



State of Wisconsin

Health Care Utilization Summary

Prepared by: WPS HEALTH INSURANCE®

May 2012

Executive Summary

State Employee Trust Funds

- High Level Summary
- The State ETF Plan has three main components/plans: the Standard Plan, the SMP Plan, and the Medicare Plus Plan. The SMP Plan has low enrollment, so most of the analysis is focused on the other two segments.
- In general, membership on WPS administered plans has dropped somewhat during the past couple years.
- Claims on a per member per month basis (PMPM) on the Standard Plan have increased by roughly 6% annually during the past two years, which is in line with the WPS book of business experience and the expected level of change. Claims on a PMPM basis on the Medicare Plus Plan have remained flat during the past two years. This is in line with the WPS book of business experience, but a better result than what was expected.
- Detailed Comments
- Enrollment: The majority of the enrollment is on two plans: the Standard Plan and the Medicare Plus Plan. Membership on all plans is generally dropping. The Standard Plan enrollment has steadily dropped from 3,236 in 2009 to 2,324 in January 2012. SMP enrollment was at 561 lives in 2009, but is now down to 200. The Medicare Plus Plan enrollment has dropped from 9,462 in 2009 to 9,141 in January 2012, though Jan 2012 enrollment is slightly higher than the average 2011 enrollment.
- Standard Plan Claims: Claims on a per member per month (PMPM) basis have increased at an average rate of 6% per year for the past two years. This is in line with our normative book of business numbers. A review by major type of service shows that most categories increased in cost between 2010 and 2011, though the increases

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Executive Summary (continued)

were spread evenly across the different categories. We saw increases in Inpatient Hospital admissions in 2011 as a result of a larger number of complex nervous/mental and substance abuse cases. We had an unusual number of complex birthing cases this year contributing to some additional costs on the plan. In addition, we saw elevated costs for Dialysis services. Though those areas increased in cost, there were other areas with lower rates of change such that the overall trends remained stable. Large claims increased, but at an expected rate of change. The Standard Plan's claims on a per member per month basis continues to be 40% to 50% above our benchmark. This is typically caused by the Standard plan's broad network, special benefits not in our benchmark, and concentration of individuals in high cost urban areas.

- SMP Plan Claims: With the small enrollment in this plan, experience here is generally unstable, showing wide swings from year to year, hinging on the chance of a high cost individual either enrolling or developing a condition on the plan during the year. Between 2010 and 2011, the PMPM claims dropped 18.9%, mainly the result of one high cost individual with $650,000 in claims in 2010 terminating from the plan prior to the beginning of 2011. The variability of this one individual's claims is seen throughout the exhibits on this plan.
- Medicare Plus Plan Claims: Claims on a PMPM basis have been flat from 2009 to 2011. This is in line with WPS Medicare book of business claims trend during that time period. Claims experience in all detailed type of service categories has been flat between the most recent two years. In plans like this that pay secondary to Medicare, it is quite unlikely for high cost claims to develop. This plan does include significant drug coverage, however, so under certain circumstances, higher cost claimants can become a reality. In 2011, we did see an increase in the number of claimants with claims over $100,000, increasing from 3 to 5. One individual this year did incur $207,000 in claims, which is higher than what we have typically seen from one individual. As expected, these were primarily drug claims.

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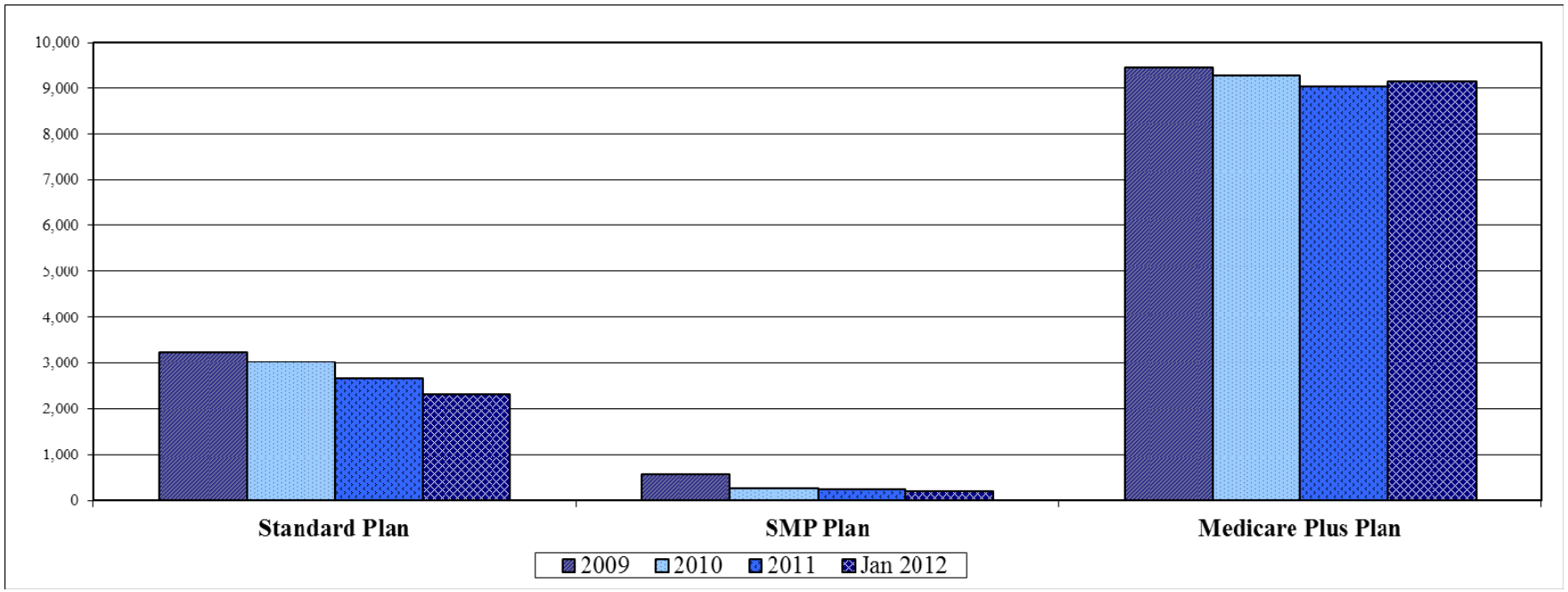
Annual Average Membership



	2009	2010	2011	Jan 2012
Standard Plan	3,236	3,013	2,655	2,324
SMP Plan	561	264	232	200
Medicare Plus Plan	9,462	9,298	9,046	9,141
Totals	13,259	12,574	11,932	11,665

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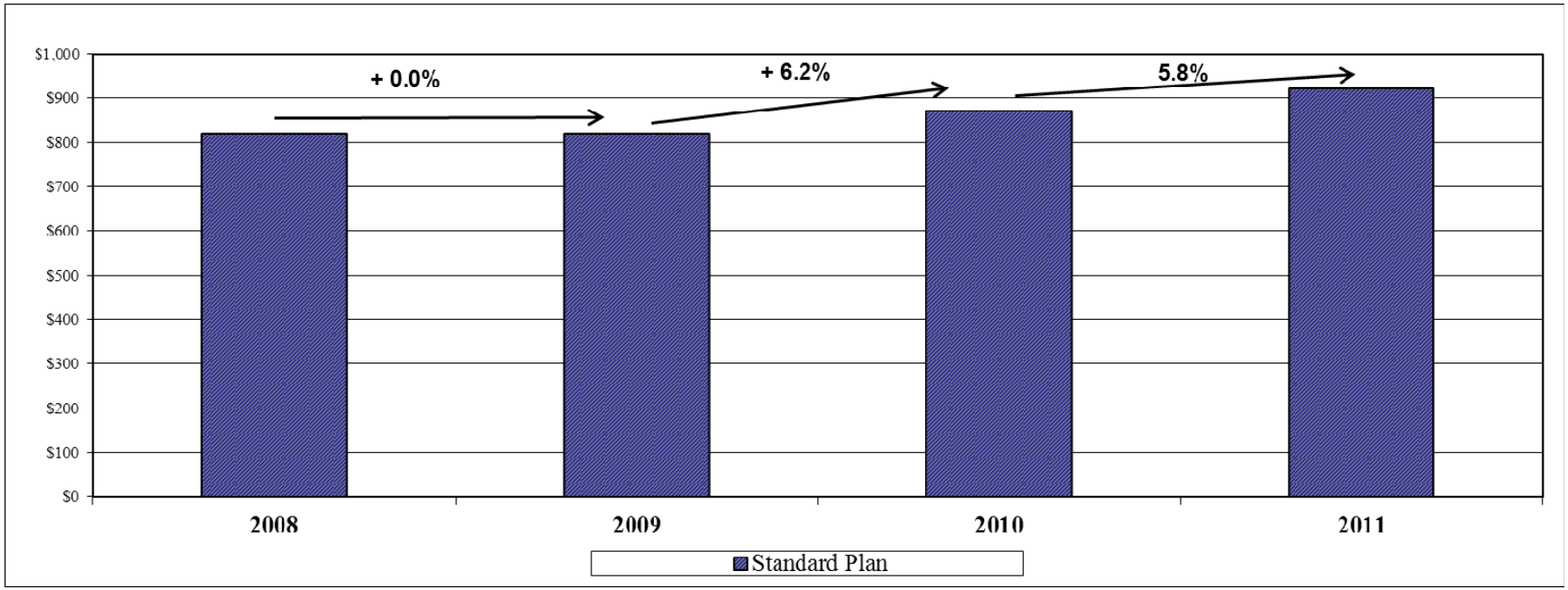
Total PMPM Trend

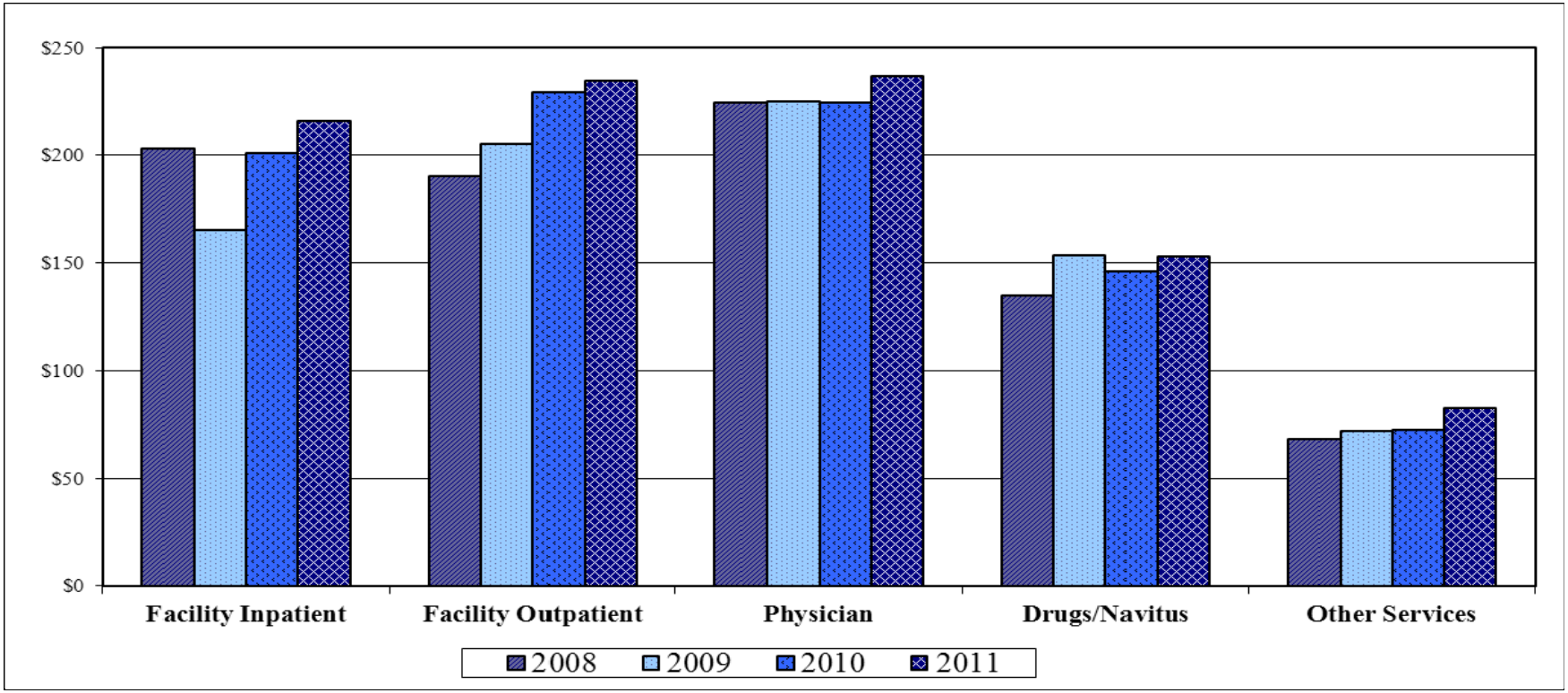
Standard Plan



	2008	2009	2010	2011
Standard Plan	$820.72	$820.95	$872.15	$922.74

Total PMPM by Type of Service

Standard Plan



	2008	2009	2010	2011
Facility Inpatient	$203.12	$165.18	$200.71	$215.84
Facility Outpatient	$190.35	$205.25	$229.05	$234.55
Physician	$224.23	$224.80	$224.24	$236.79
Drugs/Navitus	$134.71	$153.68	$145.94	$153.12
Other Services	$68.31	$72.04	$72.21	$82.44
Totals	$820.72	$820.95	$872.15	$922.74

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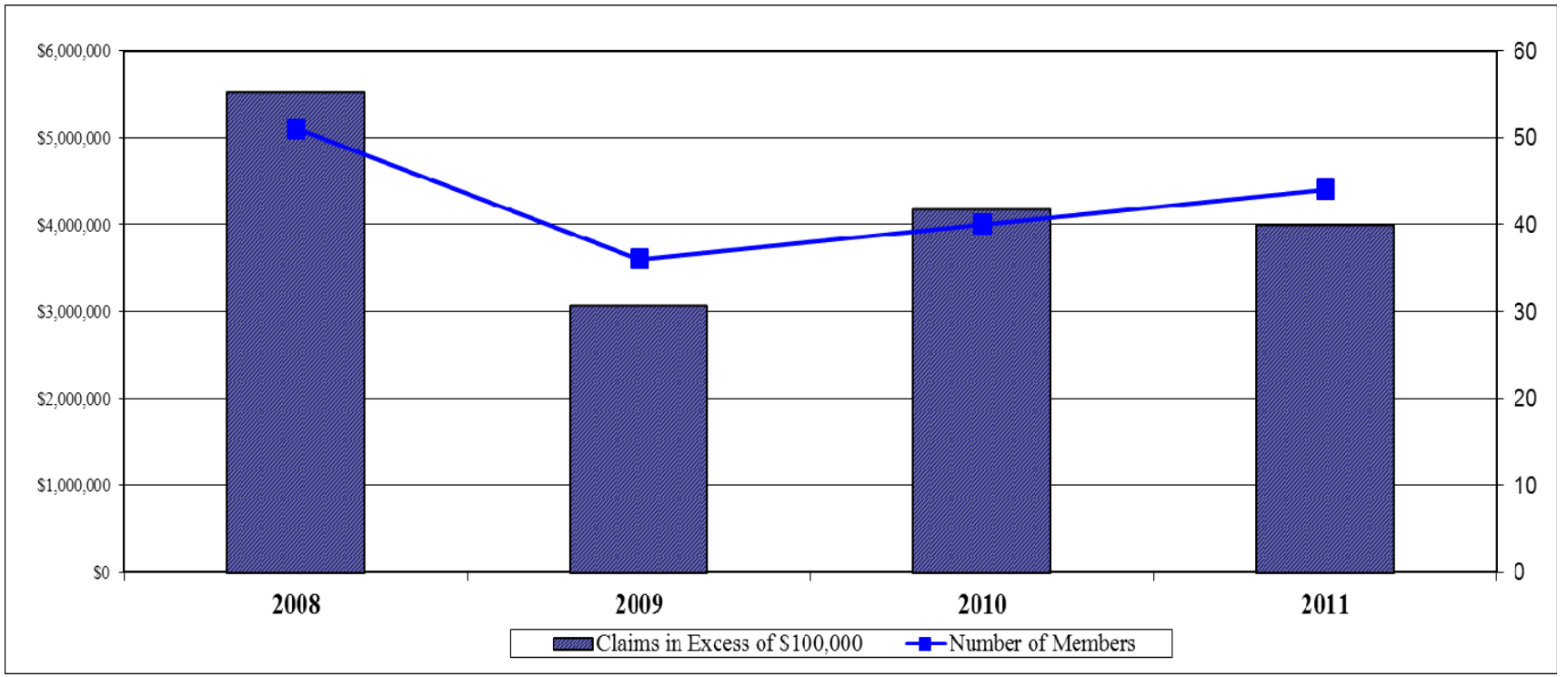
Claims in Excess of $100,000

Standard Plan



	2008	2009	2010	2011
Claims in Excess of $100,000	$5,521,101	$3,076,563	$4,186,534	$4,003,036
Number of Members	51	36	40	44
PMPM in Excess of $100,000	$117.79	$79.40	$115.57	$125.64

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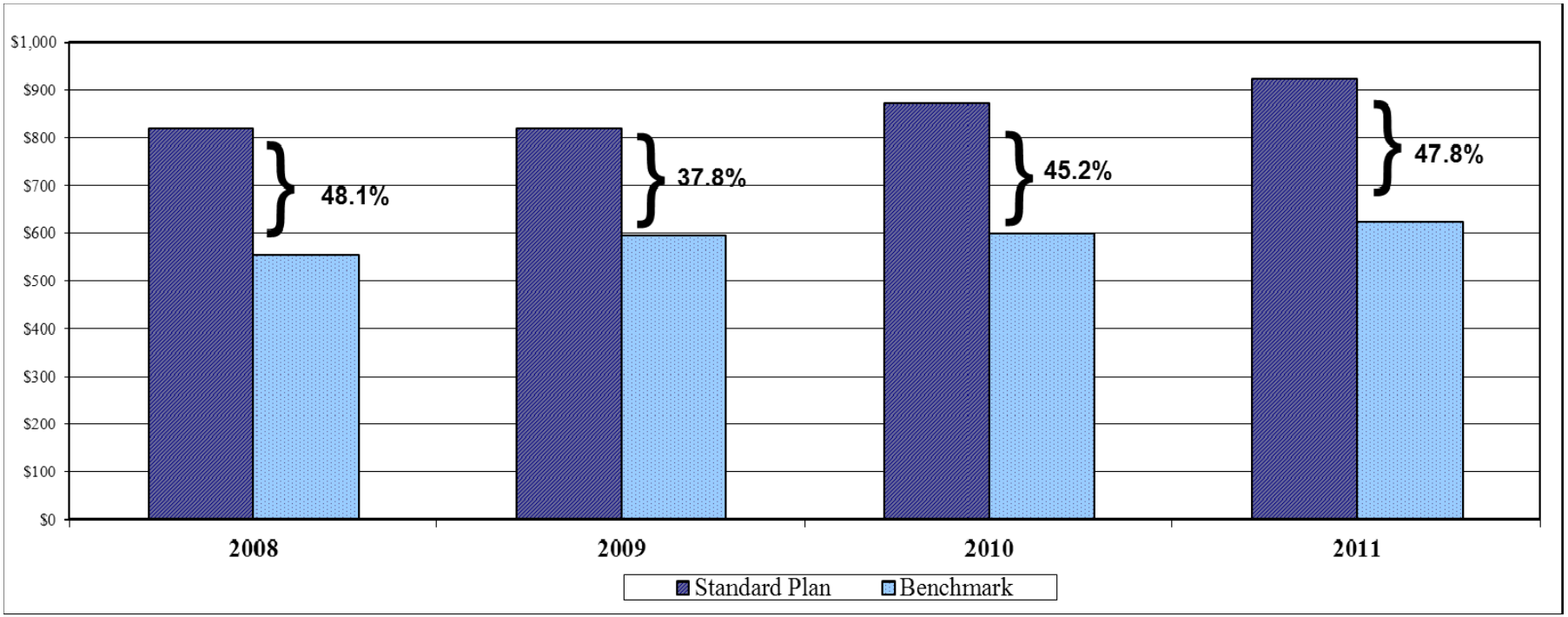
Total PMPM Compared to Benchmark

Standard Plan



	2008	2009	2010	2011
Standard Plan	$820.72	$820.95	$872.15	$922.74
Benchmark	$554.32	$595.95	$600.55	$624.23

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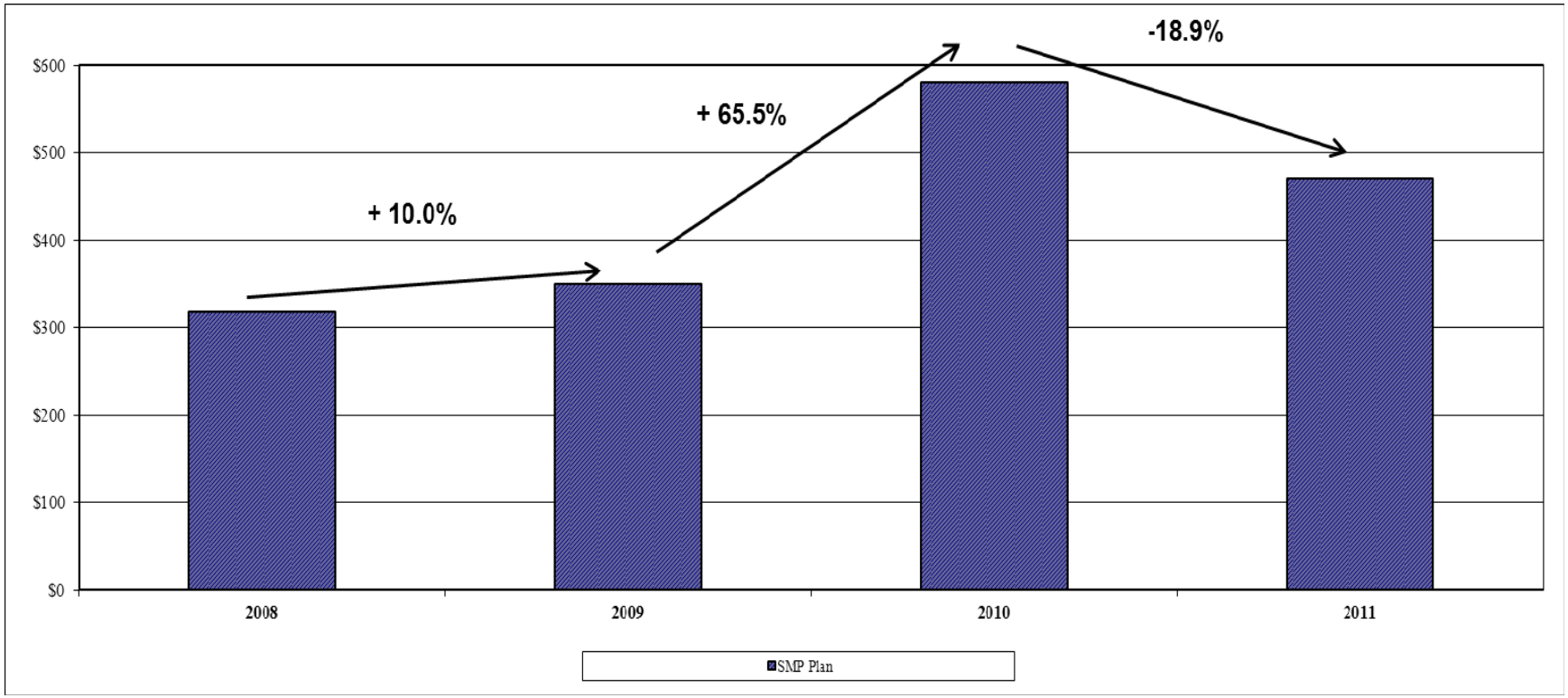
Total PMPM Trend

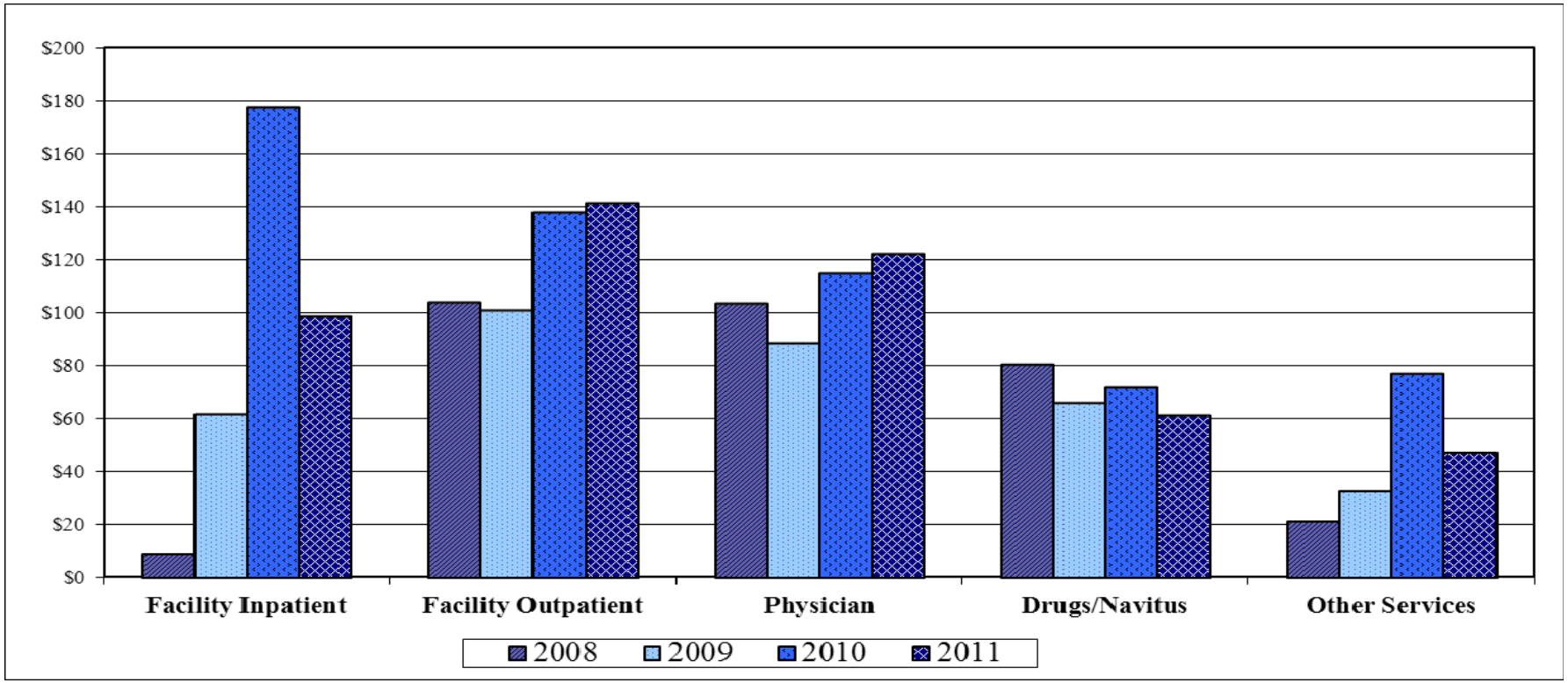
SMP Plan



	2008	2009	2010	2011
SMP Plan	$318.47	$350.32	$579.81	$470.42

Total PMPM by Type of Service

SMP Plan



	2008	2009	2010	2011
Facility Inpatient	$9.19	$61.94	$177.40	$98.64
Facility Outpatient	$104.06	$100.89	$138.07	$141.21
Physician	$103.45	$88.48	$115.08	$121.99
Drugs/Navitus	$80.57	$66.25	$72.00	$61.30
Other Services	$21.20	$32.76	$77.26	$47.28
Totals	$318.47	$350.32	$579.81	$470.42

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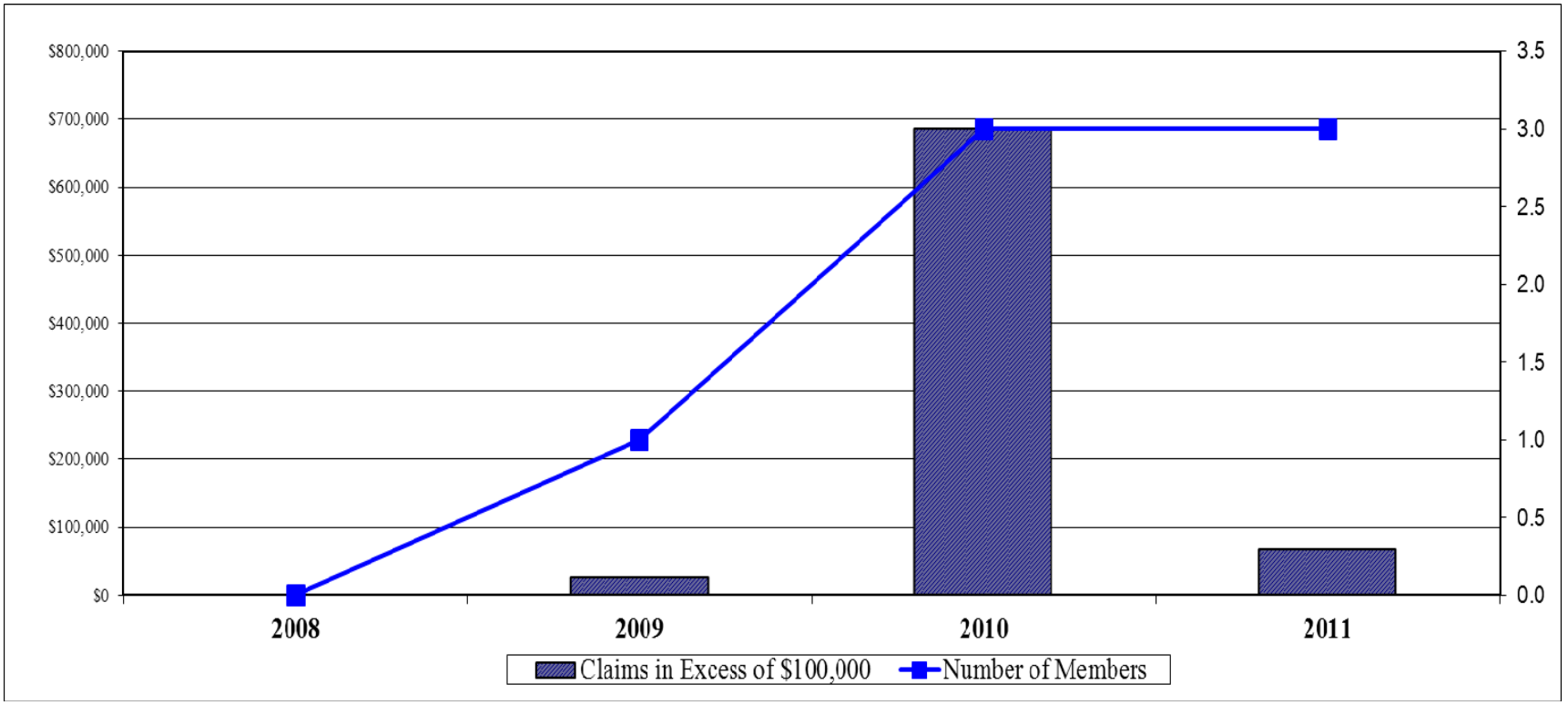
Claims in Excess of $100,000

SMP Plan



	2008	2009	2010	2011
Claims in Excess of $100,000	$0	$27,385	$686,988	$68,679
Number of Members	0	1	3	3
PMPM in Excess of $100,000	$0.00	$4.07	$216.65	$24.67

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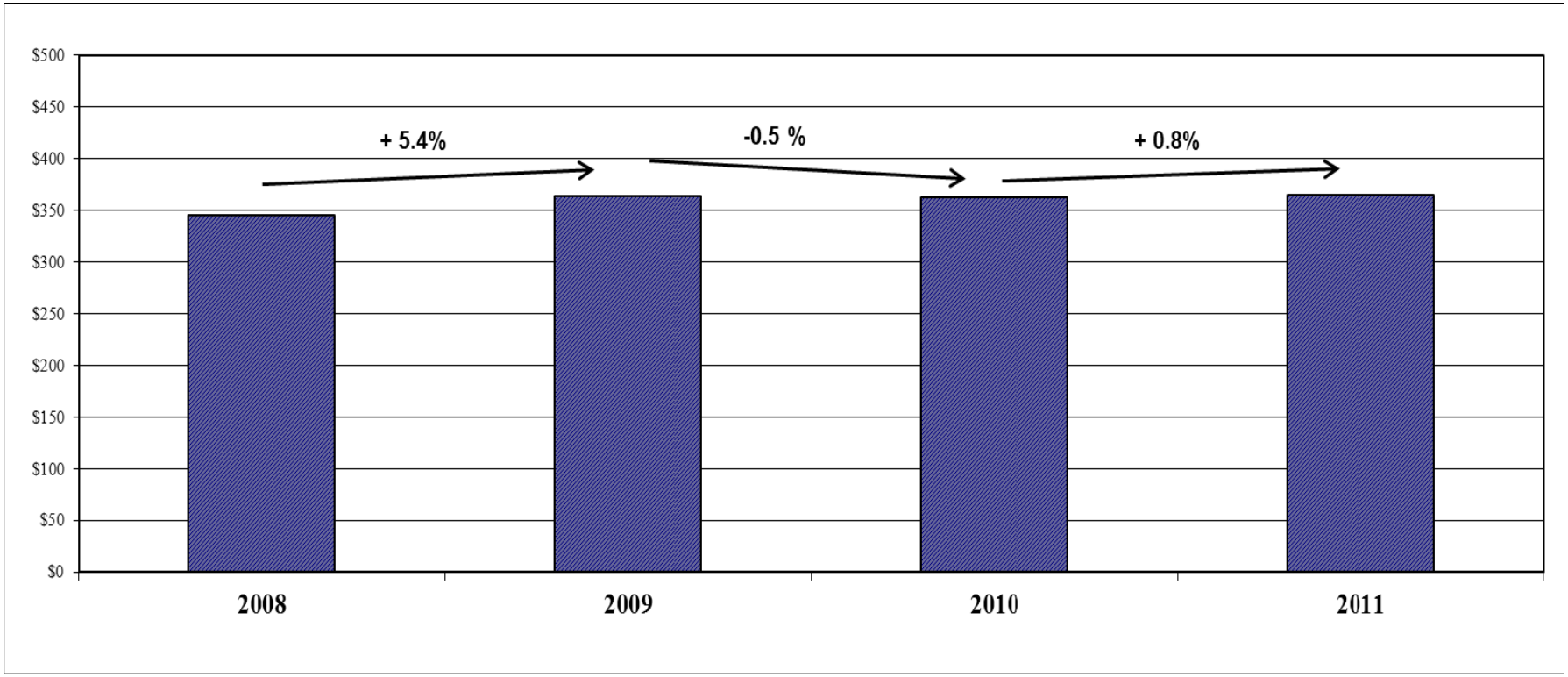
Total PMPM Trend

Medicare Plus Plan



	2008	2009	2010	2011
Medicare Plus Plan	$345.51	$364.15	$362.49	$365.41

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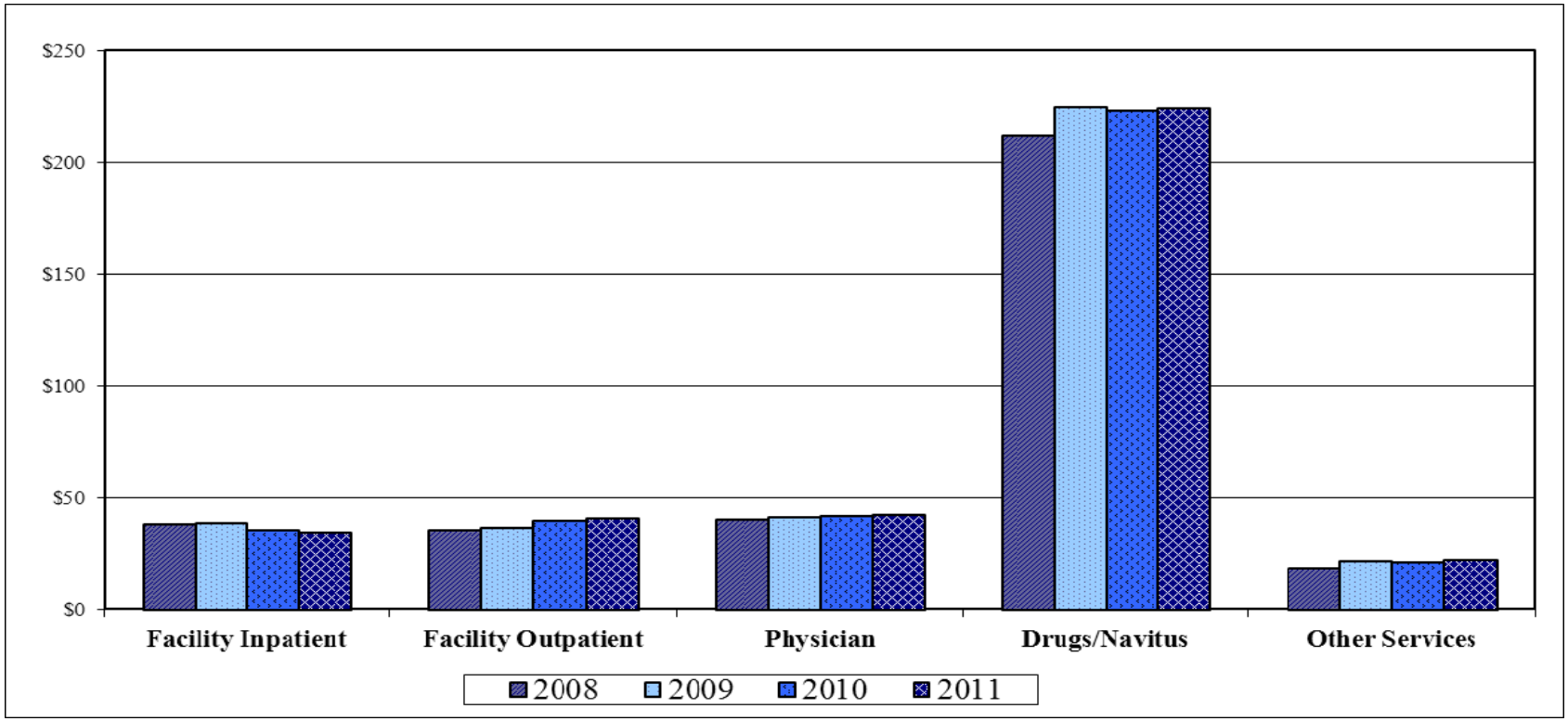
Total PMPM by Type of Service

Medicare Plus Plan



	2008	2009	2010	2011
Facility Inpatient	$38.23	$39.20	$35.73	$34.89
Facility Outpatient	$35.73	$36.58	$40.07	$40.91
Physician	$40.71	$41.44	$42.21	$42.92
Drugs/Navitus	$212.23	$225.14	$223.20	$224.36
Other Services	$18.51	$21.79	$21.28	$22.32
Totals	$345.41	$364.15	$362.49	$365.40

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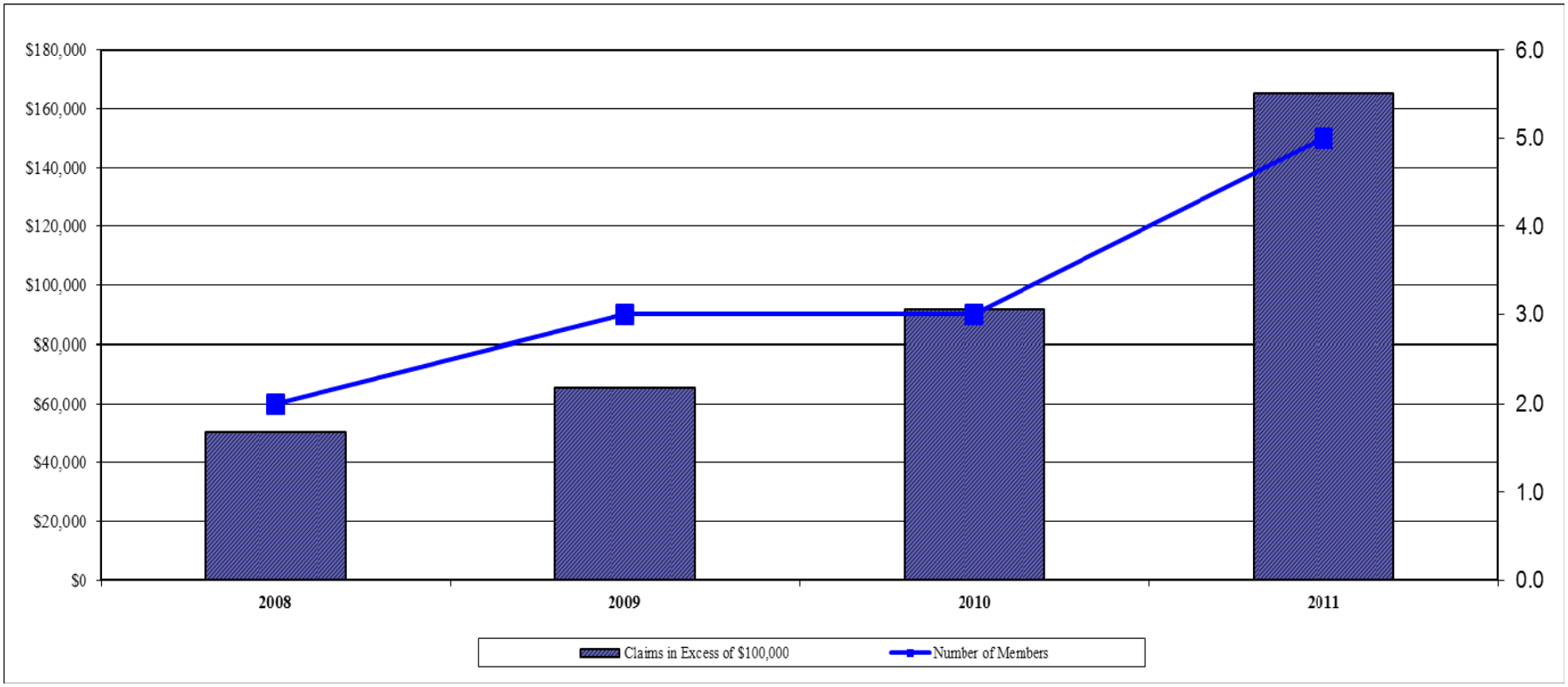
Claims in Excess of $100,000

Medicare Plus Plan



	2008	2009	2010	2011
Claims in Excess of $100,000	$50,425	$65,530	$91,739	$165,296
Number of Members	2	3	3	5
PMPM in Excess of $100,000	$0.43	$0.58	$0.82	$1.52

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State of Wisconsin

Integrated Care Management

Insuring **Wisconsin's** Health *Since 1946*

Savings and Care Management Services

- WPS Care Management generated savings of $2.53 million in 2011 compared with $3.24 million in 2010 and $3.55 million in 2009. This variance can be accounted for by member terminations and process changes.

- Only hard savings are included – future savings from Chronic Care (Disease) Management are not included. Hard savings are realized from avoided hospital days and avoided, managed down/denied services.

- The largest portions of savings resulted from medical review activities ($1.34 million), pre-authorization of outpatient services ($738K) and case management activities ($367K).

- Case Management involves planning and facilitating acute care services. The Case Manager focuses on cost effective use of services while ensuring high quality care. Case Management cases involve inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy.

- Participation in chronic care management (CCM) increased 12 percent—with 248 cases (open and closed) in 2011 compared to 222 cases in 2010 and 149 cases in 2009. Management of diabetes occurred most frequently at 138 cases (56 percent) followed by cardiac-related conditions that occurred in 98 cases (40 percent)

- All ETF Standard Plan, SMP and Medicare Plus members with high dollar claims received care management services. The number of high cost cases increased in 2011 compared to 2010 (55 vs. 46). Total amount paid increased in 2011 compared to 2010 ($9.7 million vs. $9.6 million). Eighteen of the 55 cases involved cancer diagnosis which represented 29 percent of the total costs.

- Of those patients seeking bariatric surgical services, 81% (13 of 16) utilized a Center of Excellence for inpatient or outpatient bariatric procedures in 2011. This compares with 79% (23 of 29) that utilized a COE in 2010, 81% (21 of 26) in 2009 and 93% (14 of 15) in 2008.

Preventive Health Screening Services Quality Indicators

- Preventive health screenings such as Pap tests, mammograms and diabetic testing can help members improve quality of care and quality of life.

- Mammography screening rates have declined slightly since 2009 but remain above the national PPO average (71.0 percent in 2011 vs. 67.0 percent). One in four women who should be screened is not, representing an opportunity for quality improvement (see Exhibit 8A).

- Cervical cancer screening rates have decreased since 2010 and are below the national PPO average (68.6 percent vs. 74.5 percent).

- Both diabetic care indicators have been trending up from 2009 to 2011, but one measure remains slightly below the national PPO benchmark. The 2011 HbA1c testing rate was 84.4 percent versus the National PPO benchmark of 85.2 percent; LDL-C testing was 80.0 percent versus the benchmark of 79.9 percent (see Exhibit 8B).

- In 2010, performance improvement initiatives were implemented that featured targeted written and telephonic outreach and education efforts.

The second-year results on LDL-C testing: In 2009 the proportion of individuals meeting diagnostic criteria for diabetes had increased 14% since CY 2007, but the proportion receiving necessary preventive screening tests had declined. An outreach intervention was implemented in 2010 to increase Diabetes HbA1C and/or LDL-C testing for individuals identified as meeting diagnostic criteria for the disease. That intervention included targeted outreach to members with diabetes identified as not having received the HbA1c and/or LDL-C tests in CY 2008. Letters in layman's terms were sent to those members providing a brief description of the tests and why they are important. Follow-up phone calls were also made to those members. The Quality Improvement Project resulted in a 12 percentage point improvement from 2009 and brought the ETF rate up to a level (80 percent) that compares more favorably with state and national performance levels (79.0 percent and 79.9 percent respectively).

The second-year results on HbA1c testing: The Quality Improvement Project resulted in a 18.1 percentage point improvement from 2009, sharply reversing the negative trend of the previous years and bringing the ETF HbA1c performance rate up to a level (84.4 percent) which compares favorably with state and national PPO rates (86.0 percent and 85.2 percent respectively).

Wellness Program

- Wellness programs work hand-in-glove with Medical Management and Chronic Care Management to empower individuals to prevent health problems, facilitate early detection and treatment of potentially serious conditions and successfully manage chronic conditions they may have. The Wellness program is a key component in Value Based Benefit Design.

- In 2009, WPS Wellness provided a variety of free on-line resources for ETF members.

- In 2011, WPS Wellness offered an on-line Health Risk Assessment (HRA), designed to assist members make sustainable changes to enhance their everyday well-being.

Integrated Care Management

Conditions Impacting Top Major Diagnostic Categories* (MDC) by PMPM

The top MDCs by PMPM claims costs with the most significant variation to the benchmark (greater than 30%) and at least 5% increase from 2010 include (see Exhibit 1)**:**

- MDC 8 (Muscles, Bones, Connective Tissue D/D) variance was driven by several complex cases requiring surgery to the back and legs (scoliosis, fractures, abscess, complications of previous joint replacement).
- Newborns and Newborns with Conditions Originating Shortly Before or After Birth (MDC 15) PMPM increased from $.81 in 2010 to $16.59 in 2011 and is greater than the benchmark of $2.24. This large variance can be accounted for by four complex live birth cases that were associated with over $811,000 in costs.
- Behavioral Health (MDC 19) claims costs were driven by members with psychotic conditions and depression that required lengthy inpatient and residential treatment stays. ETF Standard Plan mental health benefit may impact these costs.
- Kidney and Urinary Tract (MDC 1) PMPM is (49.6%) greater than the benchmark. Four outlier cases generating nearly $500,000 in costs are associated with this variance.
- Female Reproductive System (MDC 13) PMPM has increased in the last year and is (37.4%) greater than the benchmark. This variance was partially driven by four individuals with cancer diagnoses with over $775,000 in total costs.
- Male Reproductive System (MDC 12) had a year over year increase of 39% and is 116% higher than benchmark.

The other top MDCs by PMPM claims costs with the most significant variation to the benchmark (greater than 30%) but with a year over year PMPM decrease are:

- Blood and blood forming organ (including spleen) and immune system disorders (MDC 16) PMPM was driven by claims related to coagulation disorders and chronic conditions. Costs were greater than $560K in 2010, decreasing to $468K in 2011.
- Alcohol and Drug Abuse (MDC 20) PMPM costs decreased by 47% year over year, but remains 104% higher than benchmark.

Circulatory System (MDC 5) and Liver, Gallbladder, Biliary Ducts and Pancreas (MDC 7) both had sizable year over year decreases in PMPM and were below benchmark.

* **Per Data Dashboard DRG and Diagnosis data - coverage dates January 2011 to December 2011 Paid through March 2012.**

Exhibit 1

STATE EMPLOYEE TRUST FUNDS

Claim Costs by Major Diagnostic Categories (Partial Listing) - Standard

Top MDCs with Greatest Variation to Benchmark

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2010 PATIENT COUNTS	2010 ACTUAL PMPM *	2011 PATIENT COUNTS	2011 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2011 to 2010	DIFFERENCE 2011 to BENCHMARK
8	Muscles, Bones, and Connective Tissue D/D	1,202	$118.66	1,041	$157.87	$106.55	33.0%	48.2%
19	Behavioral Health Diagnoses	672	$37.73	539	$53.09	$10.98	40.7%	383.5%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	925	$46.05	830	$43.53	$15.33	-5.5%	184.0%
11	Kidney and Urinary Tract D/D	304	$20.32	271	$33.39	$21.37	64.3%	56.3%
13	Female Reproductive System D/D	286	$15.17	258	$27.49	$17.82	81.2%	54.3%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	13	$0.81	21	$16.59	$2.24	1948.1%	640.9%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	121	$25.53	139	$19.74	$5.07	-22.7%	289.1%
12	Male Reproductive System D/D	126	$10.57	123	$14.74	$6.80	39.5%	116.6%
18	Infectious and Parasitic Diseases	76	$14.60	53	$9.22	$6.85	-36.8%	34.6%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	12	$4.41	9	$2.32	$1.14	-47.4%	104.2%

Note: Sorted by 2011 actual PMPM. Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit.

*** Each $1.00 paid PMPM = $36,226 in plan costs.**

**** Each $1.00 paid PMPM = $31,857 in plan costs.**

Conditions Managed for High Cost Cases

- All ETF Standard Plan, SMP and Medicare Plus members with high dollar claims received care management services. The number of high cost cases increased in 2011 compared to 2010 (55 vs 46). Total amount paid increased in 2011 compared to 2010 ($9.7 million vs $9.6 million). Eighteen of the 55 cases involved cancer diagnosis which represented 29 percent of the total costs (see Exhibit 2).

    - Cancer:
        - 33% (n = 18 of 55) of high dollar cases.
        - 29% (n = $2.8M of $9.7M) of high dollars spend.
        - Five members had large claims (>$200K) for cancer treatment.
        - 13 are still active members, with 12 expected to remain high cost members in 2012.

    - Cardiac and vascular or chronic ischemic conditions:
        - 11% (n = 6 of 55) of high dollar cases.
        - 13% (n = $1.3M of $9.7M) of high dollars spend.
        - Five of the six members are active members.

    - Muscle and bone conditions:
        - 11% (n = 6 of 55) of high dollar cases.
        - 9% ($837K of $9.7M) of high dollars spend.
        - 3 of 6 remain active members.

    - Kidney conditions:
        - 7% (n = 4 of 55) of high dollar cases.
        - 7% (n = $642K of $9.7M) of high dollars spend.
        - 3 remain active members.

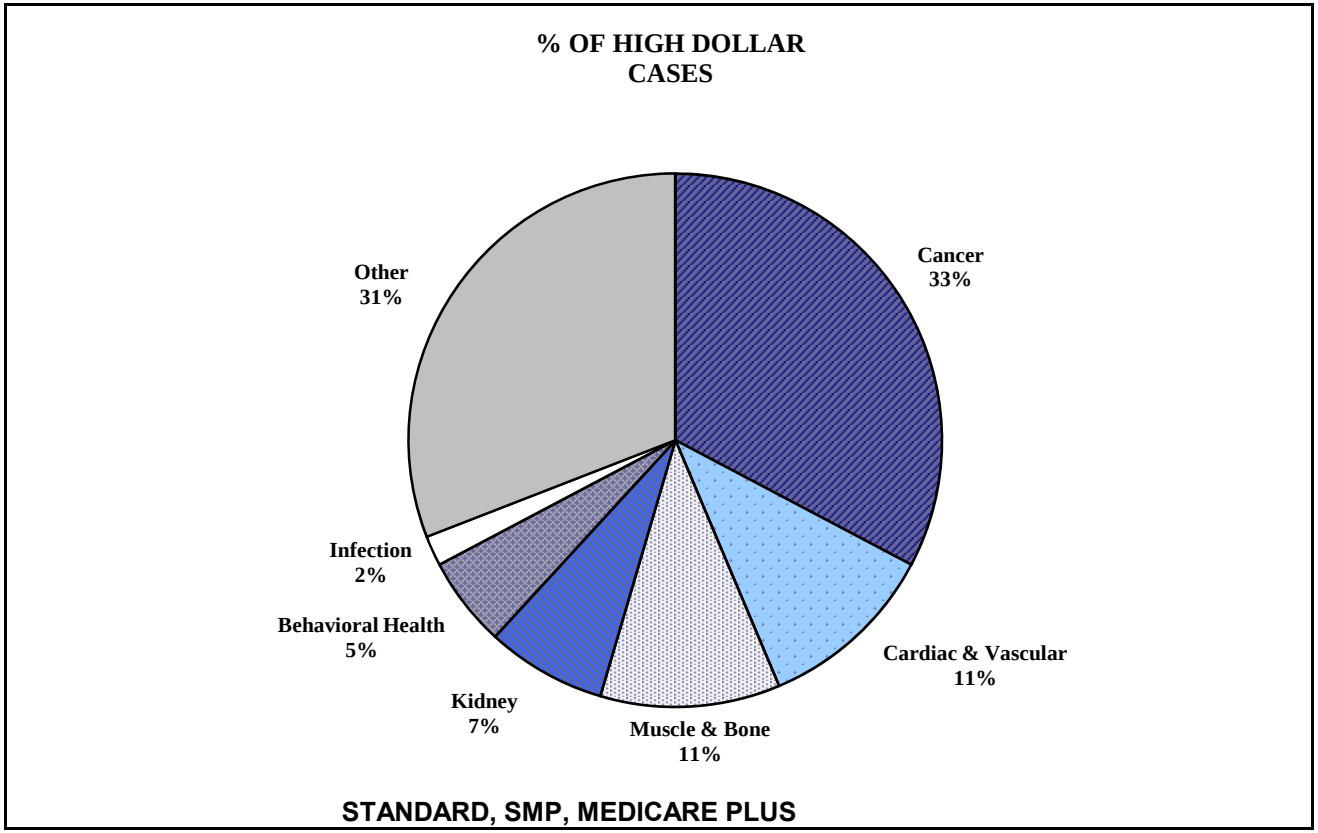
Exhibit 2

STATE EMPLOYEE TRUST FUNDS

High Dollar Claims by Diagnosis

Incurred January 2011 - December 2011 Paid Through March 2012

Diagnosis	% of High Dollar Cases	% of High Dollars	# of Cases	Paid Dollars
Cancer	33%	29%	18	$2,826,888
Cardiac & Vascular	11%	13%	6	$1,267,892
Muscle & Bone	11%	9%	6	$836,866
Kidney	7%	7%	4	$641,625
Behavioral Health	5%	4%	3	$416,895
Infection	2%	4%	1	$350,460
Other	31%	34%	17	$3,312,848
Total	**100%**	**100%**	**55**	**$9,653,474**



ETF Bariatric Surgery Experience

Centers of Excellence facilities for bariatric surgery are certified by Centers for Medicare & Medicaid Services and the programs (hospital and surgeon combinations) are certified by the American Society of Bariatric Surgeons as a COE. WPS created a bariatric surgery Centers of Excellence (COE) approach in 2007 for ETF Standard Plan members.

- Eighty-one (81%) percent (13 of 16) utilized a Center of Excellence for inpatient or outpatient bariatric procedures in 2011. This compares with seventy-nine (79%) percent (23 of 29) that utilized a COE in 2010, eighty-one (81%) percent (21 of 26) in 2009 and ninety-three percent (93%--14 of 15) 2008.

- As anticipated, the number of primary bariatric procedures decreased in 2011 with 16 compared to 29 in 2010 and 26 in 2009. The WPS Book of Business saw a decrease in the use of bariatric surgeries during the same time period (12 in 2011, 27 in 2010, 31 in 2009) see Exhibit 3A.

- ETF PMPM for bariatric procedures increased from $20.40 in 2010 to $20.52 in 2011.

- Average cost per inpatient case increased 10.8 percent since 2010, to $38,691 in Center of Excellence settings, and remained substantially below the average cost per inpatient case in non-Center of Excellence facilities, where the average cost was $50,247 see Exhibit 3B.

- The average cost of the ETF COE case at $38,691 is slightly higher than the average cost at COE for cases in the WPS population excluding ETF ($37,265).*****

- ETF members may use the WPS plan exclusively for bariatric procedures resulting in adverse selection.
  During 2007, 59% (n = 16 of 27) of members with bariatric surgery termed by January 2008.
  During 2008, 67% (n = 10 of 15) of members with bariatric surgery termed by March 2009.
  During 2009, 50% (n = 13 of 26) of members with bariatric surgery termed by March 2010.
  During 2010, 48% (n = 14 of 29) of members with bariatric surgery termed by March 2011.
  During 2011, 75% (n = 12 of 16) of members with bariatric surgery termed by March 2012.

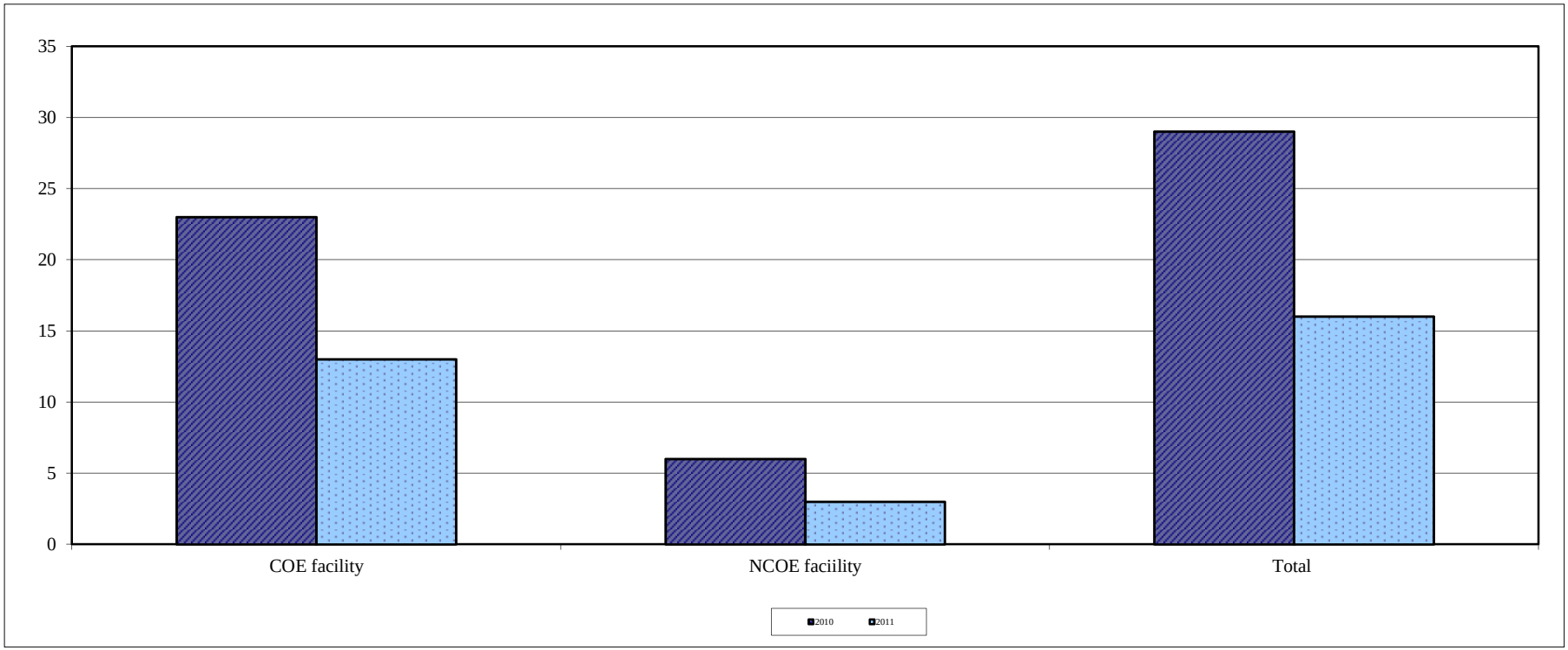
Note: Costs are calculated based on allowed amounts. WPS Book of Business data excludes ETF members.
*** n = 5; one outlier case removed with cost = $106,162.**

Exhibit 3-A

STATE EMPLOYEE TRUST FUNDS

Number of Bariatric Procedures

Comparison of 2011 to 2010



	2010	2011
COE facility	23	13
NCOE faciility	6	3
Total	29	16

Note: COE = Center of Excellence

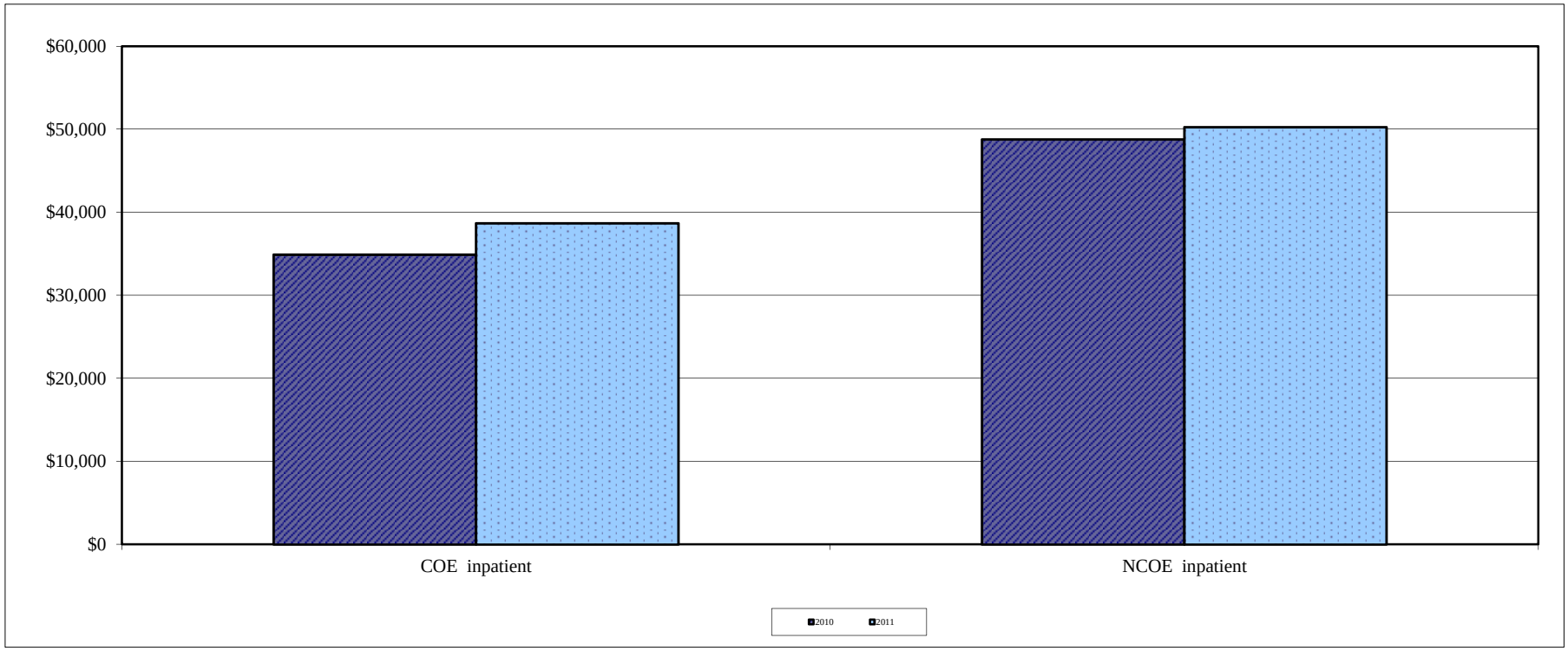
Note: NCOE = Non Center of Excellence

Exhibit 3-B

STATE EMPLOYEE TRUST FUNDS

Bariatric Procedure - Average Cost Comparison by Setting

Comparison of 2011 to 2010



	2010	2011	
COE inpatient	**$34,900**	**$38,691**	*****
NCOE inpatient	**$48,780**	**$50,247**	

***Includes one outpatient lap band procedure.**

Note: COE = Center of Excellence

Note: NCOE = Non Center of Excellence

State Employee Trust Funds

Integrated Care Management

Case Management (CM) involves planning and facilitating acute care services. The Case Manager focuses cost effective use of services while ensuring high quality care. Examples of Case Management are inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy.

Chronic Care Management (CCM) utilizes a proactive approach through identification, education and appropriate care to prevent avoidable complications of chronic conditions. Through education, the Chronic Care Manager empowers members to take ownership of their health, decreasing future health risks, minimizing the need for medical services, and ultimately, improving the quality of life.

Medical Review is a process in Medical Management that does post-claim (retrospective) review to ensure that those services that received preauthorization are billed appropriately, and services not requiring preauthorization are covered by the member's plan, and are medically necessary.

Preauthorization is the review of specific outpatient services (including surgical services, diagnostic services, and referrals) and a determination that these services meet the criteria for medical necessity under the member's benefit plan.

Utilization Management helps ensure proper utilization of services, while maximizing health care benefits and determining the most appropriate level of care. Care Management nurses monitor care through preadmission or pre-certification review, inpatient admission and concurrent review, discharge planning with referrals to Case or Chronic Care Management nurses and outpatient services review.

Integrated Care Management

Care Management Savings

- WPS Care management generated savings of $2.53 million in 2011, $3.24 million in 2010, and $3.55 million generated in 2009 (see Exhibit 4).
    - The variance in 2011 compared to 2010 can be explained by changes in savings opportunities and in the member population for 2011:
        - There was a sizable loss in members who in previous years had a high denial rate for behavioral health services totaling > $470K.
        - There was a large savings in 2010 for a member who received an organ transplant and in a case where large savings for injectable drugs were captured, that were not repeated in 2011.
        - There were changes in the Autism benefit from the 2009 mandate which also impacted savings. A pent up demand in previously denied services resulted in approximately $450K in savings for 2010 that were not repeated in 2011.

- Only hard savings are included – future savings from Chronic Care (Disease) Management are not included. Hard savings are realized from avoided hospital days and avoided, managed down/denied services.

- The largest portions of savings resulted from medical review activities ($1.34M), pre-authorization of outpatient services ($738K) and case management activities ($367K).

- Medical review is a process in Medical Management that does post-claim (retrospective) review to ensure:
    - Services that received pre-authorization are billed appropriately.
    - Services not requiring pre-authorization are covered by the member's plan, are medically necessary and consistent with evidence-based practices.

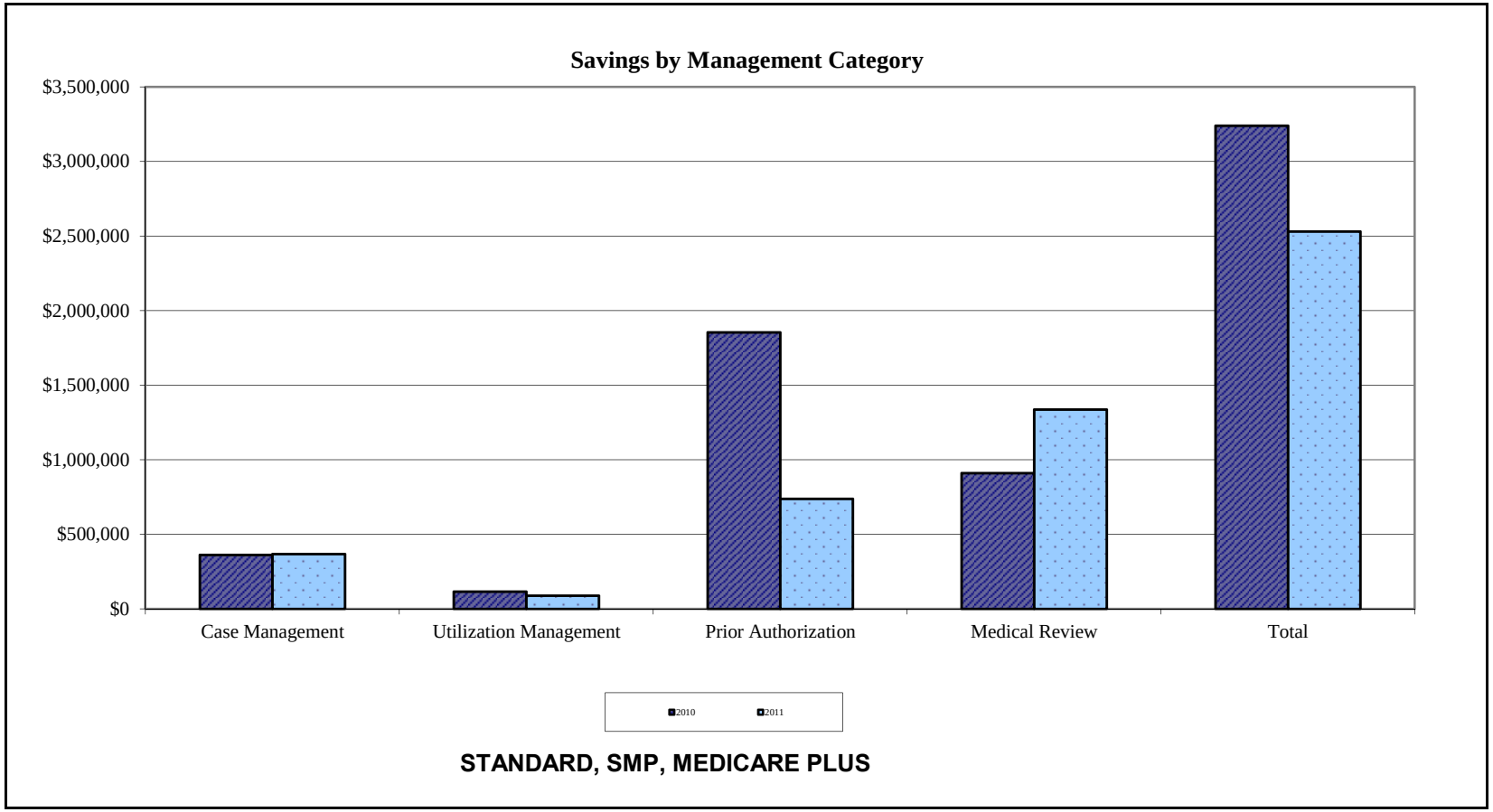
Exhibit 4

STATE EMPLOYEE TRUST FUNDS

Care Management Savings

Comparison of 2011 to 2010

Care Management Category	Savings 2010	2011
Case Management	$362,312	$367,141
Utilization Management	$115,832	$87,886
Prior Authorization	$1,853,642	$737,871
Medical Review	$909,443	$1,337,763
Total	**$3,241,229**	**$2,530,661**



Health Status Measure (HSM)

Health Status Measure (HSM) is a predictor of a member's risk for future care and related costs. Our predictive modeling tool helps improve the effectiveness and productivity of our case and chronic care managers by identifying at-risk members before their conditions and costs escalate. This enables us to enroll members in Case and Integrated Care Management programs at a much earlier stage.

Our software uses multiple algorithms, including severity indices. One of these indices, Burden of Illness (BOI), ranks members based on severity and complications. These scores are categorized into an HSM. Members with higher HSM scores are identified and screened for our chronic care management program.

Conditions managed in 2011 included asthma, diabetes, hypertension and heart disease (see Exhibit 5).

- Total number of ETF members with these conditions decreased 17.6 percent from 1,532 in 2010 to 1,262 in 2011.
- ETF members with high HSM scores (7 to 10) increased in 2011 from 2010:
  - 2011 = 106 (an increase of 43.2 percent from 2010)
  - 2010 = 74 (a decrease of 14.9 percent from 2009)
  - 2009 = 87 (an increase of 22.5 percent from 2008)
  - 2008 = 71 (an increase of 24.6 percent from 2007)
  - 2007 = 57
- Chronic Care Management services focus on members with higher HSM scores.

Exhibit 5

STATE EMPLOYEE TRUST FUNDS
HSM Table
Calendar Year 2011

HSM Score	ETF Members with:								Total
	Asthma		Diabetes		Hypertension		Heart Disease		
	Number	Proportion	Number	Proportion	Number	Proportion	Number	Proportion	
10	0	0.0%	4	1.7%	5	0.7%	3	1.6%	12
9	2	1.5%	0	0.0%	5	0.7%	3	1.6%	10
8	0	0.0%	5	2.2%	15	2.1%	5	2.7%	25
7	4	2.9%	12	5.2%	23	3.2%	20	10.8%	59
6	2	1.5%	7	3.0%	16	2.3%	7	3.8%	32
5	15	10.9%	34	14.8%	63	8.9%	36	19.5%	148
4	20	14.6%	46	20.0%	125	17.6%	44	23.8%	235
3	22	16.1%	59	25.7%	152	21.4%	41	22.2%	274
2	30	21.9%	50	21.7%	190	26.8%	19	10.3%	289
1	42	30.7%	13	5.7%	116	16.3%	7	3.8%	178
Total	137		230		710		185		1,262
CY 2010	180		368		783		201		1,532

Proportions represent the percentage within each disease group

HSM Score	Book of Business Comparison Members with:								Total
	Asthma		Diabetes		Hypertension		Heart Disease		
	Number	Proportion	Number	Proportion	Number	Proportion	Number	Proportion	
10	7	0.6%	9	1.1%	12	0.4%	12	2.9%	40
9	2	0.2%	7	0.8%	23	0.8%	8	1.9%	40
8	7	0.6%	11	1.3%	31	1.0%	16	3.9%	65
7	18	1.5%	19	2.3%	32	1.1%	21	5.1%	90
6	11	0.9%	16	1.9%	32	1.1%	24	5.8%	83
5	44	3.7%	73	8.7%	162	5.4%	49	11.8%	328
4	104	8.7%	140	16.6%	334	11.1%	83	20.0%	661
3	164	13.8%	211	25.0%	558	18.5%	110	26.6%	1,043
2	242	20.3%	277	32.9%	886	29.3%	72	17.4%	1,477
1	592	49.7%	80	9.5%	951	31.5%	19	4.6%	1,642
Total	1,191		843		3,021		414		5,469

Chronic Care Management (CCM)

CCM focuses on members with asthma, congestive heart failure, coronary artery disease (including hypertension and high cholesterol), and diabetes.

Members with chronic conditions are proactively identified and outreach is provided to help them navigate the healthcare system, manage their condition and make positive lifestyle changes.

Participation in chronic care management (CCM) increased 12 percent—with 248 cases (open and closed) in 2011 compared to 222 cases in 2010 and 149 cases in 2009. Management of diabetes occurred most frequently at 138 cases (56 percent) followed by cardiac-related conditions that occurred in 98 cases (40 percent) see Exhibit 6.

Great Beginnings

Our Great Beginnings pre-natal case management program provides services to members with high risk pregnancies. Below is a case description highlighting how the program can improve outcomes and reduce costs:

A member was pregnant with twins with two separate amniotic sacs but one shared placenta. This can be serious if the placenta is not able to pass enough nutrition to both growing babies. The WPS Care Manager provided print educational material and telephone contact during the pregnancy and verified that the specialist and facility providing care were in the member's network. The care manager coordinated serial ultrasounds to monitor the growth of the twins and services from a Maternal Fetal Medicine specialist due to the high risk condition. The pregnancy resulted in a normal, non-surgical delivery of healthy twins. The mother and her twins were all able to go home two days after delivery without any home care.

Exhibit 6

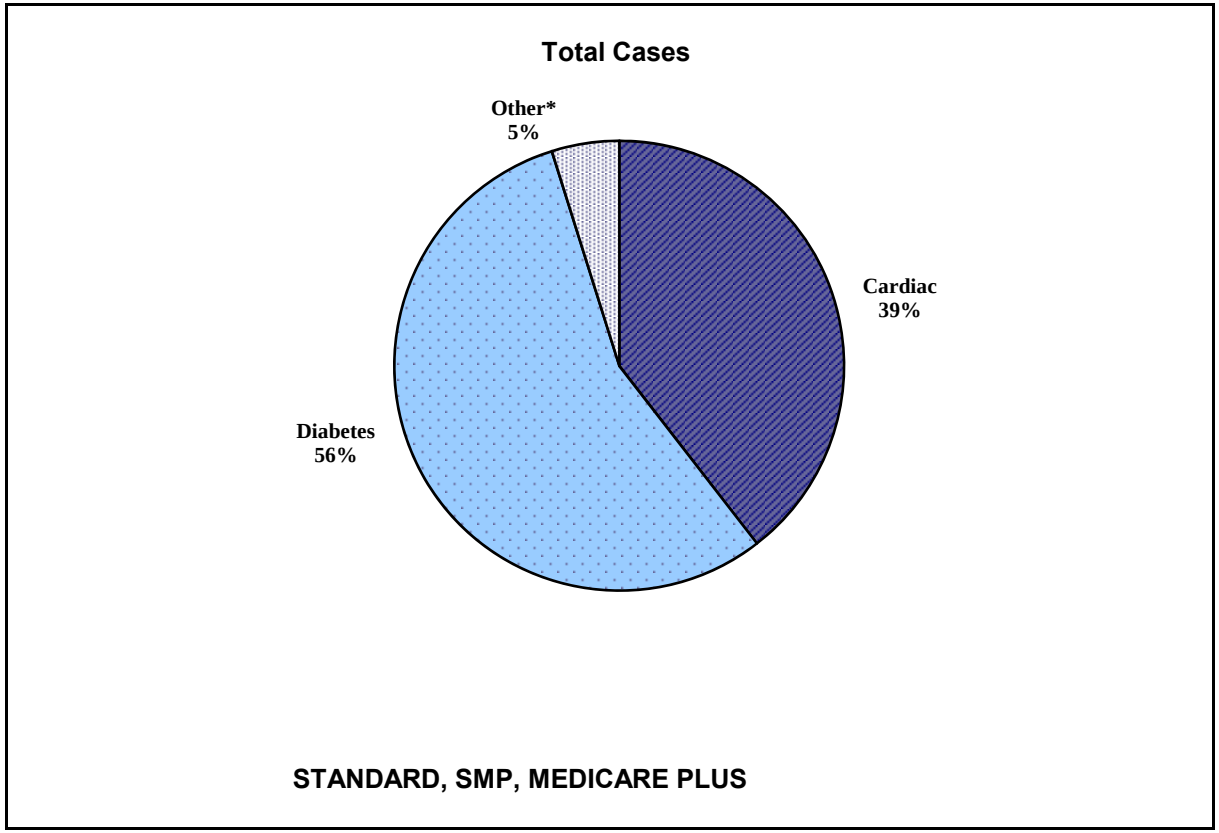
STATE EMPLOYEE TRUST FUNDS

Chronic Conditions - Managed Cases

Calendar Year 2011

Chronic Conditions	Open Cases	Closed Cases	Total Cases
Cardiac	64	34	98
Diabetes	70	68	138
Other*	11	1	12
Total	**145**	**103**	**248**

***Other = Members with other chronic conditions, such as asthma or kidney disease.**



Behavioral Health Outpatient Visits

- Behavioral Health (BH) outpatient visits have decreased over the past five years (see Exhibit 7). Since 2006:
  - Members with greater than twenty visits have decreased consistently:
    - 2006 = 191
    - 2007 = 168 (12 percent year-over-year reduction)
    - 2008 = 148 (12 percent year-over-year reduction)
    - 2009 = 121 (18 percent year-over-year reduction)
    - 2010 = 107 (11.5 percent year-over-year reduction)
    - 2011 = 92 (14 percent year-over-year reduction, 52 percent decline since 2006)
  - Members with less than twenty visits have also shown consistent reduction in the same period*:
    - 2006 = 540
    - 2007 = 507 (6.1 percent year-over-year reduction)
    - 2008 = 494 (2.6 percent year-over-year reduction)
    - 2009 = 419 (15.2 percent year-over-year reduction)
    - 2010 = 414 (1.2 percent year-over-year reduction)
    - 2011 = 332 (19.8 percent year-over-year reduction, 39 percent decline since 2006)
  - Overall, the number of members with behavioral health outpatient visits has decreased 42 percent between 2006 and 2011 (731 vs. 424).

- From 2010 to 2011, the total number of visits among those with twenty or more visits in the year has also been reduced 23.3 percent from 2,752 in 2010 to 2,110 in 2011.

- Decrease in BH outpatient visits impacted by:
  - Medical management review of all cases with greater than twenty visits.
  - Requirement for physicians to complete and submit treatment plans for review by our physician advisor prior to authorizing additional visits.

* While the numbers with fewer than 20 visits have steadily decreased, the proportion has held consistently around 78% of the members.

Exhibit 7

STATE EMPLOYEE TRUST FUNDS

Behavioral Health Outpatient Visits by # of Members

Calendar Year 2008 - 2011

Number of Visits	Members			
	2008	2009	2010	2011
1-19	494	419	414	332
20-30	60	53	51	48
31-40	45	33	29	20
41-50	24	23	20	16
51-60	11	5	4	5
61-70	4	3	0	0
71-80	0	0	2	0
81-90	3	2	0	2
91-100	0	0	0	0
>100	1	2	1	1
Total - All Visits	**642**	**540**	**521**	**424**
Total - Visits 20+	**148**	**121**	**107**	**92**

Average Visits	**12.93**	**13.02**	**12.20**	**12.59**

Quality Measures for Chronic Conditions and Health Care Screening

- Preventive health screenings such as Pap tests, mammograms and diabetic testing can help improve quality of care and quality of life.

- Mammography screening rates have declined slightly since 2009 but remain above the national PPO average (71.0 percent in 2011 vs. 67.0 percent). One in four women who should be screened is not, representing an opportunity for quality improvement (see Exhibit 8A).

- Cervical cancer screening rates have decreased since 2010 and are below the national PPO average (68.6 percent vs. 74.5 percent).

- Both diabetic care indicators have been trending up from 2009 to 2011, but one measure remains slightly below the national PPO benchmark. The 2011 HbA1c testing rate was 84.4 percent versus the National PPO benchmark of 85.2 percent; LDL-C testing was 80.0 percent versus the benchmark of 79.9 percent (see Exhibit 8B).

- In 2010, performance improvement initiatives were implemented that featured targeted written and telephonic outreach and education efforts.

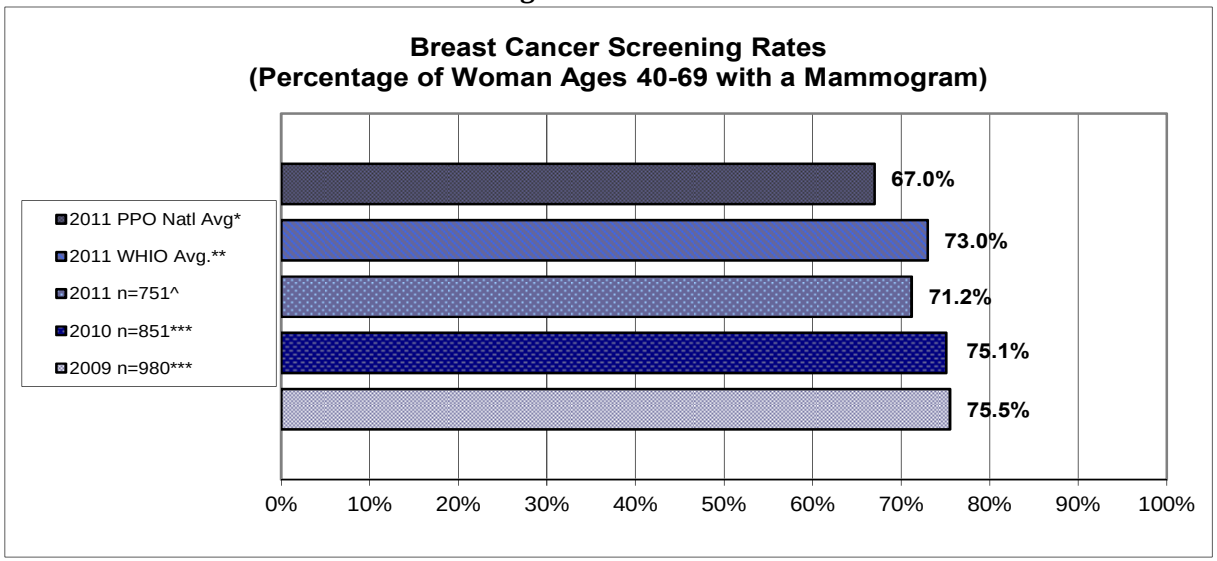
The second-year results on LDL-C testing: In 2009 the proportion of individuals meeting diagnostic criteria for diabetes had increased 14% since CY 2007, but the proportion receiving necessary preventive screening tests had declined. An outreach intervention was implemented in 2010 to increase Diabetes HbA1C and/or LDL-C testing for individuals identified as meeting diagnostic criteria for the disease. That intervention included targeted outreach to members with diabetes identified as not having received the HbA1c and/or LDL-C tests in CY 2008. Letters in layman's terms were sent to those members providing a brief description of the tests and why they are important. Follow-up phone calls were made to the identified members. The Quality Improvement Project resulted in a 12 percentage point improvement from 2009 and brought the ETF rate up to a level (80 percent) that compares more favorably with state and national performance levels (79.0 percent and 79.9 percent respectively).

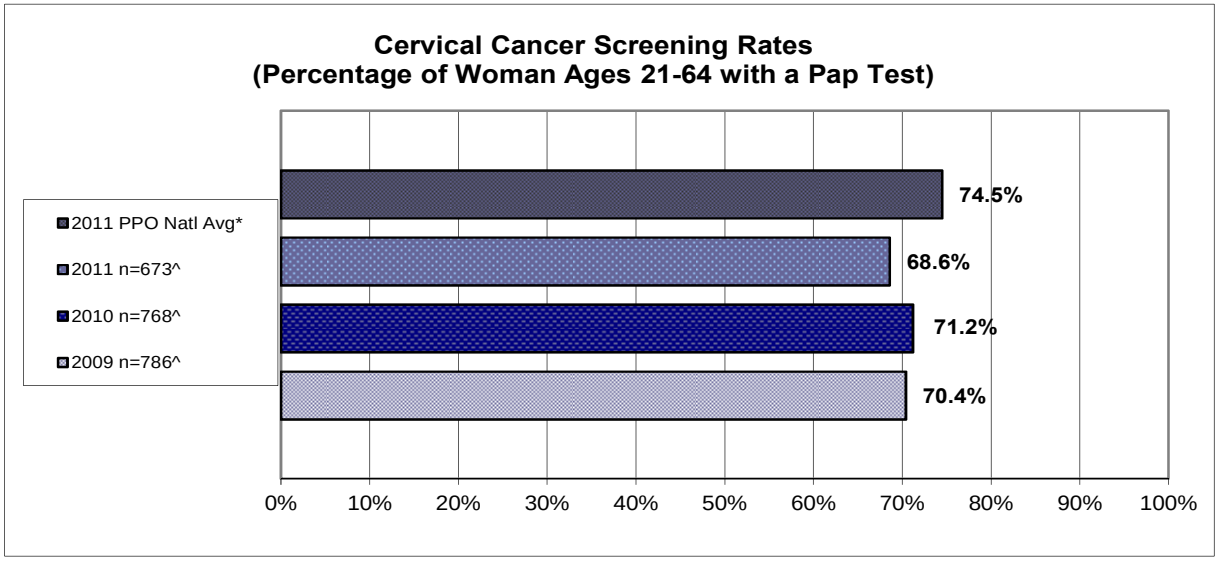
The second-year results on HbA1c testing: The Quality Improvement Project resulted in a 18.1 percentage point improvement from 2009, sharply reversing the negative trend of the previous years and bringing the ETF HbA1c performance rate up to a level (84.4 percent) which compares favorably with state and national PPO rates (86.0 percent and 85.2 percent respectively).

Exhibit 8-A

STATE EMPLOYEE TRUST FUNDS

Screening Rates - Standard and SMP





*** PPO National Average: NCQA State of Health Care Quality 2011**

**** WHIO Data: 4/01/09-3/31/11, paid through 6/30/11; PPO only; all Residents.**

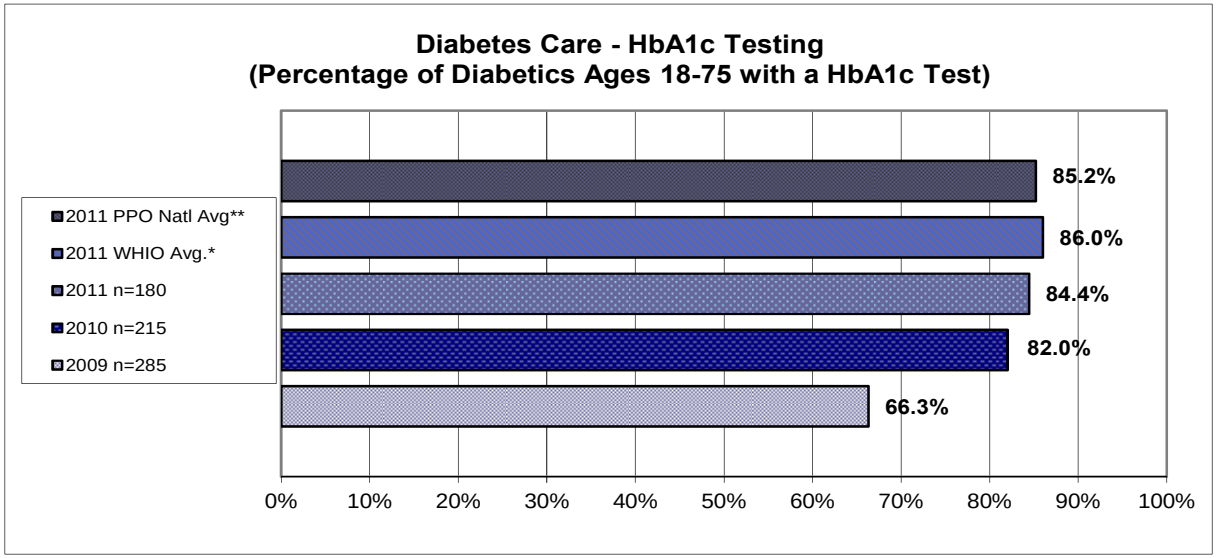
***** Rate includes screenings performed in the reporting year or one year prior.**

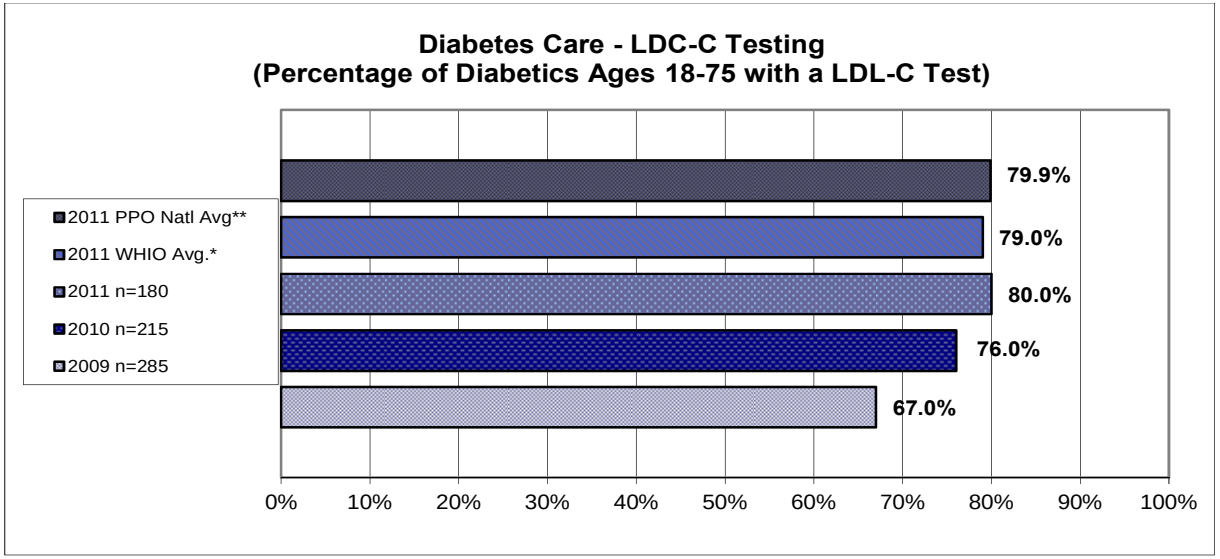
^Rate inlcudes screenings performed in the reporting year or two years prior (i.e. 2011 rate = 2009-2011).

Exhibit 8-B

STATE EMPLOYEE TRUST FUNDS

Diabetes Measures - Standard and SMP





*** WHIO Data: 4/01/09-3/31/11, paid through 6/30/11; PPO only; all Residents.**

**** PPO National Average: NCQA State of Health Care Quality 2011**

State Employee Trust Funds

Integrated Care Management

Wellness and Prevention Programs

A comprehensive Wellness program is included in WPS Integrated Care Management.

- Wellness programs work hand-in-glove with Medical Management and Chronic Care Management to empower individuals to prevent health problems, facilitate early detection and treatment of potentially serious conditions and successfully manage chronic conditions they may have. The Wellness program is a key component in Value Based Benefit Design.

- In addition to current wellness offerings, standardized wellness programs, biometric screenings and wellness coaching sessions (i.e. smoking cessation, weight and stress management, exercise) are also available for your future consideration.

Available at no additional charge through the WPS member portal are:

On-Line Resources

- WPS provides an **online health encyclopedia** from Healthwise. The Healthwise® Knowledgebase contains more than 3,200 evidence-based topics on health conditions, medical tests and procedures, medications, and everyday health and wellness issues.

- **Preventive Health Guidelines for patients.**

- **HealthSense Rewards™**, a WPS program that provides discounted access to a variety of health clubs.

- **WPS Alive & Well Newsletter** (PDF version on Web site) is published on a bi-monthly basis. Available through the WPS Member Health Center portal.

- **Health and Wellness Resource Guide** (PDF version on Web site) that refers your employees to approximately 200 local organizations, helping you to further enhance your worksite wellness program.

- **Weekly / Monthly email Wellness Tips** (available on disc) specific to your employees needs (Nutrition and Weight Management, General Wellness and/or Physical Activity).

Wellness Services for future consideration (available at an additional cost):

Biometric Screening

- This service is billed at cost and arranged through local providers or State wide vendor.

Wellness Coaching Sessions

- Six month telephonic coaching sessions can be purchased for an additional fee.

2011 Care Management Satisfaction

Satisfaction Rating: 83 percent (30 of 36) of survey respondents rated WPS care management 4 or 5 with 5 being the best rating.

Satisfaction Survey Comments:

1. “Thank you for providing good services at the most important time of my life. Keep up the quality services.”
2. “Rhonda was the best!”
3. “Was a very useful program for me!”
4. “Excellent Service!”