North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

North Carolina
State Health Plan

Strategic Plan
2014 – 20XX

May 20, 2014
DRAFT

For Discussion Purposes Only

Note: This document will serve as the foundation for the State Health Plan's strategic plan. Background, environmental scan conclusions and other supporting analyses will be included in the final version of the strategic plan.

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STRATEGIC PLAN GUIDING PRINCIPLES

The following guiding principles were used in developing the strategic priorities and measures of success for the SHP's strategic plan:

1. The State Health Plan's **Mission Statement** will serve as the primary guide in the development of a strategic plan.

   "Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being."

2. It is the intent of the BOT and SHP leadership team to ensure the **perspective of the member**, including experience and value, is factored into the strategic plan.
3. It is the intent of the BOT and SHP leadership team to support the development of benefit offerings that are **affordable** to state employees, retirees and their dependents and the State of North Carolina. Therefore the BOT and SHP leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the competitively priced offerings that **improve the health and well-being of its members**.
4. The BOT and SHP leadership team recognize the responsibility to ensure that members have **access to quality care** and that their **patient experience is positive**.
5. Given the Plan's responsibility to serve members across the state, the BOT and SHP leadership team recognize the need to develop benefit offerings and programs that **balance cost and access to quality care**.
6. There needs to continue to be a **sense of urgency** to ensure the SHP remains financially stable to fulfill the mission of improving the health and health care of its members. That said the BOT and SHP leadership team acknowledge that the ability to make operational changes requires time and resources. Therefore, it is prudent to have **a reasonable period of stabilization** to manage recent member and operational impacts and to have time to measure the results of recent changes. Continuous measurement and monitoring will be an integral part of the strategic planning process.
7. The BOT and SHP leadership team recognize the opportunity to develop benefit offerings and programs that will require longer time horizons to determine measurable results. Therefore, it is the intent of the BOT and SHP leadership team to **develop a balanced portfolio of both near and long term strategic initiatives**.
8. It is the intent of the BOT and SHP leadership team to effectively manage premiums that members are required to pay for coverage and for out of pocket health care expenses. The BOT and SHP leadership team **support the development of programs and benefit offerings that encourage healthy lifestyles** and the appropriate use of incentives and cost sharing as levers in influencing the use of healthcare services and improving the health of plan members. Ongoing communication and education will be critical.
9. The BOT and SHP leadership team acknowledge that there will be a dependency on the **support of the North Carolina General Assembly** to fund or operationally execute on the strategic plan. The BOT and SHP leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the SHP.
10. Given the dependency on 3rd party vendors and business partners, the SHP, working in the best interests of the SHP members and State of North Carolina, will take a **partnership approach** with these stakeholders in developing and executing on the strategic plan. This will include utilizing their areas of expertise and information to guide the decisions and actions of the BOT and SHP leadership team.
11. It is the intent of the BOT and SHP leadership team to act in a manner that is in **the best interests of all members** of the SHP and actively work toward **consensus** that will enable the fulfillment of the mission of the SHP.

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DRAFT SHP Strategic Plan
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MISSION

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VISION

Proposed Statement for Consideration

Our vision is to be a health plan that is a leader in North Carolina for partnering with organizations and individuals from across the state to provide access to cost-effective, quality health care and wellness programs on behalf of our membership.

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STRATEGIC PRIORITIES

Priority	What It Means	What We Will Do	Why It Is Important
Manage the health of the population	Population health management is a model for managing all aspects of member health from wellness to chronic disease with a focus both on engaging members in their health and improving the quality and coordination of care within the health care system. The goal is maintaining or improving the health of members and lowering medical claims cost for members and the Plan.	• Maintain or improve member health as appropriate including the support of members with chronic conditions • Engage healthcare providers in improving the quality and coordination of care • Promote a culture of wellness	51% of members have at least one chronic condition and account for 78% of claims expenditures. Duplication of services and the provision of services in higher cost settings significantly contribute to the cost of care. Better coordination of care and better health of the population can improve member's well-being and lower costs for both members and the Plan.
Improve member's experience	The member experience includes the relationship members have with the Plan including enrollment, access to information, benefit designs, and affordability of coverage; services and programs provided by the Plan and its vendor partners; and access to providers and quality care through effective relationships with the Plan's network providers. The Plan also seeks to foster and improve the direct relationship between the member and the provider.	• Improve communication with members about benefit design, enrollment, and eligibility to promote health literacy • Increase transparency of the cost of care and the quality of network providers • Provide reliable, quality services for enrollment, claims processing, and population health management • Address member concerns regarding Plan operations, benefit design, coverage, and costs • Develop partnerships and benefit designs that improve the member's experience with providers	Members who are informed and satisfied with service experience are more likely to engage with the Plan and participate in benefit designs and programs aimed at improving their health, leading to improved health and well-being for the member and lower health care costs for the both the Plan and the member.
Ensure a financially stable State Health Plan	The Plan must address the cost of healthcare, the delivery of healthcare, and the utilization of benefits in order to keep the Plan sustainable and ensure that costs do not exceed resources or result in the diminishment of benefits.	• Manage the cost of medical claims • Manage the cost of pharmacy claims with a specific focus on specialty pharmacy management • Encourage members to use benefits appropriately and to be informed consumers of medical services. • Develop programs focused on fraud, waste, abuse and overuse • Collaborate with the General Assembly and Office of State Budget and Management to help ensure predictable funding for health benefits	Financial stability and management of costs protect the State and members from large premium increases. Maintaining a strong reserve balance enables the Plan to invest in initiatives to improve health and experience while managing future cost increases. The Plan's expense trend has been at or below medical CPI for the last four fiscal years, and the Plan holds reserves equal to approximately 16 weeks of projected Plan spending. Recent experience has allowed the Plan to offer more options and enhanced benefits for 2014.

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STRATEGIC INITIATIVES

Priority	Initiative	What It Means	What We Will Do	Why It Is Important

Manage the health of the population	Maximize Patient Centered Medical Home (PCMH) Effectiveness	The Patient Centered Medical Home model is a way of organizing primary care that emphasizes care coordination (including appropriate setting) and communication to transform primary care to include population health management. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care	• Support providers in serving as PCMHs through data analytics, care management, and/or enhanced payment through the Population Health Management Services vendor to designated PCMH groups.
			• Groups will be identified for support/partnership (directly or through a vendor partner) based on willingness to engage and opportunity for improved patient outcomes based on review of available clinical measures.
			• Develop metrics and benchmarks to demonstrate the impact of improved care and coordination such as medication adherence, cost-effective settings of care and HEDIS measure testing and compliance measures
			• Design and communicate incentives and other benefit designs that encourage members to have designated PCMH's serve as their primary care provider
				• At the heart of the PCMH are the patient and the primary care physician who serves as the key to better coordination of care and patient engagement.
				• For 2014, 98% of members in the 80/20 and 99% of members in the CDHP plans selected a primary care provider
				• Increasing the number of primary care providers that are PCMHs will increase the focus on quality of care indicators such as:
				  • Diabetes HbA1c testing rate is 12% below the national average
				  • Cholesterol LDL-C screening is 29% below the national average

	Engage Members with High Cost High Prevalence Chronic Conditions	Focused programs designed to engage members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes.	• Develop chronic care management programs focused on high volume and high cost conditions where there is opportunity to collaborate with providers to improve both quality of care and member engagement
			• Collaborate with other state entities and stakeholders, including the NC Department of Health and Human Services, on addressing how to improve these conditions across the state
				• Members with at least one chronic condition account for 76% of total cost of care (Non-Medicare)
				• Prevalence of high cost chronic conditions (for actives):
				  ○ Hypertension - 25%
				  ○ Asthma/COPD – 10%
				  ○ Diabetes – 9%
				  ○ CAD – 3%
				• In 2013, members with managed chronic conditions utilized $5,198 of services; members without chronic conditions utilized about $1,283. Members with unmanaged chronic conditions utilized $19,899 of services, almost 4 times the cost of members with managed conditions.

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
				• Medication adherence rates for diabetes is 66%, hypertension is 75% and high cholesterol is 66%
Manage the health of the population	Offer Health-Promoting and Value-Based Benefit Designs	Benefit designs that reduce barriers to care and are directed at sustaining long-term health and managing chronic disease and incent members to seek treatment from high quality, cost effective providers	• Offer benefit designs that provide no cost access for preventive care, encourage utilization of PCMHs and use of high quality primary care providers, encourage healthy behaviors and engage members. • Consider additional value-based benefit designs that offer quality and cost options around providers, treatments and medications • Incent members to make long-term healthy lifestyle choices maintenance and more effectively manage chronic disease	• Access to high quality care at cost effective settings helps sustain health and allow for management of chronic disease • When offered a premium credit, 84% of active members selecting the CDHP and 80/20 plan options completed a health assessment, chose a PCP and attested they did not smoke or were enrolled in a smoking cession program
	Promote Worksite Wellness	Any employment based activity or employer sponsored benefit aimed at promoting healthy behaviors (primary or secondary prevention). These are programs that require longer time horizons by which to measure results and impacts.	• Using the NC Health*Smart* program, partner with state agencies to influence environmental and workplace policies and tailor programs suited to the different strata of membership across the state • Develop programs and approaches that ensure the continuous engagement of members throughout the year	• Creating a culture of wellness requires the participation and support of the employer. • National data suggests that worksite wellness programs help employees feel more valued • 45% of employees say these programs encourage them to stay with their employer

Priority	Initiative	What It Means	What We Will Do	Why It Is Important

Improve member's experience	Create Comprehensive Communication & Marketing Plan	Providing members with materials they can understand to help them effectively utilize their health benefits. Communicating regularly, not just at open enrollment, to allow members the opportunity to maximize their experience and improve health literacy.	• Develop a comprehensive and continuous communication strategy, including print, email, web-based and mobile applications and media, regarding benefit plan options, how to get the most value out of the benefit programs and explain the value of the benefits that are offered, including:
			  ○ Improve member contact information
			  ○ Develop a branding campaign in coordination with the Department of State Treasurer
			  ○ Regularly meet with provider community to distinguish SHP services from BCBSNC services
			• Influence the perception of the value of SHP offerings
				• Health benefits are utilized throughout the year and therefore, regular benefits communications will assist members with benefit questions and managing their care.
				• There are opportunities to use online communication channels as less than 1% of members access Health*Smart* resources online.
				• Over 80% of retired members prefer written materials while active members prefer online communications. This demonstrates the need for a variety of communication channels.

	Improve the Member Enrollment Experience	Members are able to enroll in the benefits they choose and their premium credits are accurately reflected. Enrollment tools meet current technology standards. Streamline customer service calls and online access	• Develop a consistent and stable platform for member's enrollment experience • Provide a superior customer service call center to provide members with timely and accurate enrollment and benefit information • Ensure that enrollment data is accurately and timely collected, maintained and transmitted • Where possible, provide single sign-on from the originating secure site to other sites to eliminate the need for multiple passwords and user IDs.	• Enrollment is the gateway to the provision of benefits and it is imperative that the member's enrollment experience is as simple as possible and that enrollment information is accurately captured, displayed and transmitted to ensure access to appropriate benefits and to improve the trust of members. • Having multiple contact numbers and login IDs can be a barrier to access and timeliness of service. • Improving member experience can enable increased engagement.
	Promote Health Literacy	Provide access to tools and resources designed to assist members in understanding costs, treatment and provider options to support members in communicating with their provider and engaging in their health care decisions.	• Develop and market tools and resources, particularly web-based and mobile applications that provide cost and quality transparency metrics and assist members in making informed choices on treatment options, cost, provider selections, and site of service.	• Providing tools to access high quality, site appropriate, and low cost care encourages improved health outcomes, raises member satisfaction, and reduces Plan cost growth • Only 0.2% of members access the provider portal, which houses the current transparency tools. • Web-based and mobile platforms improve accessibility to information

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Ensure a financially stable State Health Plan	Target Hospital and Specialist Medical Expense	The management of specific categories/ treatments of care that exceed the Plan forecast and/or medical expense trends. The management of member out-of-pocket costs in high cost services and care settings such as hospitalizations and specialized medical care. The management of fraud, waste, abuse and overuse of medical services.	• Develop and implement targeted programs or benefit designs that specifically address the following: ○ Appropriate use of emergency rooms and urgent care centers ○ Avoidable inpatient admissions, readmissions, duplicative care ○ Use, costs and/or site of service for specialty medical services ○ Implement targeted programs focused on reducing fraud, waste, abuse and overuse of medical services.	• Hospital inpatient costs averaged $3,266 per day in 2013 and represented $612 million in spending (17.5% of total). • The average cost of a hospital stay for Plan members was $15,553 in 2013 • Emergency room costs represent another $146 million in medical costs (4.2%).
	Target Pharmacy Expense	The management of specialty medications across medical and pharmacy spend as well as fraud, waste, abuse and overuse of pharmaceuticals	• Implement targeted programs or benefit designs that manage the cost, use, and/or site of service of specialty medications. • Implement targeted programs focused on reducing fraud, waste, abuse and overuse of pharmaceuticals.	• Pharmacy costs are 29% of total plan medical costs • 2.6% of non-Medicare membership uses specialty medications under the medical benefit which accounts for 6.7% of total plan (non-Medicare) medical payments • Medical specialty pharmacy trend is 11.3% • <2 % of members use specialty medications under the pharmacy benefit which accounts for 22% of plan pharmacy cost. This is projected to be 50% by 2018. • Specialty pharmacy (pharmacy benefit) trend is currently 16%.
	Pursue Alternative Payment Models	Shift away from the current pay for volume approach in health care to paying for outcomes based on evidence based metrics. Utilize the spectrum of alternative payment strategies, ranging from PCMH to pure capitation, to more efficiently compensate providers to provide care in the most effective setting. Take a long-term, prospective view to improve member health to manage cost growth versus only short-term price reductions	• Partner with current and future third party administrators (TPAs)/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in North Carolina • Partner with other payers, where appropriate, to implement consistent approaches to alternative payment strategies throughout North Carolina • Engage with providers who are able to work directly with the Plan on value based payments and metrics	• Moving away from pure fee for service provides an incentive to focus on better coordination and effective care • 15.6% of hospital admissions had a readmit within 30 days • Average inpatient cost per day has increased by 4.4% over the past year

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STRATEGIC MEASURES OF SUCCESS

EXAMPLE FOR DISCUSSION PURPOSES ONLY

Measure	Manage the health of the population	Improve member's experience[1]	Ensure a financially stable State Health Plan
Description	Measure the % of members that are classified as healthy or having experienced a significant acute encounter	Utilize a variety of survey tools and feedback sources to evaluate the impact of specific initiatives	Meet or exceed annual financial forecasts
Metric	Average of 48% over the measurement timeframe	Varies by Initiative	Medical expense trend forecast and cash balance
Baseline Year[2]	2013	Varies by Initiative	2014
Measurement Timeframe[2]	2014 – 20xx	Varies by Initiative	Each Calendar Year and Each Fiscal Year
Measurement Source	Clinical Risk Grouping (CRG) classification using a 3rd party vendor	Varies by Initiative	3rd party developed annual forecast

1 SHP Executive Committee and Board of Trustees will establish appropriate evaluation criteria based on the timing and details of specific member experience initiatives

2 All years are based on the calendar year ending in December, unless specifically noted as fiscal year

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HIGH-LEVEL ROADMAP

FRAMEWORK TO BE DETERMINED

	2014-2015	2016-2017	2018-2019	2020-2021
Benefit Offerings & Programs				
Program Administration & Contracting				
Provider Network				
Provider Payment Methods				
General Assembly Engagement				
Member Communication				