HHS/GO/ED COMM #1-2
October 18, 2012

MEMORANDUM

October 16, 2012

TO: Health and Human Services Committee
Government Operations and Fiscal Policy Committee
Education Committee

FROM: Linda McMillan, Senior Legislative Analyst
Craig Howard, Senior Legislative Analyst CH

SUBJECT: **(1) Employee Wellness and Disease Management Program – Montgomery County Public Schools (MCPS)**
(2) InforMed Cross-Agency Health Plan Data Study

The following agency representatives will be present for this session. With the exception of Mr. Johnstone, they have not been asked to prepare presentations or remarks.

Joseph Adler, Director, County Government (MCG) Office of Human Resources
Richard Johnstone, Director of Benefits, Montgomery County Public Schools (MCPS) Employee and Retiree Service Center
Sarah Espinosa, Vice President for Human Resources, Montgomery College
Tamathia Flowers, Director, Benefits and Records Management, Montgomery College
William Spencer, Director, Human Resources, Maryland-National Park and Planning Commission (M-NCPPC)
Paul Brown, Sr., Benefits Specialist, M-NCPPC
Carole Silberhorn, Benefits Manager, Washington Suburban Sanitary Commission (WSSC)

1. Employee Wellness and Disease Management Program - MCPS

Presenting:
Richard Johnstone, Benefits Strategy, MCPS

At the July 12th HHS and GO Committee session, the joint Committee reviewed responses from the agencies regarding their employee wellness programs. The joint Committee requested a more in depth overview from MCPS and asked that the Education Committee join

them at the session. Mr. Johnstone, Director of Benefits, MCPS Employee and Retiree Service Center, will provide the joint Committee with this overview.

Information provided by MCPS for this briefing is attached at © 1-8.

In its report, the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs highlighted the following regarding the MCPS Wellness Program:

- MCPS initiated a joint wellness program in 2009 when the Joint Workgroup on Health Care Cost Containment and Employee Wellness looked at data showing that about $36 million in health care costs were due to asthma, diabetes, obesity, and cardiovascular disease – all preventable and/or manageable.

- In the fall of 2010 MCPS implemented the "Well Aware" program that includes "MCPS on the Move" activities. The MCPS on the Move effort was available to 10,000 employees and 5,300 participated. Outcomes included 103,000 hours of logged activity and weight loss of 16,490 pounds. Average body mass index (BMI) started at 26.2 and ended at 22.4, moving the group from the obese category to the normal weight category.

- MCPS has a full-time Wellness Coordinator to work on enhancing and expanding efforts to all employees.

- MCPS and Kaiser have partnered to offer an 8-week smoking cessation program that will include group support. The program is available to Kaiser and non-Kaiser members. There will be an evaluation to determine if the program is successful.

Information provided to the joint Committee for the July session on agency wellness programs is attached at © 9-12. The presentation to the Task Force that was provided in September 2011 is attached at © 13-19.

2. InforMed Cross-Agency Health Plan Data Study

Presenting:
Christina M. Arenz, Director, Client Management, InforMed
Wes Girling, Health Benefits Consultant

On March 27, the Montgomery County Council approved Resolution #17-373 (©38-41) requesting the development of an executive-level report that provides information across all agencies on the major health issues for all enrolled members, top categories for spending on health claims, and trends that will show whether health risk measures are improving or declining. The Council's request was in direct response to the Task Force's finding that the county is providing group insurance to over 100,000 people.

> "Task Force members commented that such a large number of lives shows the buying power the agencies should be able to leverage when procuring group health services both in terms of costs from economies of scale and in requiring improved quality and health outcomes. The Task Force urges the Council to begin reviewing information on

the total number of lives covered across all agencies when discussing how best to provide and fund health benefits."
(report page vi)

The following data was included in the Task Force report.

MEDICAL BENEFIT for ACTIVE EMPLOYEES	Total Employees Enrolled	Total Covered (Employee and dependents)
County Government	8,187	20,869
MCPS	19,132	49,052
Montgomery College	1,375	3,495
M-NCPPC (Park and Planning)	1,827	5,785
WSSC	1,345	3,497
TOTAL - ALL AGENCIES	**31,866**	**82,698**

MEDICAL BENEFIT for RETIREES	Total Enrolled (retiree or surviving spouse)	Total Covered (retiree and dependents)
County Government	4,603	7,642
MCPS	8,307	12,442
Montgomery College	481	568
M-NCPPC (Park and Planning)	863	1,357
WSSC	1,339	2,105
TOTAL - ALL AGENCIES	**15,593**	**24,114**

The Task Force further noted that agency group health insurance budgets for MCPS, County Government and Montgomery College totaled $389 Million in FY12. These budgets do not include the employee portion of the premium or out-of-pocket expenses. It was projected that the actual cost of health care claims and administration for County Government and MCPS could be in excess of $500 million in FY12.

In May, the Office of Legislative Oversight engaged the services of InforMed, LLC, a Maryland based health care information management and services company, to prepare a Health Benefits Data Report using health claims data for the three County and two bi-County agencies.

At this session, the joint Committee will be briefed by InforMed on the findings and recommendations of this first cross-agency report. A copy of the report is attached at © 20-37. **Please note that the report does not include data for people covered through Kaiser Permanente which is not one of the county's self-insured plans.** Because of this, the report reflects data on about 90,000 people across the agencies. Kaiser Permanente has agreed to provide a similar report but will not be providing claims data to InforMed.

The InforMed report not only compares Year 1 (June 2010 through May 2011) to Year 2 (June 2011 through May 2012) but also provides comparisons to InforMed's **Book of Business (BoB)** which reflects health data in the InforMed Warehouse on about 2 million individuals.

Some key points in the report are:

- From Year 1 to Year 2 there was a 2.31% increase in the number of people covered in the CareFirst, United Healthcare, and Cigna health plans and Caremark prescription plan that are the subject of this report.

- From Year 1 to Year 2, medical claims costs increased 4.96% and prescription claims costs increased by 6.6%. Year 2 total health plan expense was about $447 million.

- The per-member per-month (PMPM) plan cost is within a reasonable range for medical claims, but over twice what InforMed normally sees for prescription plans. Generally prescription costs run 20-25% of the total expenses. For county agencies the Year 2 prescription costs are over 47% of total expenses.

- In Year 2, 72% of dollars were spent on 14% of plan participants. This was relatively unchanged from Year 1.

- InforMed does predictive modeling around members that are projected to have large claims (over $10,000 in a year). The three major practice categories are: Cardiology, Endocrinology, and Orthopedics and Rheumatology. The most prevalent conditions in these practices are: joint degeneration, hypertension, hyperlipidemia, and diabetes.

- InforMed also looks at Evidence Based Medicine Adherence and has noted that in comparison to its Book of Business. County agency plans' adherence falls below benchmarks in four areas: cervical cancer screenings, diabetes care, congestive heart failure, and colorectal cancer screening. The lower adherence with diabetes and congestive heart failure correlates with the expected large spends in cardiology and endocrinology.

Next Steps

The InforMed reports are only recently completed. Council staff suggests that the joint HHS and GO Committee schedule a worksession when the Council returns in January to discuss with the agencies their observations about the cross-agency data as well as data that is being provided to each agency on its plan members.

Montgomery County Public Schools

Wellness Program

Mission Statement

The Mission of the Montgomery County Public Schools (MCPS) Wellness Program is to establish a work environment that promotes healthy lifestyles, decreases the risk of disease, enhances quality of life, and recognizes employee health and wellness as a cultural priority in the long-term success of MCPS as a whole. This program encourages strengthening health and well-being through convenient access to educational opportunities, wellness activities, behavioral change programs, and awareness events.

WELL AWARE

Vision Statement

A culture of wellness in our workplace benefits employees both personally and professionally and it contributes to positive morale, productivity, and decreased health costs for the organization. By delivering a comprehensive, results-oriented wellness program, we will provide opportunities for employees to develop health knowledge and skills, engage in healthy activities, make lasting positive changes, and enhance overall sense of well-being.

WELL AWARE

Wellness Program History

2010	Wellness coordinator position established. Formal Wellness Program launched in partnership with Kaiser Permanente. *MCPS on the Move* implemented at the start of the school year. Wellness Committee established.
2011	*Fuel the Move* launched in the spring. *Work it Circuit* launched in the fall.
2012	*The Million Mile Challenge* launched in the fall.

WELL AWARE

Wellness Statistics

	2010	2011 SPRING	2011 FALL (ELEM. SCHOOLS)	2011 FALL	2012
Participants	5,354	1,679	1,482	3,193	4,840
Participants who entered data	3,962	1,679	979	2,156	4,037
Participants who only registered	1,392	0	503	1,037	803
Hours exercised	100,025	13,151	30,721	52,819	99,490
Calories	51,521,553	3,348,450	NA	30,235,66	NA
Steps Recorded	NA	NA	NA	NA	688,088,548
Spirit Nominations	19	NA	2	23	14
Teams registered	669	215	89	272	457
Cumulative BMI Lost*	335.4	237.9	NA	241.6	96.3
Pounds Lost	2,013	956.7	NA	1,556	613
Food Journal**	NA	8834	NA	NA	NA
Nutrition Quizzes Taken	NA	1,746	NA	NA	NA
Budget	$120,000	$99,500	$50,000	$70,000	$60,000

Wellness Education

The Wellness Program provides monthly educational seminars and offers certain screenings throughout the year for MCPS employees and their families.

The seminars and screenings are announced via e-mail and Web links are embedded into the e-mail messages to take employees to our Wellness website.

Seminar topics include the following:

- Women's Health and Aging
- Stress
- Blood pressure
- Heart disease
- Diabetes
- Healthy eating

Wellness Impact

We will establish a baseline measurement for 2010 on key indicators including the following:

- Hospitalizations/1,000
- Heart disease rates/ 1,000
- Diabetes rates/1,000
- Preventive care visits/1,000 and in total
- Cancer rates/1,000

We then will be able to track changes over time. Note that these measurements will be affected by wellness programs, but the exact impact will be difficult to quantify as many factors affect the measured items.

WELL AWARE

Disease Management

Disease management programs are built into health plans that—

- identify those at risk or diagnosed with certain conditions;
- offer programs to help manage conditions;
- provide information on traditional treatment plans;
- offer suggestions, e.g., how often to meet with physicians, recommended tests and testing intervals; and
- include case management to coordinate care.

Conditions identified through the disease management programs include:

- Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease
- Low back pain
- Heart disease
- Cancer

WELL AWARE

HHS

LAM
CC
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EMC
OLO

MCPS MONTGOMERY COUNTY PUBLIC SCHOOLS
www.montgomeryschoolsmd.org MARYLAND

April 19, 2012

Malcolm Baldrige National Quality Award 2010 Award Recipient

The Honorable Roger Berliner, President
Montgomery County Council
Stella B. Werner Office Building
100 Maryland Avenue
Rockville, Maryland 20850

067934

Dear Mr. Berliner:

Thank you for your memorandum of March 29, 2012, requesting information about Montgomery County Public Schools (MCPS) employee wellness programs. I look forward to working with you, councilmembers, and members of the Board of Education to continue to improve the health of our employees.

As specified in Resolution 17-373, Implementation of Recommendations from the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs, the County Council requests information from each agency on current resources that are allocated to employee wellness and health promotion programs. The following information is provided regarding the MCPS employee wellness program:

(a) whether the agency has a person who has primary responsibility for developing and implementing wellness programs;

In coordination with our employee associations, MCPS established a wellness coordinator position in 2010. The individual in this position develops wellness initiatives in coordination with a wellness committee and management.

(b) whether the agency has an employee-employer health and wellness committee that meets regularly;

MCPS has established a wellness committee comprising employees from all employee associations. The wellness committee works in collaboration with the Joint Employee Benefits Committee comprising employee association leadership, retirees, and management. Regular meetings are used for the development and implementation of new programs as well as the review of current programs.

(c) how often the agency communicates with employees and retirees about wellness opportunities and how often this information is provided (electronically, by mail, etc.);

MCPS has established an extensive communications strategy to provide employees and retirees with wellness information and programs. MCPS communicates monthly via our electronic *Well Aware* newsletter, which provides employees with upcoming dates for seminars and screenings. We also communicate to employees via e-mail on our systemwide wellness campaigns. Staff also is notified of wellness events and programs via the biweekly *ePaystub* as well as the weekly staff electronic newsletter, *The Bulletin*. We communicate to retirees through our print newsletter, *Retiring Times*, which is published three times per year.

Each school and central services location has assigned a voluntary wellness coach to help communicate program information as well as motivate employees to participate. Communication to coaches is weekly or biweekly, depending on which program currently is being presented. MCPS established its Well Aware website, which provides continual updates on wellness initiatives, programs, and vendor-sponsored wellness programs available to all employees. It also includes a video library with highlights from previously held educational seminars. MCPS launched a smoking cessation program at no cost for all employees and dependents in fall 2011 in association with Kaiser Permanente. Two sessions of the eight-week program have been conducted to date.

The wellness coordinator also has spoken or provided services during many school system events, including the Superintendent's Administrative and Supervisory meetings, Professional Learning Communities, in-service day programs, timekeepers and administrative secretaries' meetings. All of these events help to spread the mission of the wellness program while communicating details about upcoming programs and events.

(d) whether the agency's programs have goals and outcomes that are measured;

MCPS has conducted several broad initiatives for our wellness campaigns. Each initiative has been focused on specific desired outcomes. Measurements and goals have included body mass index (BMI) reduction, weight management, and measured hours of physical activity. Additionally, through our monthly spotlight programs, MCPS has provided various screening campaigns, which have included blood pressure, cholesterol, blood sugar, and BMI monitoring, and derma-scan. The following wellness initiatives have been offered through MCPS:

MCPS on the Move, Phase I (October through December 2010):

- Goal/Objectives: Encourage lifelong exercise habits among MCPS employees. The contest emphasized consistency over athleticism and encouraged participants to learn simple ways to incorporate physical activity into their daily routines.
    - 5,300 participants registered for the challenge
    - 100,000 hours of activity were logged
    - 51 million calories burned
    - Cumulative BMI lost—335.4 points

Fuel the Move (March through May 2011):

- Goal/Objectives: Encourage lifelong healthy eating habits among MCPS employees. The contest emphasized nutrition education and encouraged participants to learn simple ways to make healthy nutritional choices while at work and home.
    - 8,800 food journal entries
    - 950 pounds lost
    - Cumulative BMI lost—237.9 points

Weighing in on Wellness (March 2011):

- Goal/Objectives: To produce a name, slogan, and logo for the wellness program by incorporating staff input with the mission and vision statement created by the wellness committee.
  - 47 entries received
  - 3 entries were chosen and were merged to brand the Well Aware Wellness Program.

Work It Circuit (October through December 2011):

- Goal/Objectives: To give staff the tools to maintain cardiovascular activity while adding strength and flexibility components. Teach staff proper stretching and toning workout techniques. Educate staff that workouts do not need to occur only in a gym setting—workouts may take place anywhere, and do not need to take up a great deal of time.
  - *Work It Circuit* Fitness kits, and Circuit Training manuals were delivered to each elementary school for staff use.
  - 30,000 hours of activity logged

MCPS on the Move, Phase II (October through December 2011):

- Goal/Objectives: Encourage lifelong exercise habits among MCPS employees. The contest emphasized consistency over athleticism and encouraged participants to learn simple ways to incorporate physical activity into their daily routines.
  - 3,193 participants registered for the challenge
  - 52,000 hours of activity were logged
  - 30 million calories burned
  - Cumulative BMI lost—241.6 points

Quit for Good Smoking Cessation Program

- Goal/Objective: Encourage participants to quit smoking and remain smoke-free by teaching behavioral skills necessary to live tobacco-free.
  - Two 8-week sessions have been held
  - 35 participants have completed the course
  - 13 confirmed quitting by the end of the 8-week class
  - 100 percent of the participants had made drastic changes and have cut back their smoking with preparations to quit by the end of the 8-week class

Walk this Way Wellness Challenge (March through May 2012)

- Goal/Objective: Encourage staff to increase their physical activity, have fun, and reach the end goal of walking 10,000 steps a day. The goal of 10,000 steps a day is enough activity to reduce your risk for disease and help you lead a longer, healthier life.
  - 4,833 participants registered
  - 445 teams registered
  - Step counters and online journals were provided for all registered participants

(e) whether the agency has reviewed and/or incorporated national standards and best practices (such as those from the National Council on Quality Assurance);

MCPS has reviewed the accreditation requirements from the National Council on Quality Assurance. To date, no private non-health care employer wellness programs have received accreditation. NCQA has advised that 17 health care-related organizations have received accreditation.

(f) the estimated annual cost of employee wellness programs and the source of funding:

Through the contracts with our medical plan vendors, MCPS utilizes $50,000 annually for plan-sponsored activities. Additionally, the MCPS Benefit Trust provides approximately $300,000 annually for wellness campaigns and supplemental spotlight program expenses.

My staff and I are prepared to work with councilmembers and members of the Board of Education to provide additional clarification as needed.

If you have questions, please contact Mrs. Susanne G. DeGraba, chief financial officer, at 301-279-7265.

Sincerely,

Joshua P. Starr, Ed.D.
Superintendent of Schools

JPS:LAB:sgd

Copy to:
Members of the County Council
Members of the Board of Education
Mr. Bowers
Mr. Edwards
Mrs. DeGraba
Mr. Johnstone

Montgomery Co. Public Schools 9/13/2011

Presentation to Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs

Employee and Retiree Service Center

Mission Statement

The Employee and Retiree Service Center's mission is to provide one place for employees, retirees, their families and MCPS partners to transact employment-related business.

Vision Statement

The Employee and Retiree Service Center will provide accurate and proactive service to all customers. We are committed to administering our employee programs fairly and consistently and we will ensure that active and retired MCPS employees and their families understand these programs. We will develop and implement creative and innovative solutions to challenging issues.

(13)

Governance Structure

Montgomery County Board of Education

↓

Superintendent of Schools

↓

Chief Operating Officer

MCPS Population

Total Population

Employees – 22,218

Retirees – 10,184

Total Population Covered Under Benefit Plans

Employees – 19,192

Retirees – 7,775

Union Representation

MCEA –	12,222
SEIU –	9,147
MCAAP -	677
MCBOA –	96
Union Excluded -	76

(5)

Health & Prescription Plans

Medical Plans:

- BlueChoice POS – In-network and Out-of-network plan
- BlueChoice HMO – HMO plan
- UnitedHealthcare POS – In-network and Out-of-network plan
- UnitedHealthcare HMO – HMO plan
- Kaiser Permanente HMO – HMO plan

Prescription Plan:

- Caremark – 3 tiered plan (generic, preferred & non-preferred brand copays).
- Retail and mail order delivery

Wellness & Disease Management Programs

Wellness Programs

Well Aware: MCPS employer based wellness program
Fitness & nutrition based competitions
Numerous measurable outcomes including:

- BMI measurement
- Activity measurements and journaling
- Weight loss
- Food journaling

Medical Plans: Medical plan sponsored wellness programs
Multiple health/wellness/fitness plans
Measureable outcomes limited

Well Aware

Program Overview:

- Enter activity into online platform. (Maximum 60 minutes per day/activity. Minimum 3 times per week food journaling).
- Form teams of 3-9 (MCPS on the Move).
- Answer quizzes corresponding to nutrition based reading material (Fuel the Move).

Program Outcomes:

- 5,354 MCPS accounts registered with Fitness Journal.
- 103,358 hours of activity logged.
- Total weight loss of 16,490 pounds.
- Average starting BMI: 26.2. Average ending BMI: 22.4 (taking the group from the obese category into the normal weight category).
- 57,715,885 calories burned .
- Food Journal entries: 8834

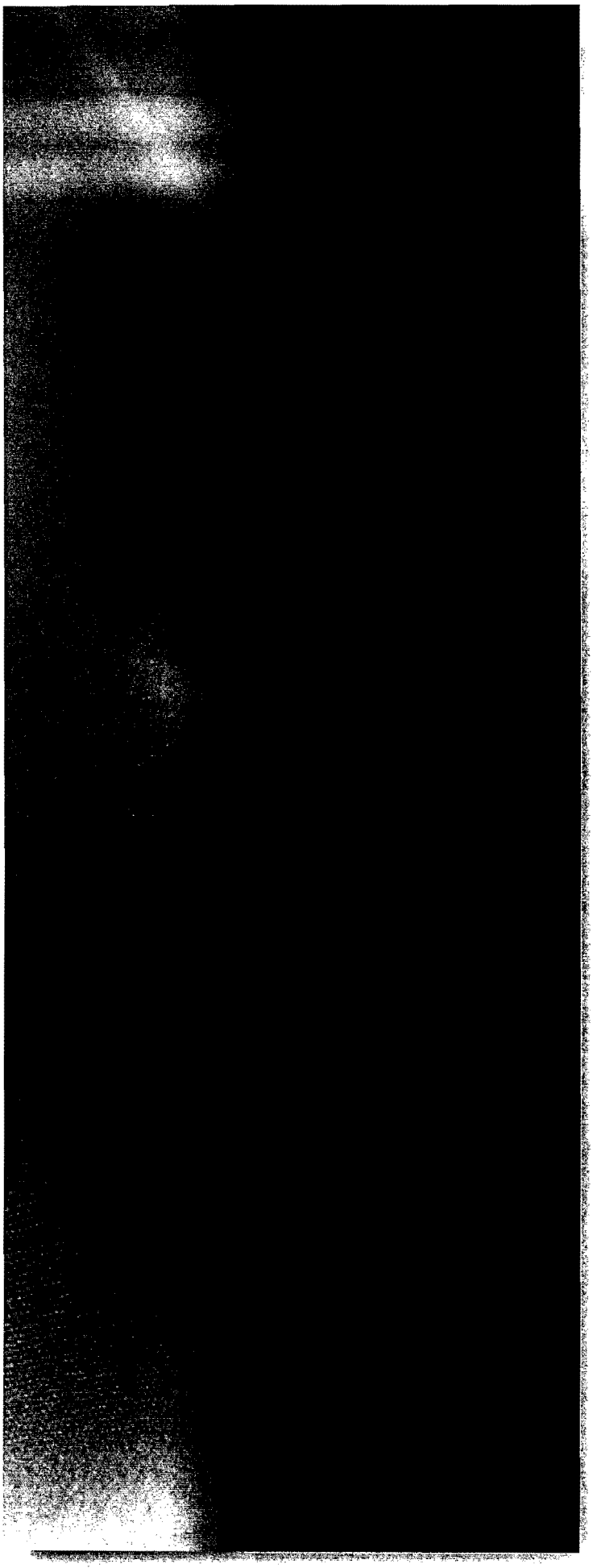
Disease Management

Disease management programs with all medical plans and Caremark (prescription plan) including:

- Chronic disease management (asthma, COPB, CHF, diabetes)
- Case management for ongoing treatment issues
- Education and awareness programs

Numerous measurable outcomes including:

- Participation statistics
- Compliance statistics (Rx use, care coordination, etc.)
- Employee contact with plan/nurse-line/DM program



InforMed
Health Care Solutions™

Health Plan Data Study

Montgomery County Agencies including:

Montgomery County Government

Montgomery County Public Schools

Montgomery College

Washington Suburban Sanitary Commission

MD-National Capital Park and Planning Commission

January 2010
through
December 2012

Prepared for:

Montgomery County Council

20

Table of Contents

Introduction

This Montgomery County Council (MCC) Health Plan report is the combined summary of the 2012 InforMed Health Plan data study performed for and in concert with the Montgomery County Council (MCC). Each MCC organization has their own report that includes individual organization information and more detail than this summary.

For the first time, data from all Montgomery County Health Plans and most of various employee Health Plans/Insurers is aggregated in a MCC unique Data Warehouse. This Data Warehouse is operated by InforMed, an Annapolis based health Technology Company. The MCC contents of the Data Warehouse belong to MCC for their private use.

This study was completed in close coordination with the advisory contract between MCC and Wes Girling.

Executive Summary

- **Total health plan expense (Medical and Prescription) for Year 2 was $447 million – which equates to a 5.48% cost increase as compared to Year 1. Contributing factors included:**
  - 4.96% increase in medical claims costs
  - 6.60% increase in prescription claims costs
  - 2.31% increase in covered members

- **Total health plan expense per employee per year (PEPY) was $10,995.56 for Year 2 compared to $10,453.29 for the previous year, a 5.19% increase**

- **Total health plan expense for Year 2 per member per year (PMPY) was $4,935.72 an increase of 3.12% as compared to Year 1**

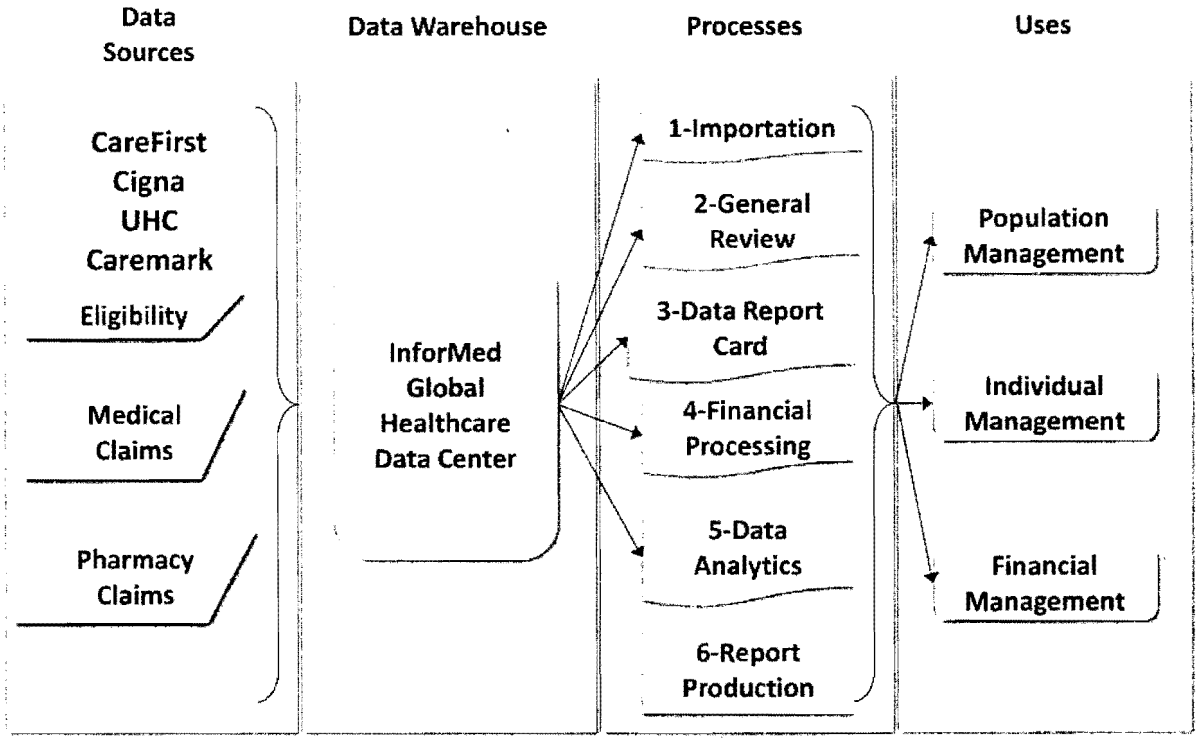
Observations and Recommendations

- **Observation 1**-Establishing the Data Warehouse and generating initial supports is done. And, this process can be ongoing and stand alone. It is not connected to any ongoing processes unless selected by MCC.
- **Observation 2 (Financial Management)**-
  - ✓ The Per Member Per Month (PMPM) increase is below national trends, but greater than InforMed's book of business during the study period
  - ✓ Plan cost PMPM is within reasonable ranges for medical claims but over twice what we normally see for prescription plans
  - ✓ Large claimants (over $50,000 annually) are increasing disproportionately which is expected in a generally closed population
  - ✓ Multiple Carriers seem to be working successfully for MCC's agencies, aggregation of data will allow for the plan to be viewed as a single plan which can provide advantages
  - ✓ Prescription costs reflect a significantly higher expense than normally observed. Generally, prescriptions costs run 20-25% of the medical expense, however, for MCC the Year 2 Rx cost is 47.26% of medical.

- **Observation 3 (Population Management)-**
  - ✓ The group is generally a stable somewhat "closed" group with numerous long term (lifetime) employees who will be with the plan throughout their career and retirement.
  - ✓ The high risk percentage of the population is above InforMed norms, and increasing during the study period. This will lead to higher costs.
  - ✓ Evidence Based Adherence across key conditions is below expected InforMed book of business ranges and presents opportunities to develop wellness initiatives and review plan design to incentivize members to be compliant.
- **Observation 4 (Individual Management)-**
  - ✓ Individuals are currently managed within individual agency plans and vendors probably using different approaches and methodology. Traditional management includes: a) utilization management, b) case management, c) disease management, d) wellness management.
  - ✓ Tools are in place within the Data Warehouse that can be used and accessed by and for individuals if desired by MCC and the agencies.
- **Recommendation 1 (Long Term Challenge)**-Managing a large plan such as MCC is long term and demands strategic thought and action. It is not a year to year challenge, but must be managed with a long term 5-10 year view.
- **Recommendation 2 (Maryland unique "waiver state")**-The Medicare waiver and Maryland's hospital "all payer" status and potential shifts in the status directly affects MCC's plan cost over the next few years and will need to be factored into strategies. The one specific outcome from the waiver issue is turbulence within the market. Another potential outcome is several years of disproportionate hospital cost increases on the part of commercial customers such as Montgomery County as Hospitals try to recoup their revenue reductions from Medicare.
- **Recommendation 3 (MCC's local population)**-lends itself to unique strategies in close concert with local Health Systems. There are three very specific opportunities here:
  - ✓ **Hospital utilization** is somewhat concentrated in key hospitals. This lends itself to developing strategies in concert with willing Health Systems as they develop responses to the Accountable Care Act.
  - ✓ **Large/prestigious academic medical centers** will play a key role in the MCC plans over the next 5+ years. It is important to capitalize on this unique Maryland asset.
  - ✓ **Physicians (High Volume/High Performing)** MCC primary care Physicians were observed in the study. These Doctors can play a key role in long term successful strategies of the Plan.
- **Recommendation 4 (MCC impact on Local Health Systems)**- MCC is sufficiently large in a concentrated geography to directly impact their local Health Systems. As strategies are developed, implemented and managed, this impact should be included in them. There will be times when what works for MCC can be damaging to local Health Systems. By the same token, local Health Systems can take actions that are damaging to MCC and its Plans. A careful balance is recommended.

Data Summary

The process InforMed uses to build a client specific (MCC) Data Warehouse is diagrammed here and outlined below.



The MCC Data Warehouse was built for this pilot study through the following process:

1. 75 separate files of eligibility, medical and pharmacy claims were provided by the MCC Health Plans, Insurance Carriers, etc. to InforMed for processing. These plans include:
    a. CareFirst
    b. Cigna
    c. United Health Care
2. These data were:
    a. Imported into the MCC/InforMed Data Warehouse
    b. Reviewed for accuracy, completeness and reconciliation with control totals provided by MCC
    c. Processed through the Informed report card engine to assure reasonableness of content
    d. Processed through the financial engine to produce financial reports combined into MCC wide reports while preserving detail access ability
    e. Processed through the analytics engine to support population management in several key areas
3. This study was then prepared based on the Data Warehouse content

This data study provides an analysis of the aggregated health plan information, including Montgomery County Government, Montgomery County Public Schools, Montgomery College, Washington Suburban Sanitary

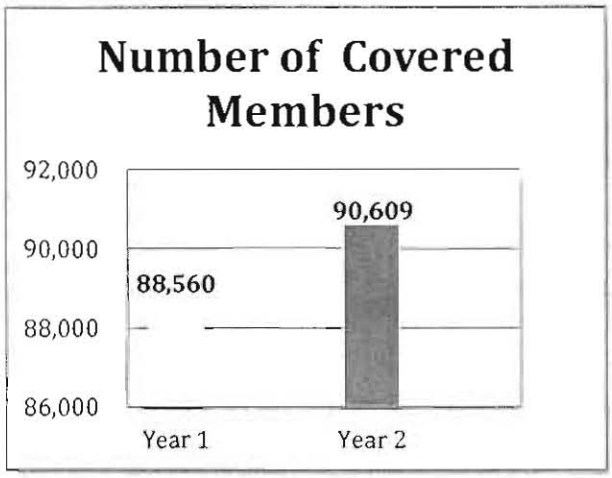
Commission and MD National Capital Park and Planning Commission, for, *the Montgomery County Council* . The information included is based on: eligibility, medical, and pharmacy claims data for the all members (employees and dependents) during the reporting period of: *July 2010 through June 2012.* All reports are based on paid claims date. The tables below define the reporting periods of Year 1 and Year 2 used throughout this analysis, describe the data sources used by InforMed, and provide a financial reconciliation for the time frame specified:

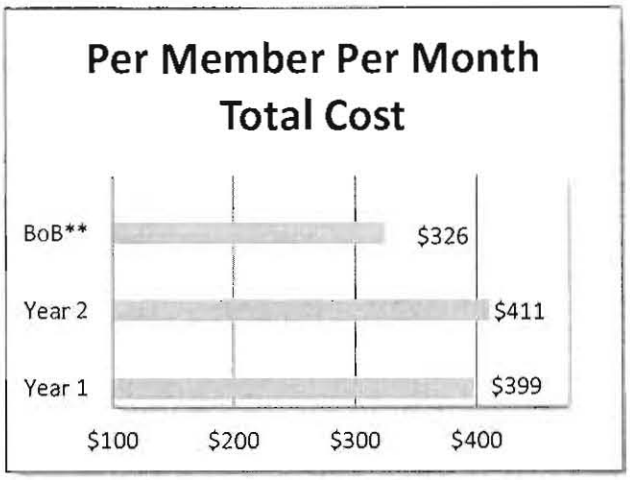
Year 1	06/01/2010-05/31/2011
Year 2	06/01/2011-05/31/2012

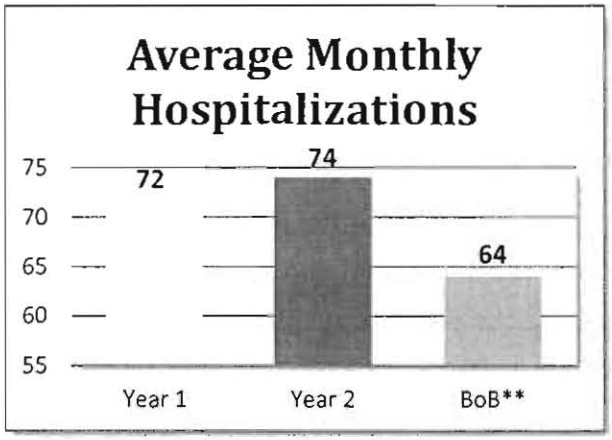
	Source	Begin Paid Date	End Paid Date
Eligibility	CareFirst, United Healthcare & Cigna	6/1/2010	5/31/2012
Medical Claims	CareFirst, United Healthcare & Cigna	6/1/2010	5/31/2012
Pharmacy	Caremark	6/1/2010	5/31/2012

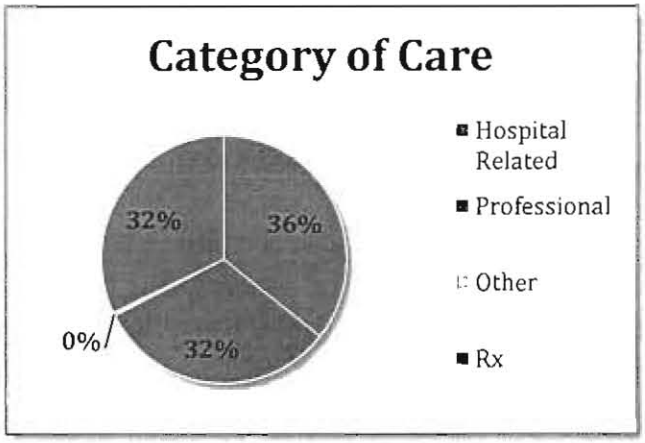
	Year 1	Year 2
Medical Claims	$ 289,297,186	$ 303,672,995
Pharmacy Claims	$ 134,631,542	$ 143,516,374
Total Claims	**$ 423,928,729**	**$ 447,189,369**

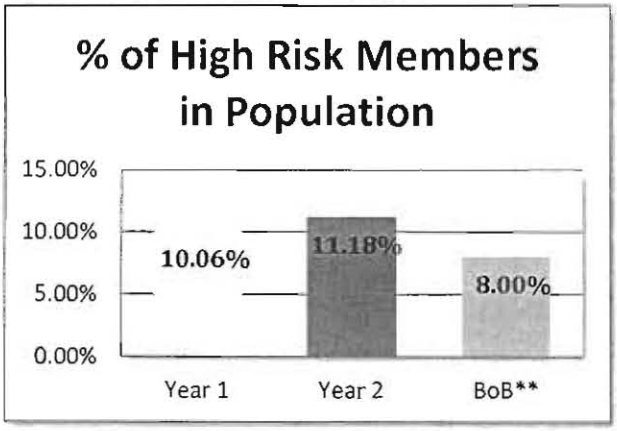
Key Indicators

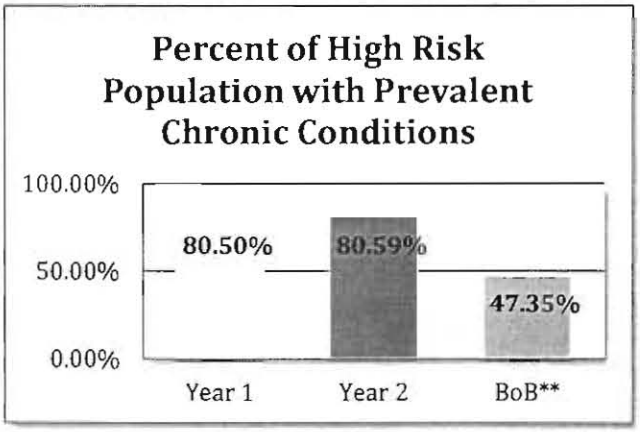












****BoB – InforMed's Book of Business encompassing over 2 million individuals for whom health data is collected and loaded into InforMed's data warehouse**

Population Future Trend Factors						
	Year 1		Year 2		BoB**	
1. Predicted Trends	Total	% of Part	Total	% of Part	Total	% of Part
a. Priority Members with specific conditions	181	0.20%	153	0.17%		0.001%
b. High Risk Members from Risk Stratification	8911	10.06%	10128	11.18%		8.00%
c. Avg Monthly Hospital Admits	72	0.08%	74	0.08%	64	0.07%
d. Predictive Modeling anticipated members costing >$50K	175	0.20%	195	0.22%	n/a	
e. % of population predicted to spend > $10,000 in next 12 months	10,006	11.30%	11,094	12.24%	n/a	
f. Prevalent Chronic Conditions of those expected to spend over $10,000 Diabetes; Hypertension; Heart Disease	8055	80.50%	8941	80.59%	n/a	47.35%
g. High Cost Cancers	85	0.10%	72	0.08%	2797	0.13%

Historic/Paid Financial Activity			
2. Historic Trending	Year 1	Year 2	BoB**
Employees	40,555	40,670	1,089,672
Members	88,560	90,609	2,146,614
Medical PMPM	$272	$279	$265
RX PMPM	$127	$132	$61
Total	$399	$411	$326
Age/Gender	1.33	1.33	1.27
CMI (Case Mix Index)	2.31	2.24	1.51
3. Historic Category of Care PMPM	Year 1	Year 2	BoB**
Hospital Related	$145	$147	$162
Professional	$124	$131	$102
Other	$4	$2	$1
Rx	$127	$132	$61
Total	$399	$411	$326
4. Historic Claimants over $10,000	Year 1	Year 2	BoB**
Percent of Total Claimants with Large Claims	6%	7%	4%
% of total paid	57.07%	57.76%	
Largest claimant	$1,419,746	$1,297,679	
Avg cost per claimant	$29,016	$28,797	

** InforMed's Book of Business reflects over 2 million individual members

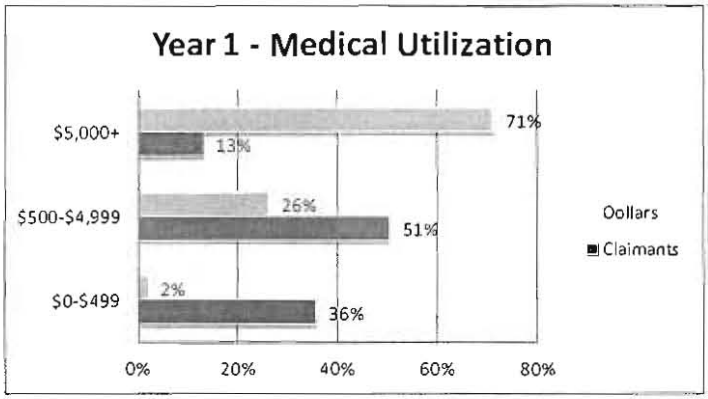
*Note: Values for BaB** reflects Quarter 2 2012*
NA= Not measured in the previous plan year or not an applicable measurement

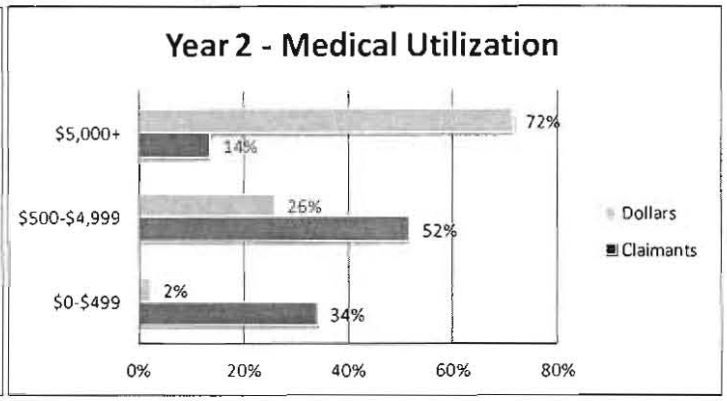
Key Indicator Observations

- Average monthly cost per member increased by 3.12%
- Number of members incurring large claims grew by 7%
- Members with priority health risks (new cancers) decreased by 0.02%
- Hospital admissions are occurring more frequently
- A slightly larger portion of the population that will incur large claims are suffering with prevalent chronic conditions

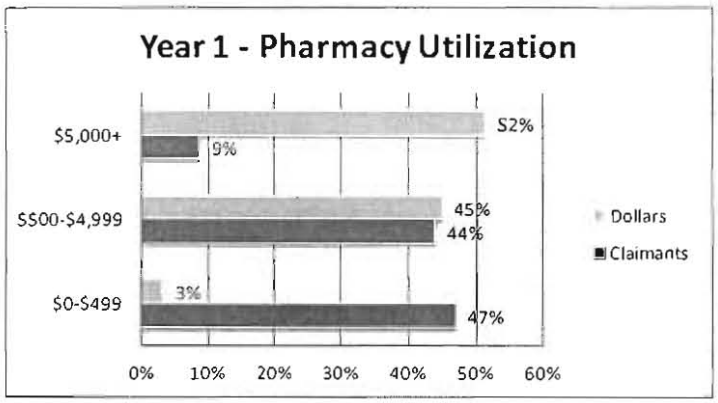
Health Plan Utilization by Claims Cost

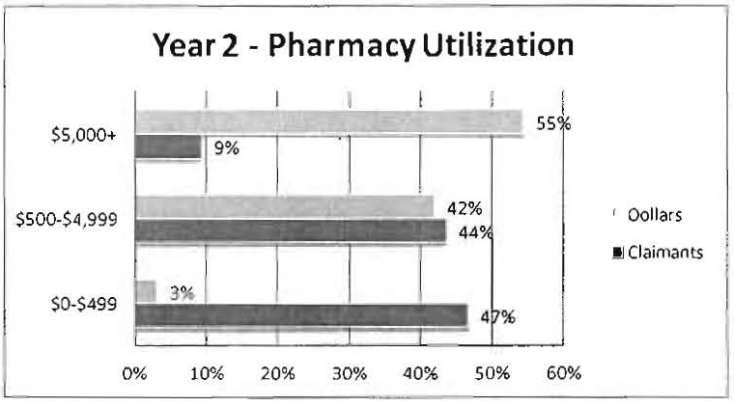
Typically, 10% of a population spends approximately 65% of the health care dollars. The illustrations below are similar to what we see across our book of business.





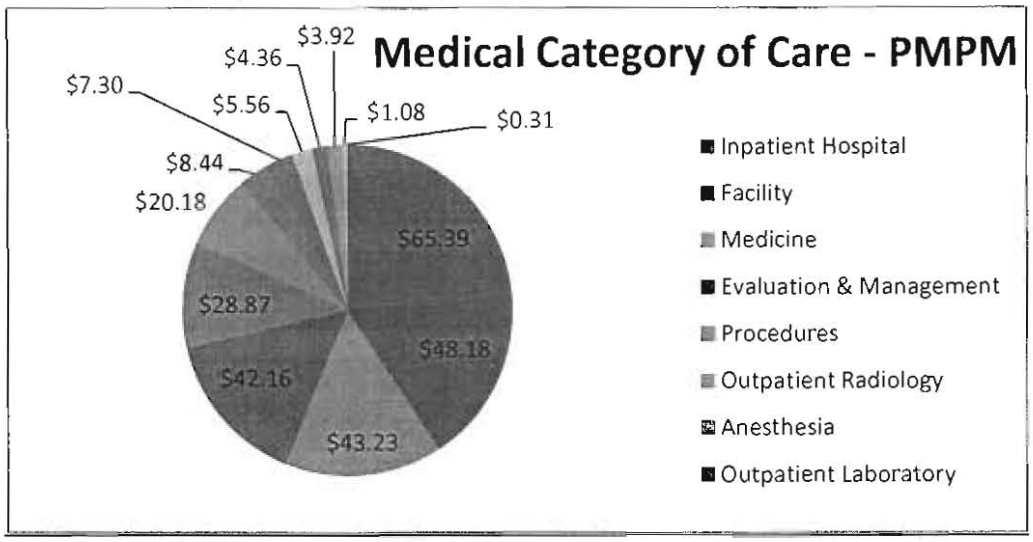
From Year 1 to Year 2, the number of the health plan's covered members did not shift in any significant way with regard to the medical claims spend. The charts above show that a small portion of the population spends the majority of the dollars.





The pharmacy benefit utilization is similar to that of the medical without any radical shifts, but it should be noted that those claimants spending between $500 and $4,999 in rx increased.

Category of Care



Through May 2012, the top three Categories of Care, based on PMPM paid, are:

- Inpatient Hospital
- Facility
- Medicine

This follows the normal spread we typically see in similar populations, with the slight exception of the **Medicine** falling into the top 3. Normally, we expect to see **Procedures** as the third greatest Category of Care spend.

Per Member Per Month Year over Year Comparison Medical CoC				
	Year 1 6/1/2010 - 5/31/2011	Year 2 6/1/2011 - 5/31/2012	Variance	InforMed's BoB
Inpatient Hospital	$ 65.05	$ 65.39	1%	$ 73.87
Facility	$ 45.94	$ 48.18	5%	$ 60.09
Medicine	$ 39.36	$ 43.23	10%	$ 23.22
Evaluation & Management	$ 39.63	$ 42.16	6%	$ 27.24
Procedures	$ 28.98	$ 28.87	0%	$ 20.53
Outpatient Radiology	$ 20.06	$ 20.18	1%	$ 16.26
Anesthesia	$ 8.37	$ 8.44	1%	$ 5.38
Outpatient Laboratory	$ 6.61	$ 7.30	10%	$ 6.37
Other Outpatient Services	$ 5.39	$ 5.56	3%	$ 3.51
Emergency Room	$ 4.86	$ 4.36	-10%	$ 7.58
Outpatient Pathology	$ 4.19	$ 3.92	-6%	$ 2.56
Ambulance	$ 1.23	$ 1.08	-12%	$ 1.89
Undefined Services	$ 0.51	$ 0.31	-39%	$ 1.54
Other	$ 2.04	$ 0.31	-85%	n/a
	$ 272.22	**$ 279.29**	**2.60%**	n/a

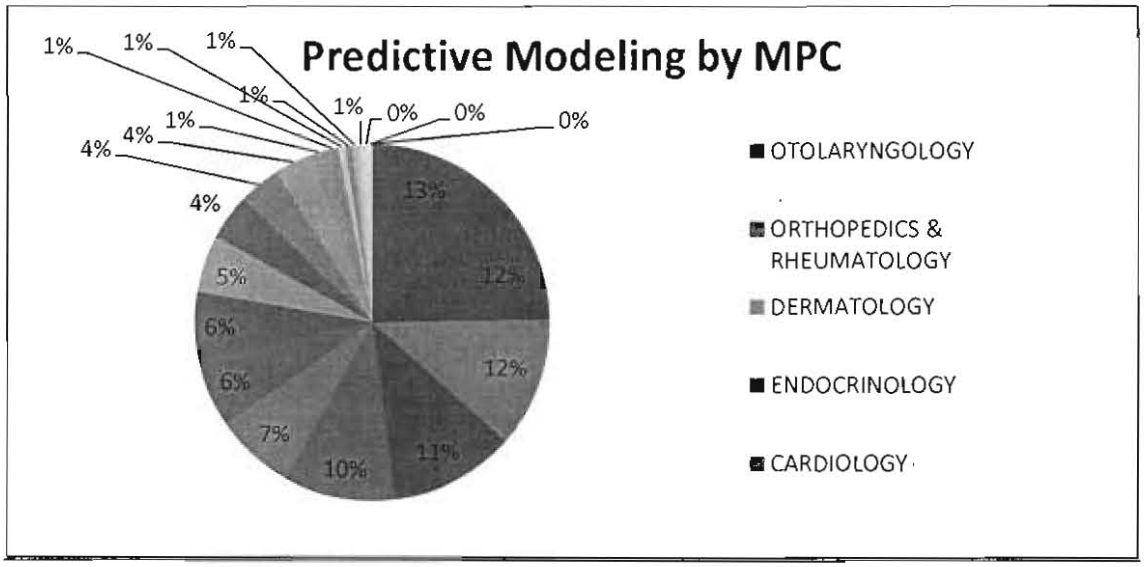
A review of the Category of Care trend from Year 1 as compared to Year 2 demonstrates the following observations:

- A significant increase in **Medicine and Outpatient Lab** services
- A notable increase in PMPM cost for **Facility and Evaluation & Management**
- A stable, but slightly increasing PMPM for Medical Claim Categories of Care reflecting a total variance of 2.60%

These observations suggest the need for a deeper dive into the **Medicine and Outpatient Lab Services.** Across our book of business, when the PMPM for these services runs high, there tends to be a correlation with an increase in the treatment of cancer and other complex health issues.

Predictive Modeling

Equally telling, InforMed's Predictive Modeling application provides a 12 month projection based on the current population's diagnosis and utilization patterns since January 2010 using Major Practice Categories (MPC). The Predictive Modeling results are as follows for the population as of **Quarter 1 2012**:



The predicted medical and prescription claims spend for the current population over the next 12 months is between $457.5 and $594.1 million dollars.*

***The Annual High and Low numbers are meant to be a guide to identify prospective patient consumption of health care resources and should not be used in a way to suggest that the claimants will not consume more than the dollar amount described, but more as a statistical reference point.**

The table below reflects the portion of predicted spend to fall in each of the Major Practice Categories for the entire population:

Predictive Modeling by Major Practice Category for All Claims in the Next 12 Months	
MPC	% of Total
OTOLARYNGOLOGY	13.00%
ORTHOPEDICS & RHEUMATOLOGY	12.00%
DERMATOLOGY	12.00%
ENDOCRINOLOGY	11.00%
CARDIOLOGY	10.00%
OPHTHALMOLOGY	7.00%
GASTROENTEROLOGY	6.00%
PSYCHIATRY	6.00%
PULMONOLOGY	5.00%
UROLOGY	4.00%
GYNECOLOGY	4.00%
NEUROLOGY	4.00%
INFECTIOUS DISEASES	1.00%
HEMATOLOGY	1.00%
LATE EFFECTS, ENVIRONMENTAL TRAUMA AND POISONINGS	1.00%
NEPHROLOGY	1.00%
OBSTETRICS	1.00%
HEPATOLOGY	1.00%
CHEMICAL DEPENDENCY	0.00%
NEONATOLOGY	0.00%
RX	0.00%
NO KNOWN CONDITIONS	0.00%

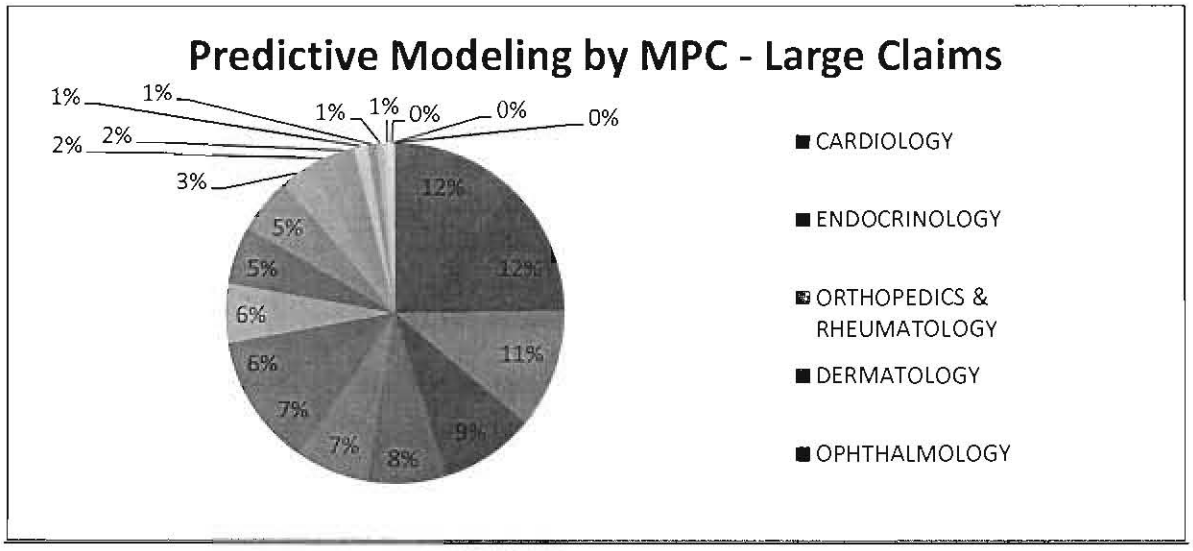
The top three Major Practice Categories as of Quarter 1, 2012 are:

- **Otolaryngology (Ear, Nose & Throat)**
- **Orthopedics & Rheumatology**
- **Dermatology**

Traditionally, we would expect to see Endocrinology and Cardiology predicting larger spends than Otolaryngology and Dermatology in similar populations.

It is important to review the Predictive Modeling for those members predicted to have large claims costs in the next 12 months, as well as those previously identified in the Priority and High Risk categories.

The Predictive Modeling results for those members predicted to spend over $10,000 in the next 12 months is as follows:



The predicted medical and prescription claims spend for members in the current population who will spend over $10,000 over the next 12 months is between $190.9 and $261.6 million dollars.* This represents approximately 43% of the expected total spend and 12.24% of the covered members.

The table below reflects the portion of predicted spend to fall in each of the Major Practice Categories for the members predicted to incur large claims:

Predictive Modeling by Major Practice Category for Claims over $10,000	
MPC	% of Total
CARDIOLOGY	12.00%
ENDOCRINOLOGY	12.00%
ORTHOPEDICS & RHEUMATOLOGY	11.00%
DERMATOLOGY	9.00%
OPHTHALMOLOGY	8.00%
OTOLARYNGOLOGY	7.00%
GASTROENTEROLOGY	7.00%
NEUROLOGY	6.00%
PULMONOLOGY	6.00%
PSYCHIATRY	5.00%
UROLOGY	5.00%
GYNECOLOGY	3.00%
HEMATOLOGY	2.00%
NEPHROLOGY	2.00%
INFECTIOUS DISEASES	1.00%
HEPATOLOGY	1.00%
AND POISONINGS	1.00%
CHEMICAL DEPENDENCY	1.00%
OBSTETRICS	0.00%
NEONATOLOGY	0.00%
RX	0.00%

For those predicted to spend over $10,000 in the next 12 months, the top Major Practice Categories include:

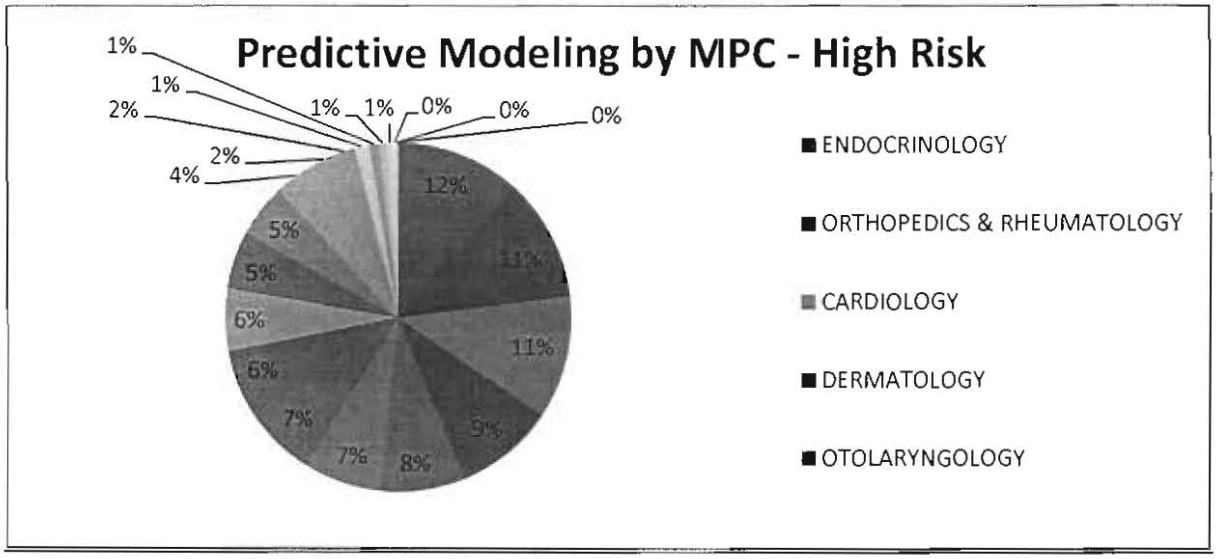
- **Cardiology**
- **Endocrinology**
- **Orthopedics & Rheumatology**

Within those Major Practice Categories, the most prevalent conditions are:

- **Joint Degeneration (48.96%)**
- **Hypertension (44.41%)**
- **Hyperlipidemia (42.93%)**
- **Diabetes (33.33%)**

This points to a concerning trend of co-morbidities across multiple Major Practice Categories, as at least **80%** of your high cost population is predicted to spend over $10,000 involving a **Cardiology, Endocrinology and Orthopedics & Rheumatology** health condition or event in the next 12 months.

The Predictive Modeling results for those members in your current Priority and High Risk categories are as follows:



The predicted medical and prescription claims spend for members falling in Priority and High Risk Levels over the next 12 months is between $152.7 million and $208.5 million dollars.* This represents 11.18% of the population expected to spend approximately 34% of the overall dollars.

The table below reflects the portion of predicted spend to fall in each of the Major Practice Categories for the members who are high risk:

Predictive Modeling by Major Practice Category for High Risk Claimants	
MPC	% of Total
ENDOCRINOLOGY	12.00%
ORTHOPEDICS & RHEUMATOLOGY	11.00%
CARDIOLOGY	11.00%
DERMATOLOGY	9.00%
OTOLARYNGOLOGY	8.00%
OPHTHALMOLOGY	7.00%
GASTROENTEROLOGY	7.00%
PSYCHIATRY	6.00%
PULMONOLOGY	6.00%
NEUROLOGY	5.00%
UROLOGY	5.00%
GYNECOLOGY	4.00%
HEMATOLOGY	2.00%
NEPHROLOGY	2.00%
INFECTIOUS DISEASES	1.00%
HEPATOLOGY	1.00%
LATE EFFECTS, ENVIRONMENTAL TRAUMA AND POISONINGS	1.00%
CHEMICAL DEPENDENCY	1.00%
OBSTETRICS	0.00%
NEONATOLOGY	0.00%
RX	0.00%

Similar to those predicted to spend over $10,000 the top Major Practice Categories for those who fall into the Priority and High Risk categories include:

- **Endocrinology**
- **Orthopedics & Rheumatology**
- **Cardiology**

Risk Stratification

It is most useful to focus on the high risk members of the plan, as they are right now, looking to future costs and needed actions. Your risk stratification for first quarter 2012 is as follows.

Stratification Level	Montgomery County Agencies Average Risk Score	Number of Members	% of total Membership	InforMed BoB Benchmark Average Risk Score	% of total Membership
Priority	65.59	153	0%	73.48	0%
High	41.62	9,975	11%	48.94	8%
Moderate	10.67	13,443	15%	12.41	12%
Low	1.36	23,977	26%	1.50	22%
No known risk	0.00	43,348	48%	0.00	58%
Participants	**6.62**	90,896	**100%**	**5.83**	**100%**

The current Risk Stratification of 11% High Risk is slightly higher than what we see in similar populations, which is typically 4-8% High Risk.

Risk Scores and Levels are determined by information for individual members made available through claims data. The actual score and risk level are defined by information in a number of categories that claims data reveal including: Utilization Patterns, Retrospective Cost, Conditions/Diagnoses, Compliance with Evidence Based Medicine and Predicted Costs.

It is often useful as well to review how the population is moving within Risk Stratification levels. Your Risk Stratification for Quarter 1 2011 vs. Quarter 1 2012 is as follows:

Change in Population Risk Between Year 1 and Year 2		
Stratification Level	**Stratification**	**Members**
Priority	0%	-25
High	1%	1245
Moderate	1%	1080
Low	0%	972
No known risk	-3%	-2454

A review of Quarter 1 2011 to Quarter 1 2012, shows a slight **increase in the average risk scores and the number of participants categorized as High, Moderate and Low priority.**

Evidence Based Medicine Adherence

Overall, adherence to evidence based medicine standards of care is 53% for the health plan's population. EBM Adherence for some key specific preventative care and prevalent chronic conditions is as follows:

Evidence Based Medicine Standard	Number of Members*	Adherence	BoB Adherence
Prenatal Care (National Standard)	756	93%	91%
Chronic Obstructive Pulmonary Disease	945	77%	75%
Congestive Heart Failure	716	73%	78%
Breast Cancer Screening (National Standard)	21,138	67%	70%
Cervical Cancer Screening (National Standard)	27,199	61%	74%
Diabetes Mellitus	8,700	60%	65%
Hyperlipidemia	17,060	60%	64%
Hypertension	22,019	51%	52%
Diabetes Care (National Standard)	6,236	41%	50%
Colorectal Cancer Screening (National Standard)	31,425	33%	38%

**Number of members reflects the individuals for whom the specific standard is applicable based on age, gender, health conditions, diagnoses, etc.*

Adherence for this population is better than benchmarks in the following areas:

- **Chronic Obstructive Pulmonary Disease**
- **Prenatal Care**

The highlighted standards above show areas where adherence is significantly below benchmarks (5% or greater):

- **Cervical Cancer Screenings**
- **Diabetes Care**
- **Congestive Heart Failure**
- **Colorectal Cancer Screening**

The lower adherence in CHF and Diabetes care correlates with the expected large spends in **Cardiology** and **Endocrinology**. Adherence with standards of care is key in driving down costs.

Resolution No.: 17-373
Introduced: March 20, 2012
Adopted: March 27, 2012

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: County Council

SUBJECT: Implementation of Recommendations from the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs

Background

1. On July 19, 2011, the County Council appointed the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs. The membership included designees from the County and bi-County agencies, the bargaining units for these agencies, and public members. The Council asked the Task Force to address two major issues related to the provision of health care benefits to employees and retirees across the agencies: (1) employee wellness and disease prevention programs, and (2) consolidation of plan design and administration.

2. The Task Force presented its report to the Council on December 6, 2011. The Task Force told the Council that County and bi-County agencies provide health care benefits to over 100,000 enrolled members when one counts employees, retirees, and dependents. The Task Force urged the Council to begin reviewing information on the total number of lives covered across all agencies and noted that this buying power should be able to be leveraged when procuring health care, both in terms of price and requiring improved quality and health outcomes.

3. The Task Force reported that 95% of the total health care costs for the agencies is for payment of claims. Generally, 80% of an organization's health care dollars are spent on 20% of the individuals covered and over 80% of health care dollars are spent on people with chronic conditions.

4. The Task Force provided the Council with information on organizations that have found ways to improve employee health and reduce the projected increase in the cost of health care. These include King County (Washington), Johnson & Johnson, Highmark Healthcare and Boeing. The Task Force also informed the Council about Maryland's P-3 Program that helped reduce the cost of diabetes care for participating employers. The Task Force provided information on consortiums and consolidated multi-agency health insurance programs in Monterey County (California), Baltimore County (Maryland), Tompkins County (New York), and the Employee Benefits Consortium of Ohio.

5. The Task Force made the following overarching recommendations:

   - Implement a process to collect and analyze aggregate health care claims data for all employees, retirees, and dependents covered by all County and bi-County agencies' health insurance plans. This population currently totals over 100,000 enrolled members. Establish a focal point for analysis of health care costs to understand aggregate cost trends and cost drivers.
   - Develop and promote a workplace culture that values employee wellness and encourages the partnering of employees, employers, and health care providers to improve health outcomes. Employees should take an active role in their health by partnering with their employer in managing and monitoring their health outcomes.
   - Implement wellness and disease management programs based on best-practices, to include outcome measures related to better management of chronic conditions. Enhance current disease management programs to increase participation, make sure they are based on best practices, and have regular reporting on outcomes in order to improve the health of employees, spouses/partners, and dependents with one or more chronic diseases and reduce the number that develop chronic diseases in the future.
   - Expand the conversation about disease management to include doctors, hospitals, and pharmacies. Explore value-based purchasing/contracting to expand the availability of care management models and reward outcomes.
   - Recognize that there are no simple solutions to bending the health care cost curve downward. Improvements will take time, may require upfront investment, and will likely be incremental.

   In addition, the Task Force offered specific recommendations regarding employee wellness and disease management programs. These include that each agency has a health and wellness workgroup consisting of represented and non-represented employees and employer representatives, each agency has an individual with primary responsibility for wellness programs, and a pilot program that uses value-based contracting and focuses on wellness and aggressive disease management. The Task Force also identified criteria for examining consolidation options and issues for further study that should be resolved before a specific consolidation proposal is considered.

6. The Health and Human Services (HHS) Committee and Government Operations and Fiscal Policy (GO) Committee held a joint worksession on the Task Force Report on February 9, 2012. The joint Committee agreed on a set of first steps to move forward with the implementation of the Task Force recommendations. The joint Committee further agreed that these recommendations should be forwarded to the full Council and, if approved, sent to the County and bi-County agencies both to obtain additional information on current programs and to provide guidance on the Council's expectations regarding improving the health and wellness of County and bi-County employees, retirees, and their dependents.

Action

The County Council for Montgomery County, Maryland, approves the following action:

As stated in Resolution 17-107, which established the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs, access to affordable health care for all employees and all residents of Montgomery County is a primary goal of the Council.

The Council strives to improve the health of all residents of Montgomery County and believes that health care plans should not just focus on how an employee's health care costs are paid for but how health plans and programs can be used to improve the health and well-being of employees, retirees, and dependents. Experts have told the Council that the cost of providing health care can also be reduced by increasing wellness, which will decrease the dollars needed for treatment and medications.

The Council endorses the following as first steps to implement the recommendations of the Task Force to develop and/or enhance outcomes-based employee wellness and disease management programs and to collect and analyze cross-agency data on major health issues, health trends, and costs.

1. The Council should request and receive information from each agency on current resources that are allocated to employee wellness and health promotion programs including:
   (a) whether the agency has a person who has primary responsibility for developing and implementing wellness programs;
   (b) whether the agency has an employee-employer health and wellness committee that meets regularly;
   (c) how often the agency communicates with employees and retirees about wellness opportunities and how this information is provided (electronically, by mail, etc.);
   (d) whether the agency's programs have goals and outcomes that are measured;
   (e) whether the agency has reviewed and/or incorporated national standards and best practices (such as those from the National Council on Quality Assurance); and,
   (f) the estimated annual cost of employee wellness programs and the source of funding.

2. As a part of the contracting process, the agencies should seek health plan providers that:
   (a) can provide specific strategies that address the top cost-drivers in health spending by the agencies;
   (b) use principles associated with patient-centered medical homes;
   (c) can provide data to the agencies that will allow for evaluation of health care outcomes for enrolled members;
   (d) include disease management programs that are based on best practices for patient support; and,
   (e) address how incentive payments might be used to improve outcomes.

3. The contracting process should allow health plan providers and other outside vendors an opportunity to bid on disease management programs.

4. As part of the contracting process, the agencies should also explore whether having a single provider for a specific type of health plan (such as point-of-service, preferred provider organization, health maintenance organization) for all the agencies would reduce costs across all the agencies while continuing to provide appropriate access to health care.

5. An executive-level report should be developed that provides information across all agencies on the major health issues for all enrolled members, top categories for spending on health claims, and trends that will show whether health risk measures are improving or declining. Council staff and Office of Legislative Oversight staff will work with the agencies to develop such a report. The report will be provided to the Council, County Executive, Board of Education, Planning Commission, College Board of Trustees, and WSSC Commissioners. Because the report will be a public document, data will be aggregated so as not to include protected information.

This is a correct copy of Council action.

Linda M. Lauer

Linda M. Lauer, Clerk of the Council