster care (1,979 per 1,000) and the low-income comparison group (1,427 per 1,000).

The rate of prescription drug use for children in residential placement was three times the rate for children in family foster care and seven times the rate for the low-income comparison group. For each of the major drug therapeutic categories, the rate of days supplied per member per year was highest in children in residential placement, lower in children in family foster care, and lowest in the low-income comparison group.

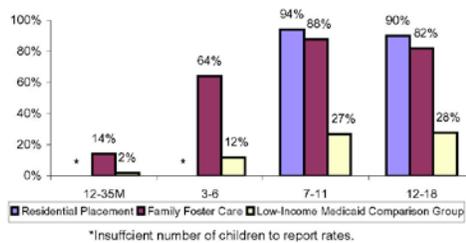
#### Mental Health Disorders

The prevalence of any mental health disorder among adolescents in residential placement (90%) and family foster care (82%) was significantly higher than adoles-

## Appendix H-1 — NH Children in Out-of-Home Placement (2 of 2)

cents in the low-income comparison group (28%). While the rate of major depression was similar between the residential placement group (6%) and the family foster care group (5%), the prevalence of bipolar and other affective disorders was four times higher in the residential placement group (26%) compared with the family foster care group (6%).

### Prevalence of Mental Health Disorders, SFY2007



Mental disorders accounted for 50% of the inpatient hospitalizations for children in out-of-home placement. The rate of psychotherapy visits was significantly higher for children with mental disorders in residential placement (11,406 per 1,000 members) or family foster care (11,893 per 1,000) compared to the low-income Medicaid comparison group (6,181 per 1,000).

Children with a serious mental disorder who used psychotropic medication had more intensive medication use in residential placement (531 days per year) than children in family foster care (465 days per year) or the low-income comparison group (366 days per year). Children can have more than 365 days supplied during a year because they may be taking more than one psychotropic medication at the same time.

### Payments

The 1,344 children in out-of-home placement incurred \$22.3 million in Medicaid payments during SFY2007: \$10 million for children in residential placement and \$12.3 million for children in family foster care. After removing services unique to special Medicaid populations, the payment rate for children in residential placement (\$807 PMPM) was more than double the payment rate for children in family foster care (\$369 PMPM) and more than five times the payment rate for the low-income comparison group (\$142 PMPM). Primary drivers of the higher payments for children in

out-of-home placement were inpatient hospital, inpatient psychiatric, outpatient hospital, prescription drugs, mental health centers, and psychology claims.

### Limitations

Claims and eligibility data are constructed primarily for administrative purposes, which poses some limitations. Certain information, especially diagnoses, may be under-reported. The residential placement population studied was small and the resulting rates for that group of children in out-of-home placement may be subject to less statistical precision. In addition, the residential placement group may have some services bundled in residential service claim billings which may impact the reliability of some measures.

### Conclusion

NH children in out-of-home placement had higher rates of disease, mental disorders, utilization, and payment rates compared with other low-income children covered by Medicaid.

The out-of-home placement group did have higher rates of well-child preventive visits than the comparison low-income group and national managed care rates, but the rates decline with age and about one-third of adolescents in out-of-home placement did not have a well-child preventive visit.

These results indicate that children in out-of-home placement are getting preventive care at higher rates than other children in NH Medicaid or national averages. However, these findings could also indicate that children in out-of-home placement had unmet need (e.g., delayed immunization, dental care) that are now being met after placement and children in out-of-home placement were more likely to be hospitalized and use the outpatient emergency department than other children.

Mental health disorders were common in children in out-of-home placement, with significantly higher rates in the residential placement group. There was some evidence that children in out-of-home placement had more intensive psychotropic medication use, but this might be driven by multiple coexisting mental health disorders. Additional value could be gained from further study of coexisting mental health disorders and the use of psychotropic medications among children in out-of-home placement.

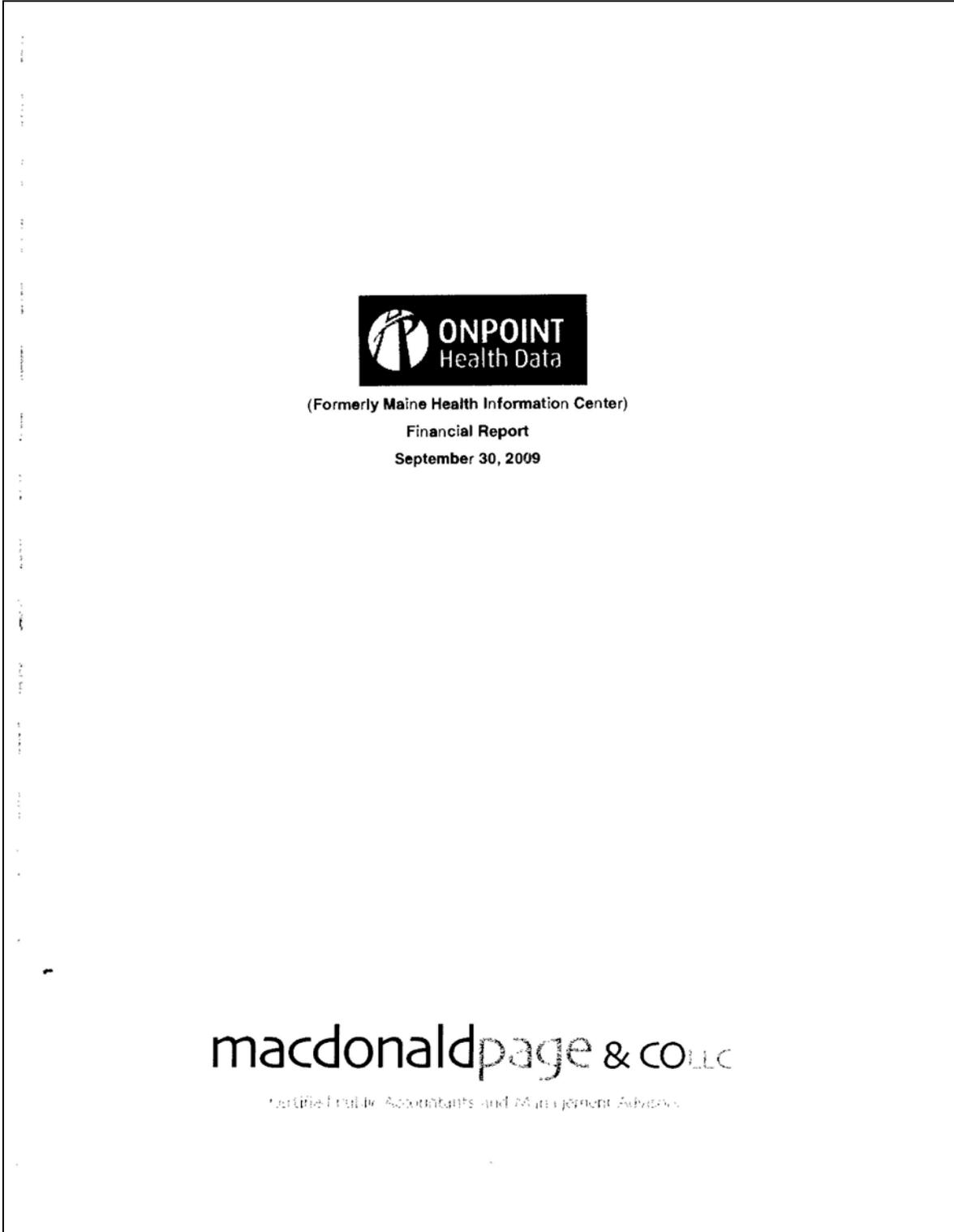
### About the New Hampshire Comprehensive Health Care Information System

The New Hampshire Comprehensive Health Care Information System (NH CHIS) is a joint project between the New Hampshire Department of Health and Human Services (NH DHHS) and the New Hampshire Insurance Department (NHID). The NH CHIS was created by state statute (RSA 420-G:11-a) to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices." For more information about the CHIS please visit [www.nhchis.org](http://www.nhchis.org) or [www.nh.gov/nhchis](http://www.nh.gov/nhchis).

## APPENDIX I – STAFF & SUBCONTRACTOR EXPERIENCE & RESPONSIBILITIES

RESPONSIBILITY & EXPERIENCE	KARL FINISON, MA	JANICE BOURGAULT	AMY KINNER, MS	REBECCA SYMES	MICHAEL DeLORENZO, PhD	DANIEL MINGLE, MD, MS	MARK PODRAZIK, MBA	JAMES HIGHLAND, PhD, MHSA
Project management	✓							
Provider attribution methods and assignment	✓			✓	✓			
Rate review process	✓							✓
Carve-out relationships	✓	✓						
Master Provider Index		✓		✓				
Ingenix ETG, ERG	✓		✓	✓		✓		
Standard reports	✓	✓		✓				
In-house reporting / BI tool	✓	✓		✓				
Customized study – Medicaid and other Human Services agencies	✓		✓	✓			✓	
DVHA legislative change cost estimates	✓						✓	
Healthcare reform	✓		✓		✓			
Medical homes / Blueprint	✓		✓	✓	✓	✓		
EMR and meaningful use	✓		✓			✓		
Statistical methods	✓		✓		✓			

APPENDIX J — ONPOINT'S FY 2009 AUDITED FINANCIAL STATEMENT





**CONTENTS**

<b>Independent Auditors' Report</b>	<b>1</b>
<b>Statements of Financial Position</b>	<b>2</b>
<b>Statements of Activities</b>	<b>3</b>
<b>Statements of Cash Flows</b>	<b>4</b>
<b>Notes to Financial Statements</b>	<b>5</b>

# macdonaldpage & co LLC

Certified Public Accountants and Management Advisors

## Independent Auditors' Report

Board of Directors  
Onpoint Health Data  
Manchester, Maine

We have audited the accompanying statements of financial position of Onpoint Health Data (the Organization) as of September 30, 2009 and 2008, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Organization's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Onpoint Health Data as of September 30, 2009 and 2008, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.



South Portland, Maine  
March 17, 2010

1

30 Long Creek Drive  
South Portland, ME 04106  
207-774-5701 • Fax: 207-774-7835

  
macpage.com

227 Water Street, P.O. Box 2749  
Augusta, ME 04338  
207-622-4766 • Fax: 207-622-6545

*An Independently Owned Member of the RSM McGladrey Network*

## Statements of Financial Position

September 30,

	2009	2008
<b>ASSETS</b>		
<b>Current Assets</b>		
Cash and cash equivalents	\$ 763,865	\$ 3,241,457
Accounts receivable	784,651	583,312
Prepaid expenses and other current assets	67,406	90,483
<b>Total Current Assets</b>	<u>1,615,922</u>	<u>3,915,252</u>
<b>Investments</b>	<u>520,074</u>	<u>261,331</u>
<b>Property and Equipment</b>		
Office equipment and software	1,185,820	1,091,430
Accumulated depreciation	(973,831)	(899,866)
	<u>211,989</u>	<u>191,564</u>
<b>Total Assets</b>	<u>\$ 2,347,985</u>	<u>\$ 4,368,147</u>
<b>LIABILITIES AND NET ASSETS</b>		
<b>Current Liabilities</b>		
Accounts payable	\$ 115,821	\$ 154,673
Accrued payroll and other current liabilities	297,498	312,992
Deferred contract revenue	73,351	2,373,092
<b>Total Current Liabilities</b>	<u>486,670</u>	<u>2,840,757</u>
<b>Unrestricted Net Assets</b>	<u>1,861,315</u>	<u>1,527,390</u>
<b>Total Liabilities and Net Assets</b>	<u>\$ 2,347,985</u>	<u>\$ 4,368,147</u>

The accompanying notes are an integral part of these financial statements.

2

## Statements of Activities

Years Ended September 30,

	2009	2008
<b>Revenue</b>		
Contracted services	\$ 4,407,839	\$ 5,522,359
Investment income	14,010	22,184
Miscellaneous income	1,017	845
<b>Total Revenue</b>	<u>4,422,866</u>	<u>5,545,388</u>
<b>Expenses</b>		
Personnel	2,856,015	2,628,348
HINFO Vendor Contract		1,429,672
Contractual services	374,315	352,187
Computer processing	288,180	331,358
Occupancy	159,595	129,182
Supplies and other	65,810	60,579
Depreciation	80,469	88,239
Telephone and postage	51,827	37,684
Conferences and training	17,452	26,115
Travel	45,768	24,038
Maintenance and repairs	28,186	21,746
Marketing	59,144	
<b>Total Expenses</b>	<u>4,026,761</u>	<u>5,129,148</u>
<b>Income from Operations</b>	<u>396,105</u>	<u>416,240</u>
<b>Non-Operating Activities</b>		
Unrealized loss on investments	(20,129)	(39,972)
Transfer of assets to HINFO	(42,051)	
<b>Total Loss from Non-Operating Activities</b>	<u>(62,180)</u>	<u>(39,972)</u>
<b>Change in Unrestricted Net Assets</b>	333,925	376,268
<b>Unrestricted Net Assets, Beginning of Year</b>	<u>1,527,390</u>	<u>1,151,122</u>
<b>Unrestricted Net Assets, End of Year</b>	<u>\$ 1,861,315</u>	<u>\$ 1,527,390</u>

The accompanying notes are an integral part of these financial statements.

3

## Statements of Cash Flows

Years Ended September 30,

	2009	2008
<b>Cash flows from operating activities:</b>		
Increase in unrestricted net assets	<u>\$ 333,925</u>	<u>\$ 376,268</u>
Adjustments to reconcile increase in net assets to net cash (used in) provided by operating activities:		
Depreciation	80,469	88,239
Unrealized loss on investments	20,129	39,972
Transfer of Assets to HINFO	42,051	
(Increase) decrease in operating assets:		
Accounts receivable	(201,339)	129,072
Prepaid expenses and other current assets	23,077	(22,479)
Increase (decrease) in operating liabilities:		
Accounts payable	(38,852)	88,235
Accrued payroll and amounts withheld	(15,494)	92,620
Deferred revenue	(2,299,741)	936,287
Total adjustments	<u>(2,389,700)</u>	<u>1,351,946</u>
<b>Net cash (used in) provided by operating activities</b>	<u>(2,055,775)</u>	<u>1,728,214</u>
<b>Cash flows from investing activities:</b>		
Purchases of property and equipment	(100,894)	(98,294)
Purchases of investments	(609,961)	(62,230)
Proceeds from maturities of investments	331,089	54,000
<b>Net cash used in investing activities</b>	<u>(379,766)</u>	<u>(106,524)</u>
<b>Cash flows from financing activities:</b>		
Transfer of assets to HINFO	(42,051)	
<b>Net cash used in financing activities</b>	<u>(42,051)</u>	
<b>Increase (decrease) in cash and cash equivalents</b>	<u>(2,477,592)</u>	<u>1,621,690</u>
<b>Cash and cash equivalents at beginning of year</b>	<u>3,241,457</u>	<u>1,619,767</u>
<b>Cash and cash equivalents at end of year</b>	<u>\$ 763,865</u>	<u>\$ 3,241,457</u>

The accompanying notes are an integral part of these financial statements.

4

## Notes to Financial Statements

September 30, 2009 and 2008

### NOTE 1 – NATURE OF ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES

#### Nature of Organizations

Onpoint Health Data is a not-for-profit entity, established in 1976, as an integrated health information system which studies the needs of appropriate users of data concerning Maine's health resources, health service utilization and costs and health status through the collection, storage and retrieval of such data. It is governed by an independent Board of Directors. The members of the Board consist of representatives of the original incorporators of Onpoint Health Data and additional individuals who are elected to the Board.

#### Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

#### Tax Status

Onpoint Health Data is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code.

#### Accounting for Uncertainty in Income Taxes

In June 2006, the Financial Accounting Standards Board (FASB) issued FASB Interpretation No. 48 (FIN 48), *Accounting for Uncertainty in Income Taxes – an Interpretation of FASB Statement No. 109*. Both FIN 48 and FASB Statement No. 109 have been codified into Accounting Standards Codification (ASC) 740, *Income Taxes*. FIN 48 clarifies the accounting for uncertainty in income taxes recognized in a company's financial statements in accordance with FASB Statement No. 109, *Accounting for Income Taxes*. FIN 48 also prescribes a "more likely than not" recognition threshold and a measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return as well as prescribes a comprehensive model for derecognition, classification, interest and penalties, disclosure, and transition.

In December 2008, the FASB published FASB Staff Position 48-3, *Effective Date of FASB Interpretation No. 48 for Certain Nonpublic Enterprises* (FSP FIN 48-3), ASC 740-10-65-1, which defers the effective date of FIN 48 for nonpublic enterprises to fiscal years beginning after December 15, 2008. The Organization has elected the deferral of the effective date and will adopt FIN 48 in its 2010 annual financial statements.

The Organization presently evaluates the likelihood of uncertain tax positions by using the provisions of ASC 450 *Contingencies* (formerly FASB Statement No. 5, *Accounting for Contingencies*). Management is currently assessing the impact of FIN 48 on its financial position and results of operations.

## Notes to Financial Statements

September 30, 2009 and 2008

### NOTE 1 – NATURE OF ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES – CONTINUED

#### Revenue Recognition

Revenue is generated primarily through contracts for services rendered to various health care data users. Revenue is recognized as it is earned under the terms of contracts. Funds received in advance of work performed are recorded as deferred revenues. Governmental grants are provided to support specific programs, and are subject to various budgetary restrictions. Grants received are expended under the time stated in the guidelines of the grant agreement. Grant revenue earned but not yet received is recorded as accounts receivable, and funds received but not yet earned are recorded as deferred revenue.

#### Cash and Cash Equivalents

All highly liquid savings deposits and investments with maturities of three months or less when purchased are considered cash equivalents for the purposes of the cash flow statement.

#### Investments

The Organization has adopted Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosures*, issued by the Financial Accounting Standards Board (FASB). ASC 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date and sets out a fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). Inputs are broadly defined under ASC 820 as assumptions market participants would use in pricing an asset or liability. The three levels of the fair value hierarchy under ASC 820 are described below:

Level 1 – Unadjusted quoted prices in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date. The type of investments included in Level 1 include listed equities and listed derivatives.

Level 2 – Inputs other than quoted prices within Level 1 that are observable for the asset or liability, either directly or indirectly; and fair value is determined through the use of models or other valuation methodologies. Investments which are generally included in this category include corporate bonds and loans, less liquid and restricted equity securities and certain over-the-counter derivatives. A significant adjustment to a Level 2 input could result in the Level 2 measurement becoming a Level 3 measurement.

Level 3 – Inputs are unobservable for the asset or liability and include situations where there is little, if any, market activity for the asset or liability. The inputs into the determination of fair value are based upon the best information in the circumstances and may require significant management judgment or estimation. Investments that are included in this category generally include equity and debt positions in private companies.

In determining the appropriate levels, the Organization performs a detailed analysis of the assets and liabilities that are subject to ASC 820. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3.

## Notes to Financial Statements

September 30, 2009 and 2008

### NOTE 1 – NATURE OF ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES – CONTINUED

#### Investments – Continued

For the fiscal year ended September 30, 2009, the application of valuation techniques applied to similar assets and liabilities has been consistent. The following is a description of the valuation methodologies used for instruments measured at fair value:

#### Investment Securities

The fair value of investment securities is the market value based on quoted market prices, when available, or market prices provided by recognized broker dealers

#### Property and Equipment

Depreciation is computed using the straight-line method. Estimated useful lives for office equipment and software is two to five years.

#### Statement of Activities

The statement of activities includes gains and losses from operations, which include operating revenue, operating expenses and investment income. Realized gains and losses on sales of investments are included in investment income in operating activities. Unrealized gains and losses on investments are excluded from income from operations and are reported as non-operating activities.

#### Pension Plan

The Organization has a defined contribution pension plan, which covers substantially all employees. Under the terms of the plan, the Organization contributes 7% of each employee's salary on behalf of the employee. Contributions vest 100% when made. The employee also has the option of contributing additional amounts up to Internal Revenue Service limits into the plan. Contributions of \$140,467 and \$130,675 were made during the years ended September 30, 2009 and 2008, respectively.

#### Concentration of Credit Risk

Financial instruments, which subject the Organization to credit risk, consist of cash and cash equivalents, investments and accounts receivable. The risk with respect to cash equivalents is minimized by Organization policy of investing in financial instruments with highly rated financial institutions. Accounts receivable consist of amounts due from a variety of governmental, health care and private corporate organizations. The Organization performs ongoing credit evaluation of its customers and generally does not require collateral.

Investments consist of common stock, diversified mutual funds and government securities and, while subject to market risk, do not represent any significant concentrations.

In addition, the Organization obtained approximately 76% and 66% of its revenue from five major sources for each of the years ended September 30, 2009 and 2008, respectively.

## Notes to Financial Statements

September 30, 2009 and 2008

### NOTE 1 – NATURE OF ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES – CONTINUED

#### Financial Statement Presentation

The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United State of America. Net assets, revenues, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Organization and changes therein are classified and reported as follows:

Unrestricted net assets – Net assets that are not subject to donor-imposed stipulations.

Temporarily restricted net assets – Net assets subject to donor-imposed stipulations that may or will be met, either by actions of the Organization and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of activities as net assets released from restrictions.

Permanently restricted net assets – Net assets subject to donor-imposed stipulations that they be maintained permanently by the Organization. Generally, the donors of these assets permit all or part of the income earned on any related investments for general or specific purposes.

The Organization has no temporarily restricted net assets or permanently restricted net assets at September 30, 2009 and 2008.

#### Recent Accounting Pronouncements

In June 2009, the Financial Accounting Standards Board (FASB) issued SFAS No. 168, *The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles*, a replacement of FASB Statement No. 162. This statement modifies the Generally Accepted Accounting Principles (GAAP) hierarchy by establishing only two levels of GAAP, authoritative and non-authoritative accounting literature. Effective July 2009, the FASB Accounting Standards Codification (ASC), also known collectively as the "Codification," is considered the single source of authoritative U.S. accounting and reporting standards for nongovernmental entities.

Following the Codification, the FASB will not issue new standards in the form of Statements, FASB Staff Positions or Emerging Issues Task Force Abstracts. Instead, it will issue Accounting Standards Updates (ASU) which will not be authoritative in their own right as they will only serve to update the Codification, provide background information about the guidance and provide the basis for conclusions on the changes to the Codification.

GAAP is not intended to be changed as a result of the Codification, but the ASC does change the way the guidance is organized and presented. The Codification is effective for interim or annual periods ending after September 15, 2009. Other than the manner in which new accounting guidance is referenced, the adoption of these changes had no impact on the financial statements.

### NOTE 2 – CASH

The Organization maintains its cash in bank deposit accounts, which at times may exceed federally insured limits. The Organization has not experienced any losses in such accounts and believes it is not exposed to any significant risk in these accounts.

## Notes to Financial Statements

September 30, 2009 and 2008

### NOTE 3 – RELATED PARTY TRANSACTIONS

The Organization has entered into various transactions with several of its corporate members. Total billings to these entities amounted to approximately \$975,329 and \$366,822 for the years ended September 30, 2009 and 2008, respectively. Various payments for goods and services were made to these entities totaling \$1,082,500 and \$516,100 for the years ended September 30, 2009 and 2008, respectively. Accounts receivable from these entities totaled approximately \$166,300 and \$35,900 at September 2009 and 2008, respectively. Deferred revenue from these entities totaled approximately \$127,800 and \$173,400 at September 30, 2009 and 2008, respectively. Onpoint Health Data also leases some office space from a corporate member.

In addition, the Organization provides management services to Maine Health Data Processing Center (MHDPC), as well as support for the development and maintenance of a database. Total revenue from MHDPC was \$465,236 and \$399,222 for the years ended September 30, 2009 and 2008, respectively, and total expense related to MHDPC was \$135,732 and \$125,820 for the years ended September 30, 2009 and 2008, respectively. Onpoint Health Data has a receivable of \$123,959 from MHDPC and a payable of \$16,897 to MHDPC at September 30, 2008 and had a receivable from MHDPC of \$143,669 and payable of \$40,860 to MHDPC at September 30, 2009.

### NOTE 4 – INVESTMENTS

Investments at September 30 consisted of the following (at fair value):

	2009	2008
Cash and cash equivalents	\$ 17,705	
Money market	305,396	
Common stock		\$ 1,229
U.S. government and agency securities	62,693	106,841
Mutual funds:		
Washington Mutual Investors Fund	134,280	153,261
	<u>\$ 520,074</u>	<u>\$ 261,331</u>

Under FASB ASC Topic 820, the organization's investments are categorized as follows as of September 30, 2009:

	Fair Value Measurements at Reporting Date Using		
	Quoted Prices in Active Markets for Identical Assets/ Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments	<u>\$ 520,074</u>	<u>\$ 502,369</u>	<u>\$ 17,705</u>
			<u>\$ -</u>

At September 30, 2009, net unrealized and realized losses on investments were \$20,129 and at September 30, 2008 net unrealized and realized losses were \$39,972.

APPENDIX K – ONPOINT’S CERTIFICATE OF LIABILITY INSURANCE

<b>ACORD</b> CERTIFICATE OF LIABILITY INSURANCE				DATE (MM/DD/YYYY) 08/12/2010	
PRODUCER (207)781-3519 FAX (207)781-3907 <b>Bradish-Young Insurance</b> 202 U.S. Route One, Box 360 Foreside Place Falmouth, ME 04105		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.			
INSURED <b>ONPOINT HEALTH DATA</b> 245 COMMERCIAL STREET, SUITE 2 PORTLAND, ME 04101		INSURERS AFFORDING COVERAGE		NAIC #	
		INSURER A: <b>Excelsior</b>		11045	
		INSURER B: <b>Maine Employers Mutual Ins. Co</b>		11149	
		INSURER C: <b>Evanston Insurance Company</b>			
		INSURER D:			
		INSURER E:			
<b>COVERAGES</b>					
THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.					
INSR ADDL LTR INSR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	B0P8193373	11/01/2009	11/01/2010	EACH OCCURRENCE \$ <b>2,000,000</b> DAMAGE TO RENTED PREMISES (Ea occurrence) \$ <b>500,000</b> MED EXP (Any one person) \$ <b>5,000</b> PERSONAL & ADV INJURY \$ <b>2,000,000</b> GENERAL AGGREGATE \$ <b>4,000,000</b> PRODUCTS - COM/PROP AGG \$ <b>4,000,000</b>
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	BA8537318	11/01/2009	11/01/2010	COMBINED SINGLE LIMIT (Ea accident) \$ <b>1,000,000</b> BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN EA ACC \$ AUTO ONLY: AGG \$
	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE \$ RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	1810020910	11/01/2009	11/01/2010	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ <b>500,000</b> E.L. DISEASE - EA EMPLOYEE \$ <b>500,000</b> E.L. DISEASE - POLICY LIMIT \$ <b>500,000</b>
	OTHER PROFESSIONAL LIABILITY CLAIMS MADE	IT801470	10/02/2009	10/02/2010	\$1,000,000 PER CLAIM \$1,000,000 AGGREGATE \$10,000 RETENTION
	DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS				
<b>CERTIFICATE HOLDER</b>			<b>CANCELLATION</b>		
Onpoint Health Data Anna Dawkins, Finance Director 245 Commercial Street, Suite 2 Portland, ME 04101			SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>10</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.		
			AUTHORIZED REPRESENTATIVE Sandra Wing, AAI, CPIW/SLW <i>Sandra L. Wing</i>		
ACORD 25 (2001/08)			©ACORD CORPORATION 1988		



Reliable data. Informed decisions. Strategic advantage.

16 Association Drive  
PO Box 360  
Manchester, ME 04351  
207 623-2555  
207 622-7086 FAX

[www.OnpointHealthData.org](http://www.OnpointHealthData.org)