GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM

Municipalities building a
stable insurance future.

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AGENDA
Joint Committee on Plan Structure and Design
June 7, 2012 – Noon
Old Jail Conference Room

1. Welcome

2. Discussion of Patient Home Centered Medical Home

3. Update on CanaRx — Steve Locey

4. Update on Request for Proposals:
   a. Flex Spending Accounts
   b. Emergency Assistance Program — Steve Locey
   c. Prescription Drug Manager

5. Discussion of Blue4U (Excellus Health and Wellness Program — Jennifer Stuckert, Excellus

6. New Business

7. Approval of Minutes:
   a. April 5, 2012
   b. May 3, 2012

Next Meeting: July 5, 2012

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draft

MINUTES
Greater Tompkins County Municipal Health Insurance Consortium
Joint Committee on Plan Structure and Design
May 3, 2012 – Noon
Old Jail Conference Room

Present:
Municipal Representatives: 7 members
Schelley Michell Nunn, City of Ithaca; Mary Mills, Village of Cayuga Heights; Don Barber, Town of Caroline and Chair, Board of Directors; Jennifer Case, Town of Dryden; Judy Drake, Town of Ithaca; Brooke Jobin, Tompkins County; Marcia George, Town of Ulysses

Union Representatives: 7 unit members
Chantalise DeMarco, County White Collar-CSEA; George Apgar, President; Ithaca Professional Fire Fighters Assoc. and Ithaca Area Fire Fighters #73; John Licitra, Town of Ithaca DPW Teamsters; Jim Bower, Bolton Point; Bradley Berggren, Town of Danby Highway CSEA; Tim Logue, City of Ithaca Executive Unit

Municipal Representatives/Union Representatives via Proxy: 1 member
Betty Conger, Village of Groton (Proxy – M. Mills)

Union Representative via Proxy: 1 member
Patricia Vandebogart, TC3 CSEA Staff Unit

Others in attendance:
Steve Locey, Locey & Cahill; Sharon Dovi, TC3; Ken Foresti, Beth Miller, Nora Putnam, Excellus; Jed Constanz, CNYMSS; Dr. Jamie Loehr, Travis Turner, Cayuga Area Physicians Alliance

Call to Order

Ms. DeMarco called the meeting to order at 12:06 p.m.

Patient Centered Home Model of Medical Practice

Mr. Constantz said he worked in this community at the time the Consortium was first created and said by coming together in this way the Consortium, as a self-funded entity, went from buying insurance to buying health care. The opportunities the Consortium has are limitless in terms of what and how it does that in terms of establishing a direct relationship with the provider community. Over the past several years he has become very familiar and supportive of the model known as the Patient Centered Home Model of Primary Care.

Mr. Constantz had served in a position similar to Mr. Turner and has narrowed his consulting work to focussing on a medical home model of primary care and embedding that in an employer-driven strategy that is designed to: 1) improve a patient's circumstance, and 2) measurably reduce aggregate spending for those patients.

Mr. Constantz said he believes the only way to do this effectively and sustainably is to have more practices like those that exist inside of CAP. He said CAP represents the only community of physicians in the geographic region that are recognized by NCQA (National Committee for Quality Assurance) as Level 1, 2, or 3 Patient Centered Medical Homes. The difference between a Level 1 and 3 is whether or not the practice has invested in an electronic medical record and the extent to which they are using the medical record to manage the population they are caring for. He said the more informed employers across the country, led by IBM, are seeking by Medical Home, recognized practices and making meaningful benefit plan design differences. He spoke of cost sharing arrangements and said many are seeking out zero cost sharing arrangements if a patient seeks out a Medical Home recognized practice that has been identified as a high-performing primary care practice. They are also increasing to the extent possible, out of possible exposure if a person chooses not to.

Mr. Constantz said this area has the largest concentration of such recognized practices for any geography and gave credit to CAP. They have invested in the tools that can help groups like the Consortium with developing a measurement because they have the tools to aggregate every area the Consortium is spending money on. With regard to additional information and learning more he suggested going to the pcpcc.net website to access information about this from across the country.

Ms. Nunn questioned what would be different under this model for both patients and providers. Mr. Constantz said in order to understand this the focus has to first be on the primary care practice and the information exchange so that the provider can have the best possible information about where the patient has been and what their needs are. The electronic medical record system would include not only a comprehensive snapshot of the patient's history but would also have a life span plan of care that goes beyond any immediate condition the patient might have and it would include both short and long-term goals for the patient. From an employer's perspective there would now be a primary care provider working to achieve the same goals.

Cayuga Medical Practice, Dryden Family Practice, and Family Medicine Associates were the first three practices in this community that moved in this direction. Mr. Turner said the number has expanded to 14 of the existing 16 practices in Tompkins County.

Mr. Locey provided an example of what currently happens when a patient visits their primary care physician, stating what the physician knows about a patient is limited to what the person tells them in a 7½-minute visit. The physician does not have access to information about whether medications have been filled or if the patient has seen any other doctors for any other conditions. Under this model not only data collected from the patient would be integrated, but also claims data from Medco and Excellus, in addition to any other information obtained by other physicians within CAP. Mr. Locey said in order to get access to the information in terms of claims data the Consortium needs to find out whether information can be released at the Consortium level or by the employer. He said the Consortium's legal counsel is looking into this now. The second issue is financial because there is some investment in terms of technology and there are some costs associated as well as what type of return on its investment there would be for the Consortium.

Ms. DeMarco asked if there is information about collectively-bargained units. Mr. Constantz spoke of the Towns River School District in Towns River, New Jersey. It was also mentioned that 50% of the workforce in the Consortium receive healthcare out of the area and this is something the Consortium is looking at.

Dr. Loehr said he has been practicing medicine using the Patient-Centered Model for approximately two years. Within this, he spends 20 minutes with a patient instead of 7-½ minutes. Although he doesn't see a lot of patients he stated he is able to bill more appropriately and explained he is able to provide more comprehensive care as well as provide more opportunities for a patient to interact with their physician. It also allows a patient to become more involved in his or her own health care. He noted that this is not a perfect system but he believes it is much better than the existing system.

Mr. Lictra asked why Guthrie is not part of this. Dr. Loehr said while he has been very impressed with the Guthrie doctors and the services provided, it is his understanding that Guthrie provides many services locally but has an overall goal of bringing many patients to Sayre rather than being committed to this community. Mr. Constantz suggested that Dr. Estill of Guthrie be asked where Guthrie stands on their Medical Home journey and are they on that journey, as well as can they make a commitment to improve the health status of the population and to lower aggregate spending?

Mr. Locey asked through CAP if there would be better access to an electronic medical record. Mr. Turner said one of the CAP's five initiatives is access information through their implemented electronic health record. That in conjunction with PCMH, allows the provider community to gain access to that information (PBN data, claims data, and eventually to the Central New York RIO Health Information Exchange which now has access to 11 other hospitals). Mr. Constantz said there will never been standardization of software but the physicians will have access to electronically submitted information through a .pdf, providing needed information. From a workflow perspective there would be a continuity of care document in a standard presentation so that a doctor would know where to look for information within the document. Depending on which EMR system a physician would be using they would be able to put information in data fields. Mr. Constantz this is something that will be available in the near future.

Update on Request for Proposals

Mr. Locey reported nine responses to the Request for Proposals on the Flex Spending Accounts were received and they are currently being evaluated; a meeting will be scheduled soon with that Review Committee. The Request for Proposals for the Employee Assistance Program will be issued shortly. The Review Committee for the Prescription Drug Manager met prior to this meeting and reviewed updated pricing information. Interviews with vendors are will be held at the end of the month with a recommendation to be brought before the Board of Directors at its June meeting.

Mr. Locey distributed information on changes to the Express Scripts/Medco formulary for the first quarter of 2012.

Update on CanaRx

Mr. Locey provided an update on CanaRx and stated information has been received and is being evaluated as to the impact the County has seen with use of CanaRx. The State has still not given a clear opinion on CanaRx. The Board of Directors has not made any decision with regard to this.

Update on Medicare Supplement

Mr. Locey reported he has received and is reviewing updated information on usage for the over 65 population; this item will be placed on the next agenda.

Excellus Utilization Review

Ms. Putnam distributed utilization information for 2011. She noted the comparison data is based on a large sample of Excellus clients, representing 648,000 members; next year the comparison will be done with actual Consortium numbers for 2011. The following points were noted during her presentation of the information:

- In 2011 there were 2,001 average contracts with 4,406 average members;
- Plan costs paid out per contract - $8,439; plan cost per member - $4,525. Plan costs were higher than the comparison population; however, the member cost was lower;
- In the outpatient setting, surgery services were the most costly, representing 29% of costs;
- Lab accounted for the highest percentage of utilized services in the outpatient setting, 27%;
- 7% of member have accounted for 74% of plan costs (generally, 20% of members account for 80% of plan costs);
- The high claimants accounted for 33% of plan costs and represent 3% of the population. Most of the diagnosis are types of cancers;
- Emergency Room visits per 1,000 – 231 (25% higher than comparison population);
- Emergency Room visits per 1,000: Potentially avoidable visits – 43 (41% higher than comparison population. Ms. Putnam was asked to break out the outpatient care by location;
- The average cost per visit: Office - $112 vs. Emergency Room - $1,302;
- Most frequent emergency room diagnoses (potentially avoidable): upper respiratory infections, back pain, headache, urinary tract infections;
- Most frequent emergency room diagnosis: skin infections, tissue infections, ear conditions, disorders of the teeth and jaw, hypertension. This information is based on coding. *Ms. Putnam was asked to provide an electronic copy of a detailed report to Mr. Locey.*
- Colonoscopy, mammogaphy, pap smears, and well child visits.

Mr. Foresti said Excellus has programs to keep people healthy as well as help those with chronic conditions to better manage the conditions through disease management programs. Chronic conditions identified include asthma, diabetes, heart disease, congestive heart failure, and COPD. Depending on the severity of the condition, there may be a need for case management where the nurse works with the pharmacy, medical team, and family members. High-risk members with behavioral health issues are identified for Behavioral Health Care Management and/or Member Treatment Coordination. In the working population, major depression is one of the most prevalent behavioral health problems and research suggests that the majority of patients with depression improve with treatment. Within the Consortium, 508 members were diagnosed and treated for depression.

Mr. Foresti spoke of utilization management and said high cost services are reviewed by a health plan coordinator to assure that services are necessary and appropriate based on national guidelines. Ms. Mills spoke of a case in which payment for an MRI that was ordered by an Emergency Room physician was not approved for payment. Mr. Locey said if the claim

is ultimately denied by Excellus, the person may go through an independent reviewer at the New York State Insurance Department.

Recommendations presented were as follows:

1. Initiate a campaign to reduce unnecessary Emergency Department visits. Also promote ways to help members find a primary care physician and utilize urgent care centers.
2. Provide wellness promotional information to help reduce incidence of back pain, cholesterol disorders, hypertension, diabetes, depression, and heart disease. Promote custom web portal and other wellness services such as Step Up, Blue 365, and Advance Care Planning.
3. Your members have access to the New York State Quitline. By increasing participation, there is potential for considerable cost savings. For each smoker who quits, an estimated $2,746 in medical costs is saved per quitter per year (excess costs per smoker total $5,398) per year when considering lost productivity and Workmen's Compensation. Your Health and Wellness Consultant can work with you to provide messaging to promote the program. Promoting it will increase participation. Providing incentives boosts participation significantly.

Excellus System Upgrade

Ms. Miller distributed a timeline for the system upgrade that will begin soon. All members will be receiving new group numbers and identification numbers through this new system. She reviewed the events that will take place and noted that information sessions will be held for members in November.

New Business

There was no new business.

Approval of Minutes

The minutes of the April 5, 2012 meeting were deferred to the next meeting due to lack of a quorum.

Adjournment

The meeting adjourned at 1:45 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk