

**Strategic Planning Committee  
September 26, 2011  
4 p.m.  
Scott Heyman Conference Room**

Present:

Betty Falcao, Director, Health Planning Council  
Travis Turner, Executive Director, CAP, Physicians Hospital Organization  
Chantalise DeMarco, CSEA and GTCMIC Board Member and Chair of the Joint Committee  
on Plan Structure and Design  
Paul Bursic, Cornell University Human Resources  
Steve Locey, Locey and Cahill  
Laura Shawley, GTCMHIC Board of Directors  
Kate Supron, GTCMHIC Board of Directors  
Scott Futia, CSEA Deputy Director  
Karen Gonta, Tompkins County Mental Health Employee

**Call to Order**

Ms. Shawley called the meeting to order at 4:08 p.m. She said Mr. Barber is unable to attend this meeting but provided her with an outline of what discussion topics. She said the focus of today's meeting will be on analyzing claims data and how the Consortium can use the data to manage healthcare. She said it will be important for the Joint Committee on Plan Structure and Design to be able to analyze data as well to recognize what data to ask for. Minutes of the previous meeting were circulated.

At this time those presents introduced themselves and provided a brief statement of what they expect to learn at this meeting.

Ms. Falcao said she is interested in learning how community organizations can partner with both employers and the healthcare system to help address some of the issues that are raised when looking at the data.

Mr. Locey said he not only works with the County's Consortium but also with the local school Consortium. His company will gather much of the data that will be reviewed and analyzed.

Mr. Bursic said he is present at this meeting to lend Cornell's experience as a self-insured group with a very long standing and dealing with the PHO. He is looking forward to continued cooperation and collaboration in a number of areas.

Ms. Gonta said she is an observer as part of her continuing education and transferring from a career in casework to HIT (Health Insurance Technologies).

Mr. Futia explained his division of CSEA oversees all aspects of healthcare across 1,200+ local government and private sector groups across New York State. He is pleased to see this committed approach to look at what can be done to tackle rising health care costs and thinks wellness is an important part of that.

Ms. Supron said she has no experience with healthcare other than her participation in the Consortium and is looking forward to learning more.

Mr. Turner said he is here to try to answer some of the questions that were raised at the last meeting as far as how does an employer begin to analyze its own data. He and Dr. Darlow spoke throughout their presentation about what they intend to do with information and how they would like to improve quality and attempt to control costs. He said a collaborative discussion at this level is required from the employers who are the purchasers of health care and the providers. Both parties need to come together to define to the insurance companies how they would like to see things and this collaborative setting allows for the opportunity to do that.

Mr. Turner distributed a sample of claims data and analysis containing generic information. He said employers should be looking at total claims, lives, medical trending, and begin looking at the E & M (Evaluation and Management visits versus procedures), hospital days, average length of stay, and emergency room visits. From the cost perspective employers should be interested in the PEPM (Per Employer Per Month) or the PMPM (Per Member Per Month).

The Category of Care (CoC) provides fundamental measurements of the Plan's performance. This report allocates claims payments into buckets derived from Current Procedure Terminology (CPT). There were 12 Categories of Care in the sample document provided. Ms. DeMarco questioned what would be an Undefined Service which was listed as a category. Mr. Turner said it could be something that doesn't fit into one of the other categories; Mr. Locey suggested one example could be durable medical equipment for prosthesis.

Mr. Turner said typically it is 20% of the population that incurs 80% of the medical expenditures. The employer used in the example defines high claimants as anything over \$5,000 per claim; employers may set this at any level. It provides a narrower window of where expenses are and within which class. An employer should also be able to receive information on medical claimants broken down by diagnosis and how expenses are incurred. There is also a report available on the medical conditions and what pharmacy prescriptions are treating conditions.

Mr. Turner spoke of breaking down high cost claimants and said an employer should be able to separate them out from the larger population, as these are the ones that incur the largest dollars in claims. In looking at where those expenses are being incurred there can be efforts to identify those within Tompkins County and help treat those with chronic conditions.

The next section of the document addressed high-risk members; Mr. Turner spoke of how to identify those who are high risk, saying patients are put into categories of risk. Based on that level of risk it would depend on how patients would be treated based on an evidence-based guideline perspective.

Mr. Bursic said most insurance companies are reasonably sophisticated and usually have the ability to do the type of profiling presented in Mr. Turner's sample. He said they should be able to identify where an employer's emphasis should be.

Mr. Turner said this is where they are working as a network with physicians and providers and are looking at this information agnostically. He said this raises the question of how to act on given conditions by working with the employers and the self-insured.

Ms. Falcao said there is a lot of work that can be done in the case management area to help patients. Often, they are going to different providers and do not understand what to do next. This is not to take away an individual's choice, but helping them to get more of what they want from the system.

Mr. Bursic spoke of lessons he has learned. One is designing a plan with "sticks" and no "carrots" is not a good idea; however, you have to be careful which "carrots" you choose. He said there are many things that need to be connected, including collaborating with the medical community. The Cornell Program for Healthy Living has put a bridge between the employee and their primary care provider. They have had mixed results and he thinks they need to go further to bolster those efforts. Mr. Bursic said Cornell has a great amount of data and has identified the 21% of the population that is generating 79% of the costs. They have also identified some of the things they would like to talk to physicians about, one example being metabolic disorders.

Ms. Falcao said she would be interested in hearing what kind of experience the 20% has had on working on the population. Mr. Bursic said they are working on it but said the threshold of getting into the healthcare industry is messy and ill defined. There are a lot of entrances and different kinds of exits from the system. He hopes local physicians are building up the idea that there is a grand entrance and a way to do this right and that the primary physician can be the guide through the system. He said there has to be as much work on medical delivery as there is on data and he thinks local primary physicians are motivated to move in a direction of providing the grand entrance into the system and to get more groups to put their people through the right portal.

Mr. Turner spoke of actionable data and explained a chart with a sample breakdown by disease and said this is how to begin to target a population on based on a condition. He said if employers are willing to share data they can help with this and help develop a wellness program or care or disease management programs.

Mr. Bursic spoke of the complexity of this and the importance of partnering with the local physicians. Ms. Supron said she is impressed with the current level that local physicians are able to share information. Mr. Turner said CAP covers 50+ practices and over 150 physicians with coordination with Cayuga Medical Center.

Ms. Falcao said she would be interested if out the 903 high-risk members whether a look was taken at how many were high-risk members in 2009. Mr. Turner said they look at high risk cases and said they may not be able to have an impact on the care of those with chronic conditions but there may be help that can be provided in the coordination of the care. He also spoke of the need for a compliance level and said as a network of clinical integration they have to have accountability of providers on evidence based guidelines.

Mr. Turner said since last July they have been having discussions with all of the major payers, such as Excellus, Etna, NBP, Health Now and other smaller payers and all discussions have gone well. Through the accessory engine that CAP is purchasing (vendor is Active Health, which is similarly used by regional health information exchange organizations and health information exchanges), they will be able to act on information that is shared by employers and insurance companies. There is a huge cost associated with creating this engine and this is where they want to reduce costs and build collaboration with the employers and insurers because health care costs are rising at an unsustainable rate. He said they want to find a way to bend that cost curve and develop a meaningful relationship moving forward.

The high-risk data is useful to an employer as a first step in discussing the development of programs that would be beneficial to the health of employees. Mr. Turner said over time it would be the hope that based on evidence-based guidelines and use of screening tools that an effect could be made on making people active or healthier and avoiding costs.

Mr. Locey said part of the complexity of this is that there are so many different targets that we are trying to influence and noted the following examples:

- Employers have goals and objectives that include reduced costs and a quality benefit package for employers;
- Providers have targets they would like to see,
- Managed care – efficient use of money and possibly redirecting resources to areas that are suffering such as adequate primary care resources, patient compliance;
- Enrollee perspective – best overall care, no strings attached, limited out-of pocket expenses;
- Cost impact targets – high-risk patients, efficient use of resources and making sure the most effective resource is being used at all times;
- Wellness and compliance
- Cost impact targets – developing ideas and strategies where the benefit structure can help facilitate the goals of the medical community to more adequately use the resources and also get higher patient compliance;
- Population education – employees and family members (users), employers (predominant payers of the plan), and the physician community

Mr. Turner agreed with this list and said it is becoming apparent that fee for services is not working and the costs of care expenditures is rising exponentially. He said as a partner he is willing to assist with analyzing any data that can be gathered. He also offered to look at past municipality data. This data is available through Excellus and can be run through the engine. Mr. Locey said he will gather some data basic data from the Consortium through August to begin analyzing.

Ms. Falcao said it is important to look at those things that have an immediate impact and those that have a longer-term impact.

Mr. Locey spoke of the importance of educating everyone from different perspectives and used an example of using generic drugs. Ms. DeMarco said she thinks it is important that a physician has a sense of what a patient's insurance reality is when they are prescribing a medication because the cost may discourage or prevent someone from filling a prescription. She also said she sees compliance as being treatment recommendations because the people still need to be the ones making decisions about their health care. She views this as being about ways to engage and motivate people in their own care.

At this time Ms. Shawley asked what actions can be taken with the data to control costs and to offer a better form of health care for the people in this community. She would like to look at wellness programs and figure out whether there needs to be community programs or programs within individual municipalities.

Ms. Falcao said she needs to look at the data and have more information about changes that could and have been made elsewhere and examples of how those changes have saved money and improved patient care.

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Mr. Futia asked if the focus initially would be workplace wellness or integrated disease management or both. Mr. Locey suggested creating short and long-term goals such as sharing data, identifying what areas could be targeted to influence cost, what can be done to promote wellness, and long-term strategies of having a healthier population and following treatment recommendations. It was noted that changes can be made in the system but not everyone will change; people will still have the freedom of choice. Mr. Locey agreed to provide actual Consortium data for the next meeting.

### **Adjournment**

The meeting adjourned at 5:53 p.m.