North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Provider Engagement Initiatives

Board of Trustees Meeting

January 23, 2015

Overview

- Purpose of Provider Engagement
- Provider Engagement through Vendor Partners
- Provider Engagement Strategies
  - PCMH Pilot
  - Wellness Wins Pilot (Jones, Greene, Lenoir Counties)
  - Advanced Primary Care Practice Demonstration
  - Wake Key Community Care-ACO Initiative

The Purpose of Provider Engagement

Provider Engagement through Vendor Partners

- Third Party Administrator (TPA) – Blue Cross Blue Shield of NC (BCBSNC)
  - Network of providers
  - Claims processing
  - Utilization management (UM)

- Population Health Management Vendor – Active Health Management (AHM)
    - Provider care considerations and alerts

Provider Engagement Strategies

- Patient Centered Medical Home (PCMH) Pilot - Novant Health Systems, Eagle Physicians & Associates, New Hanover Medical Group and CaroMont Medical Group

- Provider engagement arm of the pilot initiative in Greene, Jones, and Lenoir counties-“Wellness Wins”

- Advanced Primary Care Practice Demonstration with Community Care of North Carolina (7 rural communities)

- Leveraging Third Party Administrator Relationships with Accountable Care Organizations-Wake Key Community Care (WKCC)

Patient Center Medical Home Pilot with Active Health Management

PCMH Pilot with Active Health Management

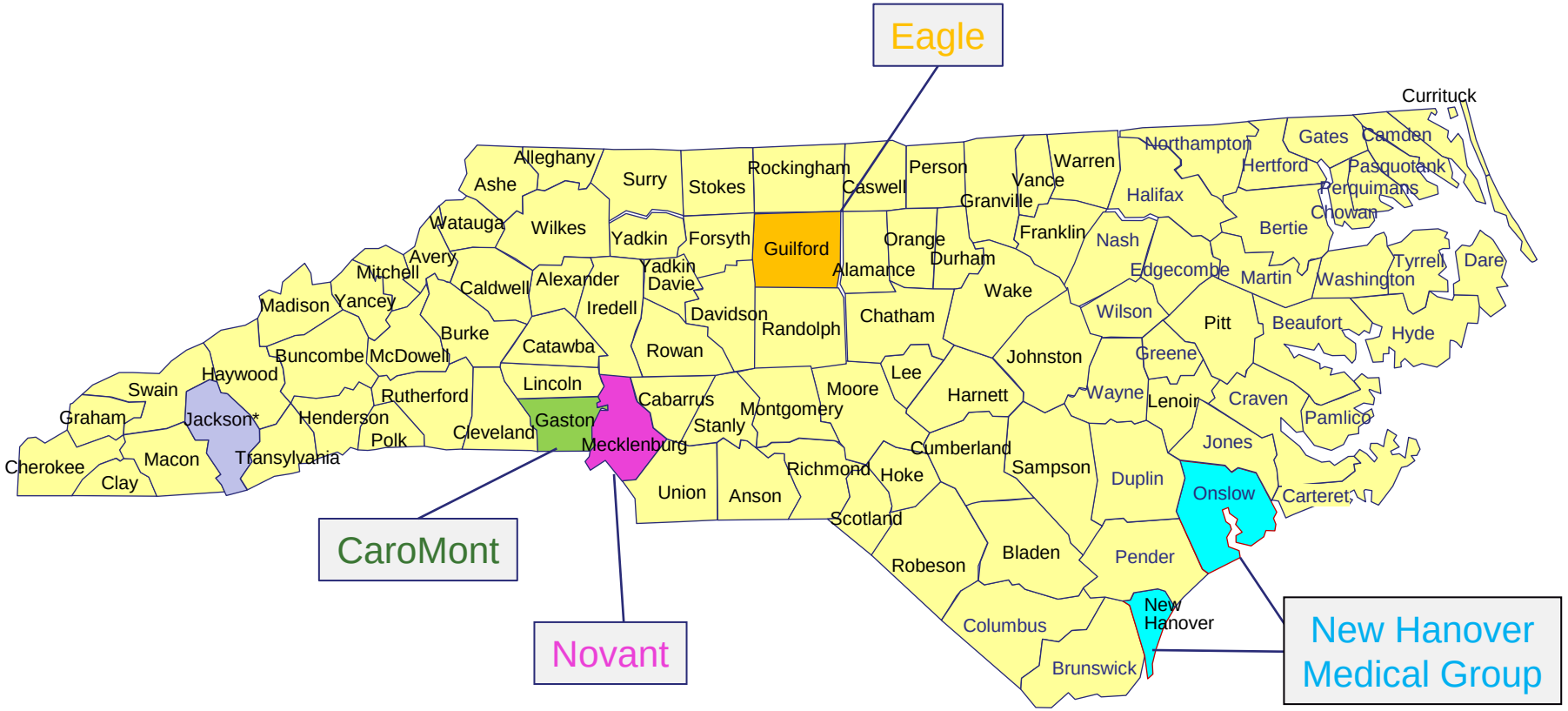
Objective: Engage physicians in the care of Plan members through *alternate payment strategy* as well as *data driven, coordinated supports* to achieve better health outcomes and to improve the member's and the provider's experience in a complex health care environment.

- Testing the model for the following:
  - Alternate payment strategy
  - Effective communication
  - Evolving role of the population health management vendor
  - Optimum utilization and sharing of data
  - Defining and measuring quality of care
  - Determining "total cost of care" in shared risks and savings

Practice Participation

Practice Group	Number of SHP Members
Eagle Physicians & Associates	4,532
Novant Health Systems	6,066
CaroMont Medical Group	1,410
New Hanover Medical Group	1,499
Totals	**13,507**

PCMH Pilot Practices and Locations



- Sylva Medical Practice in Jackson County
- Novant practices in Forsyth county are also being considered for the pilot

PCMH Overview

- Two-year pilot initiative for 2015-2016
- The State Health Plan will provide a per member per month (PMPM) payment on a quarterly basis based on attributed Plan members
- The PMPM will depend on a tier structure
  - Initial ‘onboarding’ tier determined by an objective scoring and assessment tool
  - Each practice will enter the model at a tier and will stay on that tier for a 12 month period
  - The practice may move up a tier or down depending on their achievement of targets in Year 1
  - Five to seven core quality metrics to be chosen for all practices
  - Five additional metrics to be selected in alignment with practice initiatives

PCMH Overview

- Quality metrics will be based on claims data as well as practice level EMR information (to be provided by the practice)
- Chosen quality metrics will be monitored quarterly by AHM and the Plan
- Targets are set based on baseline for each individual practice
- Active Health Management's role will vary with each practice depending on the tier of participation
- Practices will refer members who need disease management and other supports to AHM/SHP resources

Onboarding Tiers and Payment Strategy

Tier 1

$1.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

Tier 2

$2.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

- Internal QI process including QI committee
- Other PCMH relationships w/payers
- NCQA recognition minimum Level 1 PCMH recognition
- Historical performance on quality metrics meets or exceeds 50th - 75th percentile of regional performance (HSA regions)

Onboarding Tiers and Payment Strategy

Tier 3 — $3.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

- Internal QI process including QI committee
- Other PCMH relationships with payers
- NCQA recognition minimum Level 1 PCMH recognition
- Historical performance on quality metrics meets or exceed 50th - 75th percentile of regional performance (HSA regions)

- Current partnerships with specialists and/or hospitals
- Has internal care coordination supports or is willing to hire a Care Coordinator
- Patient communication and engagement tools available

Tier 4 — $4.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

- Internal QI process including QI committee
- Other PCMH relationships with payers
- NCQA recognition minimum Level 1 PCMH recognition
- Historical performance on quality metrics meets or exceed 50th - 75th percentile of regional performance (HSA regions)

- Current partnerships with specialists and/or hospitals
- Has internal care coordination supports or is willing to hire a Care Coordinator
- Patient communication and engagement tools available

- Member and provider satisfaction data available (12 month period)

Quality Improvement and Tier Movement (12 months)

Tier 1

$1.50 pmpm

- Contract signed and onboarding Tier 1 requirements met
- Over the next 12 months, meet targets on 70% of all decided upon quality metrics

Tier 2

$2.50 pmpm

- Contract signed and onboarding Tier 2 requirements met
- Over next 12 months meet target on 80% of all selected quality metrics
- Achieve 50% 'engagement' with members

Quality Improvement and Tier Movement (12 months)

Tier 3

$3.50 pmpm

- Contract signed and onboarding Tier 3 requirements met
- Over the next 12 months, meet target on 90% of all decided upon quality metrics and achieve 65% engagement with members

- Practice provides care coordination
- Practice can identify and target members for population health management based on clinical data available
- Practice provides analytics and reporting from EMR
- Increase to a minimum of NCQA Level 2

Tier 4

$4.50 pmpm

- Contract signed and onboarding Tier 4 requirements met
- Over the next 12 months, meet target on 100% of all decided upon quality metrics and achieve 85% engagement with members

- Practice provides care coordination
- Practice can identify and target members for population health management based on clinical data available
- Practice provides analytics and reporting from EMR
- Increase to a minimum of NCQA Level 3

- Member satisfaction is $\geq$ 90%
- Provider satisfaction is $\geq$ 90% (previous12 month period)

Core Quality Metrics

Clinical Measures

Diabetes Composite Measure

1. Members with diabetes meeting all 5 criteria below
    a. HBA1c test 2 per year
    b. LDL 1 per year
    c. Blood pressure every visit
    d. Tobacco assessment and referral
    e. Aspirin therapy

Asthma Management

1. Members with Persistent Asthma on ICS

Utilization Measures

1. Rate of ED visits per 1000
2. Rate of inpatient avoidable hospitalizations
3. Rate of all cause readmissions
4. Radiology costs/member per year

Optional Metrics (Examples)

1. Preventive Health

a. Influenza vaccine
b. Pneumococcal vaccine
c. Tobacco screening and intervention
d. Annual adult physical or preventive care visit
e. Adolescent well-care visit in last 12 months
f. Age appropriate cancer screenings
g. Mammogram
h. Colorectal cancer screening
i. Depression screening

2. Clinical Measures

a. CAD composite, persons with CAD meeting criteria below
Drug therapy for lowering LDL cholesterol
Ace inhibitor or ARB therapy for patients with CAD, diabetes or LVSD

b. Heart failure
Beta blocker therapy for LVSD

c. Hypertension
Members with hypertension whose BP is under control (140/90)

d. Diabetes
Members with diabetes whose HBA1c is under control (HBa1c< 8%)

Pharmacy

Adherence to preferred drugs
Patients with multiple comorbidities receiving medication reconciliation

Behavioral Health

Screening for depression

PCMH Pilot Status

Pilot is on target for implementation April 1, 2015

Current Activities

- Practices are reviewing draft contracts
- Review assessment tools from practices and assign to Tier Level

Next Steps

- Develop contract agreements with practices
- Select quality clinical metrics and targets jointly with practices
- Develop practice workflows and data exchange processes
- Develop reporting mechanism and frequency

‘Wellness Wins’ Pilot: Provider Engagement

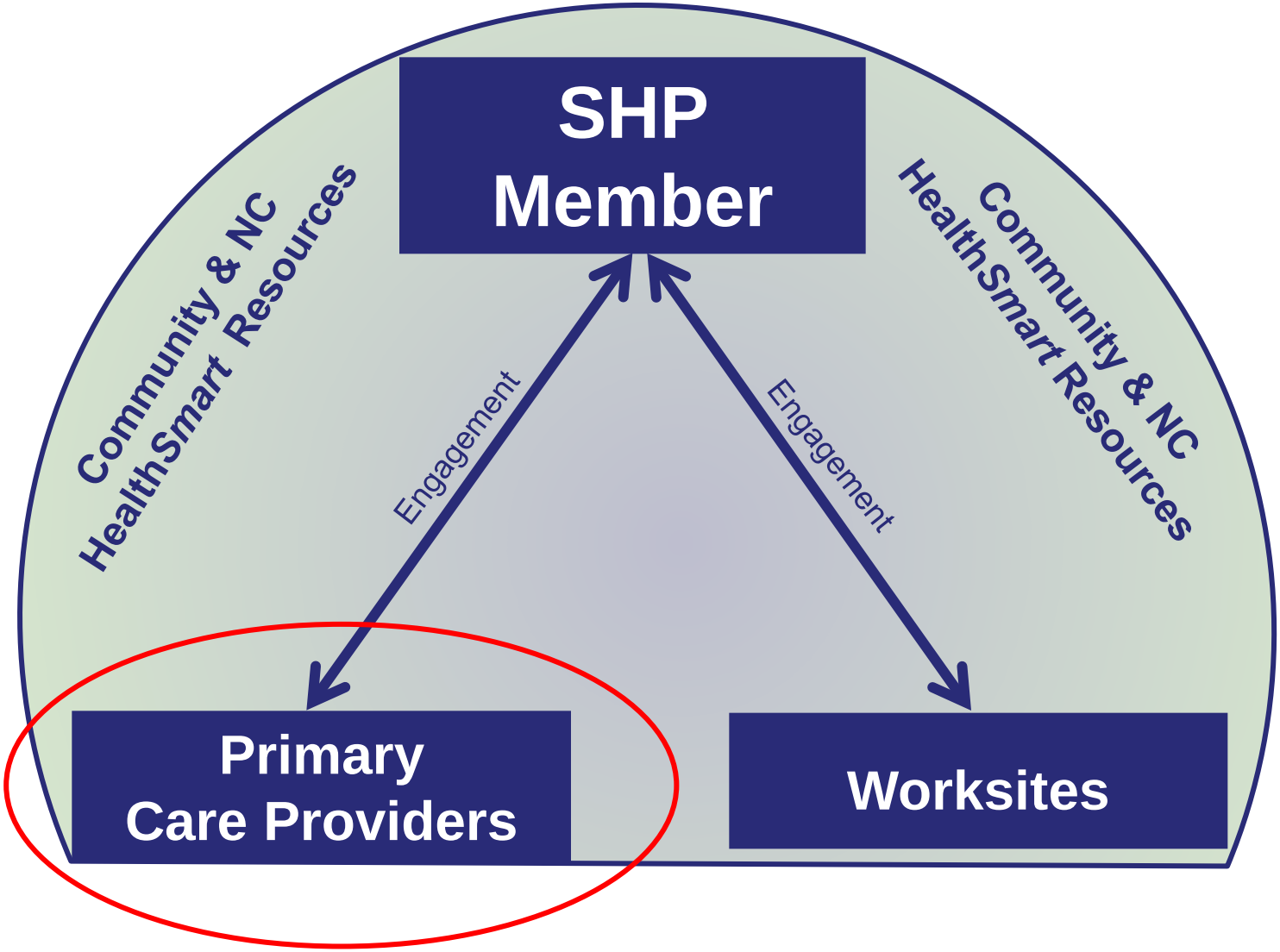
Wellness Wins Pilot Initiative: Overview

The Integrated Health Management (IHM) team proposes a two-year targeted pilot initiative for three eastern counties, utilizing a multipronged approach.

- Engage and support providers in delivering a higher level of care to our members
- Develop and strengthen wellness networks and worksite wellness initiatives
- Connect local leadership and resources to worksites
- Engage and empower members in their health care

Target counties: **Greene, Jones, and Lenoir** (Eastern NC)

Wellness Wins Pilot: Provider Engagement



Wellness Wins: Provider Engagement

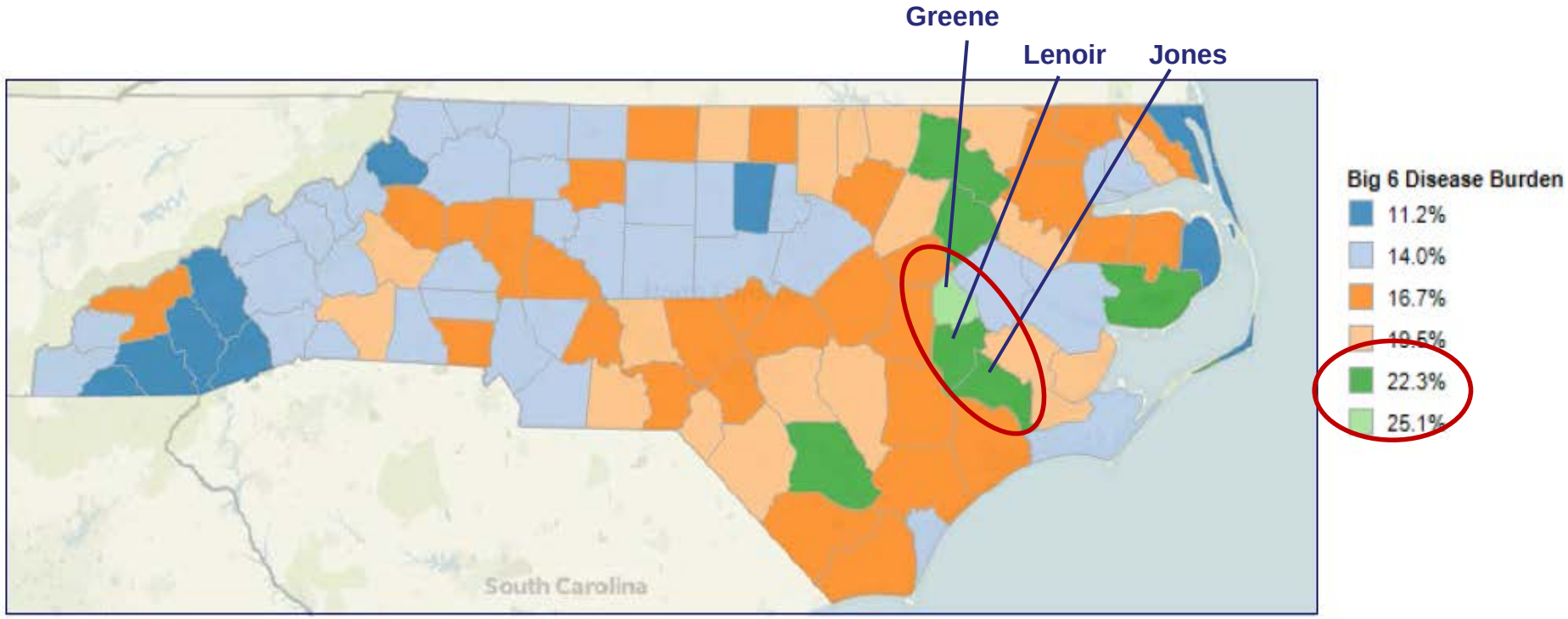
Objectives:

- Engage with local providers to deliver optimal care to Plan members
- Begin the conversation between the Plan and providers on how we can work together to meet common goals
- Practice supports to deliver optimal care to their patients
  - Practice management support
  - Care coordination
  - Referrals to NCHealth*Smart* resources

Wellness Wins: Greene, Jones, and Lenoir

Major Chronic Conditions

Disease Burden = Prevalence x Severity



Active Health Management, Heat Maps, 2014

Wellness Wins: Provider Support and Engagement Strategies

- Provider forum to understand practice needs
- “Hands on” quality improvement coaching and technical support to develop data driven improvements in clinic workflows, quality of care, and member experiences
- Care coordination and member engagement supports
- Collaborative networking and stakeholder meetings
- Continuing medical education opportunities:
  - Clinical updates for chronic disease management
  - Quality improvement tools and processes
  - Population health management

Wellness Wins: Provider Engagement Update

- Completed initial contact and conversations with the following:
  - Alber Arrigo-Delia, Director of Health Access, ECU
  - Lorrie Basnight, Pediatrician, Eastern AHEC
  - Skip Cummings, Pharmacy Dean, ECU
  - Jacqueline Halladay, MD, Professor of Medicine, UNC Chapel Hill
  - Angel Moore, QI Director, Eastern AHEC; ECU
  - Joan Templeton-Perry, Pediatrician
  - Greg Griggs, Executive VP, NC Academy of Family Physicians

Next Steps

- Conduct meetings with other community stakeholders and providers by February 2015

Advanced Primary Care Practice Demonstration

Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)

Objective: Federal demonstration project to evaluate outcomes using a PCMH model to deliver medical care to Medicare and commercial members between January 2013 to December 2014.

- Involves 7 rural counties and 47 Primary Care Practices
- Payer Participants: NC Medicaid, BCBSNC, NC SHP
- Community Care of NC (CCNC) Strategies**:**
  - Care managers embedded in each participating practice
    - Identified gaps in care
    - Worked with practice and members to close gaps
    - Practice supports provided by CCNC to achieve NCQA certification
    - Enhanced payment to providers

Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP) Outcomes

Timeframe: January 1 - June 30, 2014

Provider and Member Engagement

- Average 10,000-12,000 SHP members reached monthly
- 775 members engaged in care management
- 48 members received Transition Of Care (TOC) services when indicated within 30 days of hospital discharge
- 48 members received medication reconciliation services
- 100% of participating practices achieved National Committee for Quality Assurance (NCQA) Patient Centered Medical Home and Blue Quality Physician Program (BQPP) recognition

Health Outcomes (Baseline, July-December 2013)

- Decrease in Non-Emergent Emergency Room (ER) visits
- No change in total ER visits
- No change in breast cancer screening
- HbA1C testing compliance rate 76%*
- Lipid testing compliance rate 72%*

*Claims & EMR data. Comparison data unavailable.

Advanced Primary Care Practice Demonstration Outcomes (APCP)

- The Federal demonstration (MAPCP) ended in North Carolina as of December 2014.

- The Plan has decided to continue the initiative with CCNC for the 7 counties as the *Advanced Primary Care Practice Demonstration*.

Next Steps

- Contract with CCNC to continue model for 2015
- Does not include enhanced payment or PCMH recognition support
- Analyze and review outcomes from MAPCP efforts, 2014